MENTAL HEALTH AND RECIDIVISM

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By
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CERTIFICATION OF APPROVAL

MENTAL HEALTH AND RECIDIVISM

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DEDICATION

This thesis is dedicated to the most important people in my life. Without you, I would not have been able to accomplish this. This is ours.

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I would like to acknowledge all of the participants in this study. Without your consent and participation, I would not have been able to complete this thesis.

To my thesis chair, Dr. John Garcia, thank you for always being there for me through this process, making it as smooth as you have. Your attentiveness, patience and guidance is refreshing and much appreciated.

To the outpatient mental health agency used in this study. Thank you for allowing me to present my thesis and assisting me with referring participants and trusting me to maintain the values and ethics of the agency. I am grateful for the opportunity.

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ABSTRACT

This study explores the perceptions and experiences of individuals with a history of incarceration and mental illness who are engaged in outpatient mental health services. This study specifically explores perceptions on what each participant feels was most helpful in maintaining stabilization in the community, what may have contributed to their barriers or re incarceration, and how they feel about the services they have received and continue to receive. Eight male participants were surveyed using in person semi-structured interviews for this qualitative exploratory study. The findings indicated that the participants agree the most helpful to maintaining placement in the community would be having a support system, engaging in services, and self-motivation. Barriers identified include alcohol and substance abuse, bureaucracy of services, and lack of employment opportunity leading to low finances and homelessness. Most of the participants had overall positive responses to the services that they have been involved with. Additionally, findings are meant to aid in the alteration of services to help reduce recidivism in the mental health community.

CHAPTER I

INTRODUCTION

Statement of Problem

Many individuals incarcerated in jail or prison suffer from mental illness. According to Varney (2014), in state prisons, 73 percent of women and 55 percent of men have at least one mental health issue; in federal prisons, 61 percent of women and 44 percent of men struggle with mental illness, and in local jails, 75 percent of women and 63 percent of men have mental health issues (Varney, 2014). Although there are plans in place to reduce high levels of recidivism for individuals with mental health issues into the criminal justice system, a failure to provide sufficient support and evidence-based treatment models contribute to the revolving door. Prison can also exacerbate symptoms of those with mental health issues due to conditions of the prison environment, such as having experiences related to violence and isolation (Metzner, Jeffrey, & Fellner, 2010). Unfortunately, parole and probation are not specifically aimed for rehabilitation. Alternatives for those with mental health issues include mandated mental health court and intensive outpatient community-based services. Details on effectiveness of these programs are limited. Although there has been an increase in the use of diversion programs and outpatient community-based support, many individuals are still returning to locked settings.

The possibility of reoffending for those with severe mental illness is higher than it is for those without a mental health diagnosis. A summary of 27 studies

reported that among prisoners who were released, those with a psychotic disorder had a 60% higher rate at reoffending than those without a mental disorder (Torrey et al., 2017). In 2013, a report completed by the Center for Evidenced- Based Corrections at UC Irvine indicated that mentally ill prisoners were approximately two times more likely to be re-arrested within one year of release as opposed to those who did not present with mental health issues. In that same report, it was found that chances of re-incarceration was approximately two times greater (Torrey et al., 2017). Deinstitutionalization is considered a contributing factor to these numbers. It was a policy based on the principle that mental illness should be treated in the least restrictive environment. The movement of mentally ill persons from state-based psychiatric facilities into the community was meant to be a plan of assisting those with achieving self-determination, dignity and worth, and autonomy (Torrey, 1997). Those who were in these settings were released from state hospitals, acute psychiatric facilities, and other mental health institutions into community-based programs. Nevertheless, those who were being discharged were not ensured to have sufficient services essential for them to remain successful and maintain placement in the community (Torrey, 1997).

Although the aim was to provide supportive outpatient services, there was limited preparation and resources including financial support and adequate structures of the programs. Essentially, those who suffer from mental health issues are not receiving adequate services and treatment (Douglas, 2013). They are without guidance and support in the community, which makes them vulnerable and

susceptible to committing crimes due to impaired cognitive ability and a host of other environmental conditions including unstable housing, limited employment options, and a fractured support system (Douglas 2013).

Efforts are being put in place to address the concerns around inadequate services and treatment for individuals with mental health issues who have been incarcerated. Mental Health Court is a nationwide alternative for those with mental health issues to participate in a community-based program as opposed to being incarcerated. The main goals of Mental Health Court include reducing criminal recidivism, improving quality of life for those involved, and engage in treatment in order to maintain placement in the community (Almquist & Dodd, 2009). A study by Burns (2013) was done to add to research to see if Mental Health Court is a solution to the issue of persons with mental illness being arrested and incarcerated. This particular study followed participants two years after the completion of mental health court. This specific study showed that about 75% of the graduates were not re-arrested. According to Burns, these findings are more positive than 2 previous studies that showed higher rates. In comparison, another study (Linhorst, Kondrat, & Dirks-Linhorst, 2015), utilized a sample of 811 participants in mental health court and found that 23.2% were rearrested during court supervision. This study showed that graduates had lower recidivism than those who did not complete mental health court, although each had a quarter who were rearrested. There were no data to show what participants felt about their experiences participating in services and what they felt contributed to their arrests.

