

Improving Public Safety by Positively Changing Lives

Reentry Systems

Fact Sheet | October 2025



FY25 HIGHLIGHTS

2389

Individuals referred for Navigation Services

1873

Individuals who received assistance with an Individual Reentry Plan

1137

Individuals who received assistance with a Release Needs Survey

1077

Reentry Team Meetings conducted

72

Participants attending Reentry Planning Workshop Pilot



Program Overview

The Reentry Systems Unit within the Reentry Division plays a vital role in fulfilling the department's mission and strategic plan by directly supporting the Governor's Executive Order 24-03 Building Safe and Strong Communities Through Successful Reentry, Washington's commitment to Reentry 2030, and in accordance with RCW 72.09.270 concerning Individual Reentry Plans.

The Reentry Navigator team consists of 25 committed staff who provide services statewide. This includes two Cultural Specialist Navigators who work with releasing Veteran and Native American/Alaskan Native populations. Our work ensures that reentry is not just a process, it's a pathway to stability, opportunity, and reduced recidivism.

Reentry Navigation

The Reentry Navigators for the Reentry Division works closely with various navigators throughout the state including college/education navigators, workforce navigators, health services navigators (psychiatric social workers and medication-assisted treatment navigators), housing specialists, and community partners. In addition, the Reentry Navigators receive requests for assistance from classification counselors, various community stakeholders, and DOC leadership to support individuals in their reentry planning efforts.

Primary services include assisting individuals in identifying strengths by completing their individual reentry plan, essential needs planning to prepare for their transition to the community, and resource navigation. Additionally, services include helping transitioning individuals and corrections staff to navigate through numerous supportive services being offered and addressing potential barriers to transition.

The primary focus of Reentry Navigators is connecting individuals to essential needs and support services, which may include food, clothing, phones, healthcare, wellness, supportive housing with pathways to permanent housing, identification, education, vocational training, job search assistance, financial benefits, and support. In addition to these services, Navigators collaborate with community partners and stakeholders to create a more efficient handoff process to ensure a smooth transition to community-based providers. They also follow up with individuals in the community to assess their progress toward meeting their goals, identify barriers, and address those challenges.

In 2025, Reentry Navigators served 68 intensive management unit (IMU) direct release participants, 157 Indeterminant sentence review board (ISRB) participants, 13 Community Parenting Alternative participants, 650 Graduated Reentry Participants, 514 Reentry Center participants, and 290 other referrals. Cultural Specialist Navigators served 293 participants, with 132 veterans and 161 Alaskan Native/ American Indian.

Integrated Reentry Model

The department utilizes an integrated reentry model that focuses on individual needs, collaborates across divisions, and leverages connections to state, local, and community-based resources to assist with transition and help individuals in the community.

This model includes three phases:

- Facility Phase begins at reception with continuous case planning, orientation, evidence-based programs and treatment, education, and employment readiness as identified in the Washington State risk assessment tool which assesses the individual's criminogenic risks and programmatic needs. In addition, the Individual Reentry Plan guides the individual through setting individualized SMART goals to prepare for their reentry based on the goals they identify.
- Transition Phase begins at the time the individual is approaching transfer to partial confinement or release to the community. The transition phase includes updating the Individual Reentry Plan, essential needs planning, health and wellness transition, short-term housing assistance, community navigator connection, continuity of care transition planning, identification, and connections to resources.
- Community Phase begins at the time the individual is stable in the community and includes pro-social supports, long-term housing, health and wellness, financial stability, long-term employment, and educational pathways.



Why Our Work Matters

Being prepared for release changes outcomes. Individuals who participate in structured IRP workshops and have access to coordinated resources are more likely to secure housing, obtain employment, and maintain stability in the community. When we follow up post-release, we not only address immediate needs—we also reinforce long-term success by helping people stay connected to support and opportunities.



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