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The Rehabilitation Paradox

BY BRUCE WESTERN

A new study reveals the struggles of prisoners who want to turn their lives around, but are too mentally and physically troubled to do so.

ILLUSTRATION BY TOMI UM

A man is a twenty-three-year-old man with schizophrenia. As a child, he moved to Boston from the Caribbean, settling with his mother in the predominantly African-American section of Dorchester. During his teen-age years, he got into gang fights and was stabbed three different times. In his junior year, he dropped out of high school and lived in homeless shelters. He was arrested twice for drug possession, and, at seventeen, he was caught with a sawed-off shotgun and sentenced to eighteen months, the mandatory minimum.

Because of his schizophrenia, which first emerged during his incarceration, Aman was transferred from jail to Bridgewater State Hospital, a facility for psychiatric patients with violent tendencies. The conditions at Bridgewater were isolating and harsh, but Aman received antipsychotic drugs that helped regulate his brain function. In 2012, he was released to a secure psychiatric ward at a Boston hospital. His medication had a sedative effect, and he moved slowly down the corridors, speaking just above a whisper. He received a new diagnosis—paranoia—and got into a fight. When Aman's mother visited they talked about his future, and about the importance of finishing high school, while she braided his hair.

I first met Aman in his mother's apartment, in Dorchester, where he had moved after leaving the hospital. I was there as part of the Boston Reentry Study (https://www.hks.harvard.edu/programs/criminaljustice/research-publications/incarceration-socialcontext-consequences/boston-reentry-study), a project I began, in 2012, with researchers at Harvard, where I am a sociologist studying poverty and incarceration. We

followed a hundred and twenty-two people as they travelled from state prison back into their communities, interviewing them five times over the course of a year. Our subjects were in prison for everything from probation violations to homicides. We wanted to learn how they reconnected with their families and secured housing and jobs—and to find out why, in some cases, they returned to jail.

Politicians from both parties agree that the U.S. prison population must be reduced. Many, including President Obama, have called for more lenient treatment of "nonviolent drug offenders." But drug convictions account for only fifteen per cent of the prison population. In fact, just over half of all prisoners (http://www.bjs.gov/content/pub/pdf/p14.pdf) are serving time for violent offenses. Big reductions in prison populations, therefore, will require basic changes in how we respond to violent crimes.

It's well known that people who go to prison are much more likely to have problems with addiction, mental illness, and physical disability. Even so, it's easy to underestimate how vulnerable some of them are. About a third of the hundred and twenty-two prisoners we interviewed reported no mental or physical problems. But, of the two-thirds who did have histories of mental illness or addiction, half also reported serious back pain, arthritis, or some other chronic condition. In other words, around half of the prisoners we met were, like Aman, extremely vulnerable.

A year after Aman left Bridgewater, he still hadn't found a job. He and his mother talked about the future every day, but he still depended on public assistance and her financial support. He had stopped taking his medication, but his speech remained slow and circuitous. When I asked Aman why he was willing to talk to me, he said, "I just want friends like yourselves to come by." He explained that he had stayed out of prison because he wanted more out of life. His biggest challenge was "wanting progression . . . wanting things to happen, to be complete, wanting over-all respect as a young man who is slow. . . . Stuff like that. That intimacy, that belonging." Unfortunately, the likelihood of progress for Aman is remote. The challenges he faces may be too great.

It's no surprise that physical and mental problems go together. Addicts often struggle with issues like chronic pain or manifestations of post-traumatic stress; physical ailments can feed depression and other emotional problems. Those who study poverty and inequality often point to the poor schooling and bad work histories of disadvantaged people. But disadvantage can run much deeper than educational failure and unemployment. In many cases, it has a physical reality that limits a person's capacity to think clearly, without pain, and to bring energy to daily affairs. Sometimes, a feedback loop takes hold. People with physical- and mental-health problems spend disproportionate time in community health clinics and other institutions for the vulnerable and poor; such places can both help and hurt them. During Aman's time at Bridgewater, for example, he received treatment for his schizophrenia but was also assaulted by another inmate.

Over the course of the Boston Reentry Study, my team and I wrestled with the problem of how to describe the vulnerability of people like Aman. Ultimately, we settled on "human frailty," borrowing a term from demographers who study patterns of death across the population. More ambiguous alternatives, like "vulnerability," could describe the condition of a healthy person who finds him or herself in an unhealthy situation. "Human frailty," by contrast, inheres within an individual's mind and body. It persists even when your environment changes.