Another study was completed to explore the effectiveness of providing a psychological intervention at reducing the risk of recidivism of offenders with mental illness. A GSIR scale (General Statistical Information on Recidivism) was used and is a predictive tool to determine an offender's risk for reoffending once out in the community. Among the findings of this study, individual therapy played an imperative role in reducing recidivism. Participants who received more than 20 hours of individual therapy were 12 times less likely to reoffend. The GSIR also discovered that moderate doses of treatment showed that participants were 7.7 times less likely to reoffend, and high doses of treatment revealed that participants were 11.6 times less likely to reoffend in comparison to those who received no treatment or only completed an assessment for treatment (Abracen, Gallo, Looman, & Goodwill, 2016). This study did not provide input from the individuals who participated in the therapy sessions to determine their take on effectiveness.

One study was completed to discover what individuals who had a mental health diagnosis felt were their reasons for recidivism. The aim of the study was to provide some insight that could be used in reducing rates of recidivism. According to Douglas (2013), there is little information regarding recidivism among people receiving mental health services and who are involved in criminal activity. A reason this study was done was because data are limited in how these individuals feel about what they believe was the cause of their inabilities to maintain community placement and in turn, what interventions they feel could be most effective. Five participants with a mental health diagnosis and history of criminal justice involvement were asked

to complete a questionnaire regarding what contributed to their relapse. The findings revealed that among the factors were homelessness, financial struggles, substance use, and medication non-compliance. It is suggested that taking these factors into account and increasing services to address this issues, would have a significant increase in the likelihood of successful recovery.

Statement of Purpose

The purpose of this study is to explore perceptions of individuals with mental health issues who have a history of incarcerations to reveal themes that could aid in reducing recidivism through effective outpatient support and reduce likelihood of re-incarceration. This qualitative research used in-depth interviews to capture the views of participants regarding those factors that they believe contributed to relapse and re-incarceration. The guiding research questions of this study are: 1) What do individuals with a mental illness believe contributes to their ability to maintain placement in the community? 2) What do individuals with a mental illness who return to prison believe contributed to their recidivism? 3) What are the perceptions of participants regarding how outpatient mental health programs could be improved to accommodate the needs of the participants? The underlying assumption is that when participants' ideas, thoughts, and perceptions about their treatment after incarceration are validated and integrated into community programs for mental health, then there would be a significant decrease in recidivism.

Significance of Study

This study is essential to social work, because this study acknowledges basic social work values such as self-determination. In social work practice, self-determination is the empowerment of the individual to increase his or her motivation and efforts in his or her goals and desires. In the theory of self-determination, three main psychological needs include autonomy, competence, and relatedness. Autonomy refers to independence and sense of volition in the individual, competence includes perception of individual of achievements and success, whereas relatedness refers to feeling cared for and empathized with (Perlman et al., 2018). This study involves self-reflection which has potential to increase insight into experiences, ultimately increasing confidence and autonomy. The interviews are assessing their perceptions of successes and barriers, and the researcher provided empathy as appropriate throughout. The data will be used to assist individuals in maintaining placement in the community. The results of this study will assist the enhancement of practice and intervention in programs and expose the relation among the change factors solely from the vantage points of the participants themselves. Data are limited on what participants feel contribute to their successes. Research presents that persons with mental illness have a greater chance of re-incarceration than those who do not suffer from a mental illness (Torrey et al., 2017). From a social justice perspective, these individuals are at a disadvantage. The results of this study strictly highlighted participants' thoughts and feelings about their own treatment and allow participants to claim their roles as the experts in their own lives. Program developers and

practitioners can use this knowledge to change and implement existing programs and create new programs that could have an increase in success in reducing recidivism.

CHAPTER II

LITERATURE REVIEW

The purpose of this chapter is to review the literature regarding three themes: mental health and community placement, mental health and recidivism, and perceptions of participants in community mental health services. This chapter begins with the historical context of mental health and recidivism as well as provide overview of Ecological Theory. The second section of the chapter examines the literature on effective or ineffective interventions that assist individuals with maintaining placement in the community including diversion programs, mental health court, and psychological intervention. The third section of the chapter reviews the literature on factors that hinder and create barriers for individuals with mental illness. The fourth section of the chapter highlights mental health services, including perceptions of participants.

Historical Context and Ecological Theory

Rehabilitation among mental health and criminal justice began in the prison systems. In the 1800s, prisons were structured and aimed for one goal: housing inmates. Prisons were specifically made to prevent people from committing crimes, taking away personal freedoms, mandated hard labor, and essentially living in harsh conditions. It was not until the early 20th century that a prison reformer, Zebulon Brockway, noted that rehabilitation could be met through education. As superintendent of a reformatory facility, he implemented these policies and allowed

early release for those who progressed in education. This was able to be implemented after legislature involving parole regulations was passed as ways to reduce recidivism and deter from committing crimes (Gale, 2006).

Although it was difficult to implement, this correctional philosophy progressed throughout the period of World War I in which discipline was gradually being replaced by education, learning of vocational skills, and rehabilitative approaches. Eventually behavioral science ideas were applied to the correctional environments, and it was believed by progressives that changing the social environments in which inmates came from would be a constructive solution to rehabilitation and successful at reducing recidivism (Gale, 2006).

Being that progressives during the rise of rehabilitation model believed that changing the social environments in which inmates came from would be a constructive solution to rehabilitation and successful at community placement (Gale, 2006), it is important to highlight the Ecological Theory when discussing rehabilitation in community and locked settings. The Ecological Theory holds a premise that individuals, families, groups, and communities are shaped by their environments (Teater, 2014). It continues to withhold the belief that subjects do not act in isolation but are a direct result of physical, social, and cultural agents around them including the political and legal structures they live in, economic status, relationships, educational levels, employment statuses, upbringing, values, traditions, and norms. These connections continue to evolve over time, essentially shaping individuals through the life course (2014).

Between the 1930s and 1950s, the rehabilitation model of corrections was flourishing. Among the services provided in the prison system for those who were diagnosed with a mental health diagnosis were counseling, group therapy, and behavior modification interventions. These ideas were not congruent with financial budgets of the correctional facilities and on top of lack of funding was a lack of qualified and sufficient prison staff (Gale, 2006). Increase in crime in the 1960s paved a way for conservative officials to restore law and order, directly opposing the correctional rehabilitative approach to prison reform (Lipsey & Cullen, 2007).

According to Phelps (2011), the fall of rehabilitation in the prison systems continued into the 1970s, as the concept of Neoliberalism took hold. During these years, there was no legitimate evidence to support the objective of the rehabilitation model. Being that there were no significant effects, this led to a shift in the power away from the aforementioned experts and professionals into the hands of politicians, causing an increase in legislature around criminal justice policies including but not limited to repeat offender laws and mandatory minimum sentences following a result of the increase in crime during these decades (Phelps, 2011). The increase in crime continued into the 1980s and 1990s, and the increasing amount of offenders on parole and in correctional settings dramatically taxed the system. As a direct result of this, prisons became overcrowded and many states did not generate the kind of budget it would take to be able to house the extensive amount of offenders and to employ a sufficient amount of staff (Gale, 2006). According to Phelps (2011), some states have

used their budget crises to downsize population in locked settings to increase use of programs in the community.

Mental Health and Community Placement

Individuals with mental illness who are released from a locked setting including jail or prison have higher rates of reoffending than those who do not (Torrey et al., 2017). Among those services that emerged from the concerns related to reoffending are reentry programs, diversion programs, and established mental health courts. According to Wikoff, Linhorst, and Morani (2012), a study was completed that followed a group of offenders for six months post release who were a part of a popular program called Project Re-Connect. This program provided participants with stipends, payments for transitional housing, substance abuse treatment, and job and skills training programs. Results showed that the program participants were convicted at decreased rates than those who did not participate. Among the demographics of the participants included older age, female, and were most likely to have achieved a high school diploma than those who did not participate highlighting significance of education in this particular study.

According to the literature, an analysis of 24 employment-based reentry programs was assessed for effectiveness including 1-3 year follow up of participants. According to Mulhaulsen (2018), programs funded by Department of Justice have failed to reduce recidivism, specifically employer focused re-entry programs. In this study, he criticized programs for not being more comprehensive, in that programs involving drug abuse counseling, anti-gang counseling, and employment preparation

before release showed more effective results to reduced arrests. Another successful intervention was having the incarcerated individuals connected with case workers in prison whom they continue to work with upon release from prison along with implementation of Therapeutic Communities while in prison including residential drug treatment. According to the Director of the National Institute of Justice, there is an understanding in terms of what is effective and what is not, and additional research is necessary, as reentry programs alone do not reduce recidivism (Muhaulsen, 2018). To maintain community placement, substance abuse treatment in and out of prison is essential due to co-occurring disorders that are associated with higher risk for future offense (Balyakina, et al. 2014).

Another intervention at maintaining community placement for individuals with mental illness is Mental Health Court. According to the literature, there are more than 300 MHCs in operation around the U.S., yet research on effectiveness has only begun to emerge within the past decade (Loong, Bonato, & Dewa, 2016). In 5 previous studies, graduates had lower recidivism than those who did not complete the program. In a 2013 study, a pre-enrollment-post-exit design followed participants in mental health court for 2 years after exit. This study found a negative association with recidivism 2 years after graduation from MHC when supervision, structure, treatment, and case management services were no longer offered to the graduating participant. Those who opted out or had their opportunities for MHC terminated had an increase in median jail days; however, it was not as significant. Specifically, 75 percent of graduates were not arrested in the 2 years after departing from legalities of the court

(Burns, Hiday, & Ray, 2013). The limitations of this study included fewer resources offered to graduates and staffing instability. Burns, Hiday, and Ray (2013) also noted that the homeless group of the participants in MHC did not graduate and essentially returned to jail, suggesting that housing is imperative and increases the likelihood of maintaining community placement.