Among the people we interviewed, mental and physical frailty were startlingly common. In many cases, those frailties derailed their efforts to become better parents, children, neighbors, and citizens. Take another of our survey participants, Carla, who, like Aman, got into fights at school. At home, her mother, a Cape Verdean immigrant, used physical punishment to keep her in line; at fourteen, Carla ran away and was charged with possession of marijuana and assault and battery. Carla began committing robberies and using heroin and cocaine. She told me about living with "drug friends" and making money by "hustling, selling drugs, and doing dates."

A drug charge sent Carla to M.C.I. Framingham, the Massachusetts women's prison. She got into fights there, too, but she also saw a doctor and a dentist, received counselling, and spent time in a detox program. A number of her ailments, such as Hepatitis C, arthritis in her hands, a heart condition, and back pain—the result of an

assault—were all monitored or medicated. During the year after her release from Framingham, Carla remained largely drug-free. She attended an addiction-recovery program, a course on religion at the University of Massachusetts, and a G.E.D. class. She spoke enthusiastically about her women's-literature reading list, and received the "client of the week" award in her recovery program. She embraced the project of self-improvement.

As time passed, however, Carla began to talk more frequently about her health problems and physical disabilities. Many of the physical problems she had described in prison grew worse. Her hands became swollen and painful, despite treatment with arthritis medication, and her back pain limited her mobility. A year after her release, Carla was wearing a back brace and moving gingerly around her house. Her disability prevented her from working, chronic pain dulled her mood, and she was diagnosed with depression and bipolar disorder. In past interviews, we'd noticed her mood swing from bright and optimistic to tearful and regretful; now her sister told us that there was a family history of depression, and that other family members had struggled with explosive moods, alcoholism, and heroin use.

Carla's story shows how it can be hard to separate cause from effect in the lives of people involved in violence. Carla had sought relief from mental illness in drugs; later, the physical aftereffects of that drug abuse (arthritis is a common side effect of heroin use) plunged her into depression. The fact that mental illness, drug use, and physical disability so often reinforce one another challenges how we think about the capacities of people who go to prison. Carla had the will to change until that will was compromised by the ongoing consequences of the difficulties that placed her at risk of incarceration in the first place.

One lesson we can learn from frail prisoners like Aman and Carla is that life is a one-way street. Rehabilitative programs are often too little, too late; we need to intercede early. In talking about their lives, our respondents often recalled schools that were unable to respond to serious behavioral or learning problems except through suspension or expulsion. They described how their slides into heroin or crack addiction led straight into the criminal-justice system, rather than into an addiction program. They described using marijuana or heroin to

ameliorate chronic mental or physical pain that had gone untreated for years. Our social safety net focusses most of its limited resources on poor mothers, their children, and the elderly; unattached adults often slip through it. It's only after untreated addiction and mental illness lead to arrests and incarceration that they get help. By investing more in drug treatment, health care, and housing programs, we could offer a basic level of material and bodily security for people with broken minds and bodies who must try and adjust to life after prison.

A realistic public policy, moreover, needs to recognize that stable housing, employment, and a functional family life may be out of reach for the most fundamentally disadvantaged. In these cases, human dignity can at least be respected by enabling the effort to struggle for it. This means, sometimes, providing a place to stay, a transitional job, and support for families even when the outcome is uncertain. In these cases, the struggle itself is intrinsically meaningful. It is meaningful for clients who might envision a better future. It is also meaningful for society as a whole to do something more than abandon the least capable among us. This is difficult ground for our criminal-justice system. From the perspective of human frailty, a program that barely reduces recidivism may still succeed in the formidable challenge of treating with decency people convicted of violence who have struggled all their lives with mental illness, addiction, and disability.

If we're really going to reduce our prison populations, we will have to acknowledge that human frailty under conditions of poverty puts people at risk of becoming, simultaneously, the perpetrators and victims of violence. This is challenging for a justice system designed to assess guilt or innocence and mete out punishment. In the past, we saw violence as an assault of the strong on the weak, and we punished it. Now we need to heal the frailty from which it springs.

Watch: At a prison outside Detroit, ten men serving life sentences for murder gather each week to write and discuss poetry.

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