Another intervention aimed at reducing the risk of recidivism is psychological interventions including individual and group therapies. In a study done by Abracen, Gallo, Looman, and Goodwill (2016), 136 offenders with a variety of psychiatric conditions residing in a Community Correctional Centre participated in the research. Of the participants, 86 received no treatment, 23 received moderate treatment (19 or fewer individual therapy sessions), and 27 received high treatment (20 or more therapy sessions). Essentially, the study found that the amount of individual therapy received was inversely associated with recidivism. Those who received the highest amount of treatment were approximately 12 times less likely to return to jail or prison. In keeping with these findings, a qualitative study done by Barrenger, Draine, Angell, and Herman (2016), highlights men with mental illnesses leaving prison and their struggles with managing their symptoms and stressors. Not only are the stressors of adjusting to community settings difficult, their intrapersonal conflicts create challenges and barriers to maintaining placement, essentially pressing a need for emotional support in order to maintain stability in a community setting.

Mental Health and Recidivism

Recidivism is defined as a relapse into a previous condition or mode of behavior, specifically returning to jail or prison and losing community placement. According to the literature, those with mental health disorders often cycle between being in the criminal justice system and being in mental health treatment without adequate progress in their mental health recoveries, often being cited as the "revolving door" (Eschbach, Dalgin, & Pantucci, 2018). The issue of mental health in the offender population has received increased attention in literature (Abracen, Gallo, Looman, and Goodwill, 2016). Research has shown that services as well as social and environmental factors impact results on psychiatric and criminal recidivism. According to Barrenger, Draine, Angell, and Herman (2016), individuals with mental illnesses are overrepresented within the correctional system and once released, they have an increase in rates of returns to jail or prison.

There is an abundance of factors that can hinder an individual's chances of maintaining placement in the community; however, the literature shows that substance abuse appears to be a highly significant factor in returning to jail or prison. A study completed by Balyakina et al. (2014) consisted of assessing 2077 probationers at risk of future crime and violence in relation to mental health disorders and substance use disorders. Participants were each given a set of validated surveys under the Mental Health Screening Tool. The results indicated that those with co-occurring substance use were significantly more likely of future crime and violence compared to those who do not have a co-occurring disorder. Specifically, participants

with substance use and Bipolar Disorder were at the greatest risk. Another study consisting of 180 inmates, some a part of outpatient programs and some who were not, who were released and followed for 6 months, showed that substance abuse was significantly associated with increased risk of reconviction and had a higher chance of being convicted on new charges. Additionally, those with a history of substance abuse also had an elevated rate of new conviction (Wikoff, Linhorst, & Morani, 2012). Lastly, a study completed by Barrenger, Draine, Angell, and Herman, (2016) consisted of 28 men. Each participated in an in depth interview within 6 months of release from prison in order to examine the effectiveness of Critical Time Intervention, a program to assist with transition to community. Participants emphasized the importance of avoiding negative influences, acquaintances and new associates who could potentially draw them back into substance use, believing that this was essential to maintaining community placement. This suggests that substance use is highly relevant to re incarceration, previously confirmed by Denton, Foster, and Bland (2015), who illustrated that lack of access to substance use treatment designated a relapse in risk behaviors among those leaving prison.

Other domains contributing to recidivism are that of education and employment. According to Wikoff, Linhorst, and Morani (2012), extensive research was previously completed and found that educational programs did not have an impact on recidivism; however, in their aforementioned study, individuals with less education were more likely to be convicted on new charges than those at the equivalent or less of a high school diploma. Ellison (2017), conducted a Rapid

Evidence Assessment in which 18 studies were part of a meta-analysis that identified education in prison settings has a positive impact on reducing recidivism and reportedly having a positive impact on employment. Although employment appears to have a positive impact, the transition from prison to the community for individuals with mental illness is difficult and is mirrored in Barrenger and colleague's study in 2016 on a risk environment analysis for individuals with mental illness just released from prison. The participants faced barriers such as lack of work history and job skills. Those who did secure employment still struggled with maintaining the job and making enough to provide for their families, creating tensions and financial burdens, and exacerbating psychiatric symptoms, increasing risk of re offending (Barrenger, Draine, Angell, & Herman, 2016).

Perceptions of Participants in Community Mental Health Services

Over a quarter of individuals with mental illnesses in public mental health systems will essentially become involved within the criminal justice system (Wilson, Bonfine, Farkas, & Banwar, 2017). Since the number of persons with mental illnesses has considerably increased within the prison system, many states have implemented community mental health services to lower these rates through supervision and treatment programs (Balyaina, et al., 2012). These services produce mixed results in regards to their goals, and according to Douglas (2013), mental health services often do not have the ability to provide sufficient services due to a number of factors including funds, staff, and insufficient facilities.

A study completed in 2017 highlights consumers' thoughts and opinions on services in the community, consisting of a large research project that had a purpose of examining interventions for risk factors with those in the mental health and criminal justice systems. A part of the research included a focus group of consumers in which they were recruited from a mental health center serving those with severe mental illness who have criminal justice issues. Topics to provoke responses included perceptions of Cognitive Behavioral Therapy and perceived barriers and facilitators to participating in group therapy (Wilson, Bonfine, Farkas, & Duda- Banwar, 2017). Cognitive Behavioral Therapy is a type of psychotherapy which aims to change one's behaviors and attitudes by maintaining focus on one's thoughts, images, and beliefs and altering thought processes (Martin, 2018). Each participant had the chance to complete a questionnaire highlighting demographic information, number of arrests, and their experiences in group therapy. Overall, consumers felt a need for services to integrate community mental health with interventions to reduce criminal behaviors. For example, they felt a need for an assessment of risk of criminogenic factors to be implemented into the intake process of mental health assessments following more education for treatment providers on the topic. Others highlighted needs for assistance with transportation and a more variety for group schedules to increase engagement. Lastly, incentives for participation were a must including promotion opportunities for peer leadership and achievement awards for successful participation in community services (Wilson, Bonfine, Farkas, & Duda- Banwar, 2017).

A study completed in 2018 by Eschbach, Dalgin, and Pantucci focused on graduates' perspectives of the intervention of Mental Health Treatment Court. Eleven participants had diagnoses that included PTSD, Schizoaffective Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Bipolar Disorder, and Schizophrenia and a variety of ages ranging from 22 to 70 and a mixture of men and women. They proceeded to participate in services offered by the MHTC including counseling, groups, medication support, food, housing, and transportation. Group interviews were then conducted to elicit response relevant to their perceptions of the services that were offered. It was found that developing trusting relationships with the staff increased their motivation to participate in mandates of the program. They also used concluded mandates as providing structure and maintaining their levels of motivation. This ultimately increased their desires to avoid going back to jail. There continued to be a general consensus that praise, encouragement, and positive feedback from staff and the judge were reassuring for success in the community. They emphasized peer support in the community through volunteer programs, AA groups, and recovery support, had a positive impact on their perspectives of the services offered with the program (Eschbach, Dalgin, & Pantucci, 2018). This coincides with previous research from Bullard and Thrasher (2016) that MHTC that integrated additional program supports with mandates including intensive monitoring interventions were the most successful in reducing recidivism. Based off of the limited amount of literature available, it is important to continue to explore

perceptions of participants in services who live and persist through mental health challenges in the community.

CHAPTER III

METHODOLOGY

Overview

The purpose of this study is to explore perceptions of participants involved in mental health services and their responses to the treatment interventions they receive. This study focused on those participants who have been incarcerated, since recidivism is significantly high for those who suffer from mental illness despite community-based support upon release (Torrey et al, 2017). There is also limited information surrounding recidivism and mental health and how these individuals feel about the support that they received. This study used an exploratory design, which is a type of design that is used when there is limited information on a given issue. The research done in this study serves a purpose of identifying concepts, questions, and building explanations. The qualitative questions the study examined are: a) What do individuals with a mental illness believe contributes to their ability to maintain placement? b) What do individuals with a mental illness who returned to prison believe contributed to their recidivism? And c) What are the perceptions of participants regarding how outpatient mental health programs could be improved to accommodate their needs? Individuals who are incarcerated at the time of conduction of interviews will not meet criteria for study.

Research Design and Instrumentation

This exploratory research, with a design of phenomenology, consisted of in depth interviews with purpose of understanding the lived experiences of the participants. In research, phenomenology methodology seeks to understand how participants experience a particular situation or phenomenon. It is centered on their experiences without regard to social or cultural norms that allow the researcher access to perceptions, attitudes and understandings of the phenomena (Phenomenology Research Overview). In-depth interviews consisted of open-ended questions that permitted the participant to reflect on and consider his or her experience in the prison and mental health systems. These answers aimed to assist in answering the research questions presented in this study. Specifically, the in-depth interviews consisted of semi-structured questions where the participants voluntarily answered preset open-ended questions related to their perceptions of treatment in their history of mental health services upon release and focused on what they felt was successful, what was not successful, and or what could have been successful (see Appendix A). Researcher framed questions to elicit more relevant response to capture depth of response as appropriate and at participant's discretion.

Other demographic information was considered such as age, type last offense, age at first adult conviction, marital status, number of dependents, previous incarceration, and employment status at arrest. These questions were asked at the end of the interviews. The select items were chosen for informational purposes only. These questions in focus were answered to achieve findings in the guided research

questions including general findings of perceptions of what contributes to success in maintaining community placement and or what contributes to re-arrest and re incarceration. This collection of data assisted in understanding the phenomena of mental health and recidivism. The demographic information (such as age, type last offense, age at first adult conviction, marital status, number of dependents, previous incarceration, and employment status at arrest) was collected for the purpose of exploring themes related to other dimensions of the participants' lives to view from an ecological perspective.

Sampling Plan

The sample in this study is a purposive, non-probability sample. Purposive sampling involves screening participants in terms of certain important characteristics. This is most fitting because participants must meet certain criteria. The criteria in this study are: 1) The participant must have a current mental health diagnosis and current status of receiving mental health services as confirmed by participant, 2) The participant with mental illness needs to have a history of at least 1 conviction that led to incarceration, 3) The participant must be 18 years of age or older, and 4) The participant is not incarcerated at time of interview. Because participants with mental illness and history of criminal justice are evaluated in this research study, non-probability sampling is most adequate since the study aims to capture their perceptions and experiences of individuals who are not incarcerated at time of interview.

The goal of this research study was to obtain a sample of 8-10 participants with mental illness, history or current involvement in mental health services, and history of incarceration. The participants were contacted through an agency that provides specialty mental health services to consumers who meet criteria for specialty mental health services in Sacramento County. Medical necessity for specialty mental health services is defined to include criteria based on inclusion of specific signs, symptoms, and conditions including a covered diagnosis on a spectrum of severe mental illness, an established level of impairment, and an expectation that specialty mental health treatment is necessary to address condition (Special Mental Health Services, 2014). The nominal definition of a covered diagnosis included Major Depressive Disorder, Post Traumatic Stress Disorder, Bipolar Disorder, Schizoaffective Disorder, Schizophrenia, Psychotic Disorder Not Otherwise Specified, and Borderline Personality Disorder. The agency proposed was a community-based mental health outpatient provider. Participants included new referrals and intakes as well as active short and long-term participants of services. The researcher obtained consent from the CEO, Clinical Director, Program Directors and Program Coordinators of the outpatient provider, and participants of the in-depth interviews.

Data Collection

After obtaining permission from the CEO, Clinical Director, Program Directors and Coordinators, the data were collected using in-depth interviews as part of the exploratory design and will be collected by the researcher. The researcher

worked with service coordinators and outreach staff who have built relationships with their clients and who know participants who would fit the criteria. Service Coordinators and Outreach Workers assisted with providing researcher with contact information and coordination of interviews. Each interview was approximately 45-60 minutes, depending on the detailed responses of questions. Data were collected from select participants in a private therapy room on premises of agency. The researcher ended interviews with asking specific demographic information. The researcher began the interview process after reviewing the overview of the study as well as informed consent. The researcher took notes of the interview process and reviewed these notes in a private office. The researcher worked on selecting existing participants with support of Service Coordinators and Outreach with relevant backgrounds as well as seeking perspectives of newer participants so long as the criteria are met. Data collection process was complete over the course of 2 months and or after responses from 8-10 participants are collected, whichever comes first. A strength of this process is the feasibility of the process in that the researcher has access to private rooms to protect confidentiality of participants. The weakness of the data collection process is the limited amount of time the researcher has to complete interviews.

Plan for Data Analysis

Qualitative analysis procedures involving sorting and classifying, coding, and interpreting were used to analyze the data retrieved from the open-ended questions in the in-depth interviews. In the first step of the analysis strategy, the data are organized

around relevance to the questions proposed, becoming familiar with the responses and main points. The second step included an open coding process in which the researcher passed through the data and identified themes and key events, ultimately labeling observations to transition to the next step. In the third step of axial coding, there was a second review of the data which focuses on the initial codes and themes. Key concepts were retrieved through identifying information. In this stage, new ideas emerged and potentially dividing concepts and categories were completed. Definitions emerged as well. In the fourth step, selective coding took place including another passing through data, scanning codes, and identifying major themes. In the final interpretation stage, the summary of the key characteristics and elaboration of data was completed as a whole (Neuman, 2003).

The demographic information gathered including age, type last offense, age at first adult conviction, marital status, number of dependents, previous incarceration, and employment status is guided by the theoretical framework of the ecological perspective. From an ecological perspective, individuals are believed to not operate in isolation but are influenced by social environments in which they live and interact (Teater, 2014). In this case, collecting these data will provide a better understanding of how the participants may have been shaped by their environments.

Protection of Human Subjects

The researcher and support of Service Coordinators and Outreach made phone and or face to face communication to invite participants to the study, upon release of consent for communication. The researcher then thoroughly reviewed informed

consent procedures and provided full disclosure of the purpose and benefits of the study. The researcher was available to answer questions open and honestly, providing a safe space and ensuring the participants of their rights and responsibilities. Potential harm in this study could result from the questions being asked, which may or may not trigger unwanted thoughts and feelings. To minimize harm, the researcher was in tune with participants' affects and demeanors when answering questions, being mindful of discomfort and unsettling feelings. If this had resulted, the researcher would have stopped the interview process and offered a break or to reschedule the rest of interview at another time. They were also advised that they could stop answering questions altogether at any given point of the interview. Once full disclosure of all aspects of study were provided, they then decided if they would want to be a part of the study, and their wishes were acknowledged and validated. Storage of their data was protected from inappropriate disclosure by ensuring data are kept in a locked setting at all times, specifically in a locked file cabinet, in a secured room during and after completion of study. The data collected did not include names of the participants. The study was reviewed and approved by the Institutional Review Board prior to the collection of data.

CHAPTER IV

FINDINGS

The purpose of this study was to explore the experiences of individuals who have mental health diagnoses as well as histories of incarceration to discover themes and thoughts to consider that could aid in reducing recidivism through services catered to these individuals and reduce likelihood of re-incarceration. The design of this study was meant to interview adults who met the criteria of having a mental health diagnosis and a history of at least one incarceration. The study had a purpose of highlighting their thoughts and feelings about their own treatment and participation in services and further allowing them to claim their roles as the experts in their own lives. The goal for this qualitative research is to add to the knowledge base and implement changes and integrate new ideas to existing programs and or produce new programs that could assist in maintaining community placement. The major themes found in this study were divided into three sections: community placement, barriers and recidivism, and perceptions of outpatient mental health services. The guiding research questions were:

1) What do individuals with a mental illness believe contributes to their ability to maintain placement in the community?

2) What do individuals with a mental illness who return to prison believe contributed to their recidivism?

3) What are the perceptions of participants regarding how outpatient mental

health programs could be improved to accommodate the needs of the participants?

Sample Overview

The sample of the research study included eight individuals who are currently engaged in mental health services within an outpatient program in Sacramento County and who have a history of at least one incarceration. The ages of the participants ranged from 36-69. All participants referred to the researcher were male and single. One out of the eight participants was employed, seven received supplemental security income, and one had general assistance and food stamps. One of the eight was enrolled in school for a bachelor's degree program and another was enrolled in a master's degree program. Histories included assault, drug convictions, felony theft, assault with a deadly weapon, grand larceny, and stalking. None had dependents in their care. Residences ranged from transitional housing, housing with roommates, and single bedroom apartments subsidized by the government. All of the participants of the study identified their mental health diagnoses and included a range of Schizophrenia, PTSD, Schizoaffective Disorder, and Major Depressive Disorder.

Participants were asked to describe their experiences in the community with their mental health struggles along with progress and barriers they continue to face and anticipate facing. The questions focused on exploring their opinions of the services that they receive or have received and were asked to critically analyze what they feel works and what does not work in helping them maintain community placement defined as not being in a locked setting. There was a mix of emotion and

thought surrounding the services they are receiving as well as their histories with services, historical barriers, and other stressors in their current social environments. One of the themes discovered from data was that there was not one overarching factor that influenced stability. Rather, stability was defined differently by each person and was the result of multiple factors unique to each individual. This evidence is based on the perceptions of each participant's definition of his own stability which are listed below:

Table 1

How Did Each Participant Define Stability in the Community?

Participant 1	Let's go to addictions. To be able in the community, sometimes, we lean to different addictions, alcohol or whatever. The stability that I found in the community was not to go back to my lifestyle. .And my lifestyle was the worse addiction I know. Addiction isn't the drug. It's the lifestyle.
Participant 2	Consistent interaction with the community. In all honesty, there has to be an established kind of being in a place and interacting with what's around you for a time period that shows that there's no problems and that things are going ok and that you're building.
Participant 3	It means giving back. No longer doing crime or disrespect. Like I'll take care of the neighbors if they have trash in front of the house. There is a lemon tree, I will collect some and give to certain neighbors.
Participant 4	I don't know. Well stability to me is feeling good, and I can't do that. The insurance I have, anytime I need something, my doctor has to refer me to it. If it's a referral, its like 3-4 months out….It's just a matter of services that I need is just to feel comfortable.
Participant 5	Stable housing. The money that I am getting from SSI. That's it. Those 2 things. Psychologically, I've got one thing I'm waiting for, God.
Participant 6	To have my own home again, to have responsibility again.
Participant 7	It's trust. When there is no secrets in the community, I think it's more stable, because people know what's going on with each other, and they can help each other. I think information is power, and it's money. Having information. Like the secrets that were kept in my home, the sexual abuse that was going on, didn't help. I got therapy right away. It was helpful but as a little boy, I didn't want to do it.
Participant 8	Work and family

Community Placement

Participants were asked what they felt contributes to their abilities to maintain stability in the community which they had each defined, what assists them with maintaining placement, and what situations assisted them in overcoming barriers.

One of the major themes associated with what participants believed helped with their ability to maintain placement in the community was self-motivation. Over half of the participants shared that one of the main motivators in staying in the community was his desire to maintain focus. One of the men interviewed stated his need for "self-service" to maintain stability in the community, whereas two of the participants turned to their education as ways to motivate themselves. One of the two participants enrolled in a bachelor's degree program shared, "Well I have to stay motivated to stay in school." The other participant who is currently enrolled in a master's degree program at a university shared:

> Being self-sufficient is a strength and challenge, because I don't know how to ask for help when I need it. That's a good thing for me for the most part. This is the first time in my life things are working out. College has been really performing for me. I'm really good at getting into and out of things. I have degrees and certificates and actually having the opportunity that is happening is actually working out well.

While education has assisted a fraction of the participants in gaining self-motivation, another percentage used their experiences being homeless as a way to

motivate themselves to be successful in the community. When asked what helps him maintain housing, one of the participants who had become homeless after being released from prison when he got into an altercation with management stated, “My sure will. There are programs and stuff that part of my ability to stay in this housing and keep the money I’m getting is to stay in this housing,” as he reflected at one point in his life “being desperate for housing.” Another participant shared that after being linked with services, he was “pulled out of the gutter,” which sparked his “self-motivation.”

While it was a simple explanation for another participant with the one of the most extensive records of criminal justice history including larceny, drug charges, trespassing, and DUI to find self-motivation, “Me. Myself. I don’t wanna go to jail, to be honest with you, I don’t like jail,” it was different for the first participant interviewed in the research study. This participant historically has an estranged relationship with his family involving trauma, hardships, as well as his struggles with homelessness and addiction. He shared what assisted him in overcoming barriers and staying out of jail was his ability to let go of the past. He said:

> To be strong enough to accept that the past is a done deal. Letting all the negativity go. You know, tunnel vision. I was motivated. I was focused. That was my biggest turn around, when I fell back in love with me.

Another common theme that answered the question of what assisted participants with maintaining placement in the community was having a support system whom most commonly defined as “someone to talk to.” Some defined their

support system as having a natural resource such as family whereas others highlighted their treatment providers as supportive, emphasizing the significance of being linked with services as a focal point of their stabilities. One of the participants who struggles with Major Depressive Disorder stated:

> I used to be a bundle of tears for a lot of years, angry you know what I mean? Violent. I didn't really speak a lot, but in counseling, I was able to talk, I was able to cry on their shoulder and let all my anxieties out.

Another participant echoed his need to maintain stability in the community as therapy. This particular participant who has extensive history of homelessness is currently dealing with chronic physical health issues that exacerbate his depressive symptoms including having to go to dialysis three times a week for failing kidneys. When asked how therapy met his immediate need to maintain in the community he replied:

> Just to talk. Somebody to talk to, they're there. Emotions get harder to deal with, because the older I get, I understand more and know more. I see life differently. Out there on the streets, there were times I was ready to give up, I did not see a future where I was at. And Guest House (treatment provider) reached out. My health and stuff have woke up me, it's taken my life away like that. What's taking my whole life to get, I lost like that, now I got to start all over and get back what I can get back out of life. I'm not ready to quit.

While these participants were not averse to natural socialization, two participants shared socialization as being a barrier, one stating, "I have plenty of opportunities to

interact with people, I just prefer not to….I think it's something that we have learned over a period of time that the less we interact, the less drama we have to do with. The less drama, I can concentrate on who I am and what I need to do." Another stated, "I tend to avoid interaction with other people on a personal level, because it's easier to stay focused on my goals and get stuff done." Although this participant does not see benefit of a natural support system, he did attribute having people to check in with as significant for reducing likelihood of reincarceration. He stated:

> Basically just understanding having some place to sit down at and having some reality testing going on and having people check in who understand that I am diagnosed and give me an opportunity. I make sure there is a few people in each setting who understand where I'm at and my diagnosis so that they can call me on my crap, so that I can check myself before I wreck myself.

Partly mirroring this statement is another participant who shared that although he does not have any "permanent friends," he has "different people that come along in his life that have kind of given him a piece of themselves," which he claims has assisted him with overcoming barriers while functioning in the community. Most of the participants who have experienced a lack of support highlighted this as a barrier and factor to contribute to past and future recidivism.

Barriers and Recidivism

Participants were asked to describe their experiences with mental health challenges while incarcerated, factors that contributed to their histories of

incarceration, what barriers have they faced and or anticipate facing, and what situations contributed to these barriers.

Most of the participants agreed that their mental health issues were not rehabilitated while they were incarcerated, and some went on to elaborate they were not offered services upon release, agreeing that they were not set up to be successful. The participants' responses to their experiences while incarcerated supports previous literature emphasizing the lack of rehabilitation while in jail or prison with the exception of two responses. The responses are listed below:

Table 2

Describe Your Experiences With Mental Health Challenges While Incarcerated

Participant 1	I did group counseling. It gave me hope. I was sick and tired of being sick and tired. They asked me what did I really want to do, and I said what I really want to do is go back to being the head of my family.
Participant 2	I like crazy people. I'm more comfortable with crazy people. They tend to be more real. They don't have an agenda except the psych. It's more natural. It's easier to manage.
Participant 3	PTSD, stress of crowds, riots, and fights. Having to deal with someone else in a bathroom sized cell.
Participant 4	Every day was just challenging being there. There are so many different personalities, so many different engraved reactions you know. I think that some of the guys went in there and were doing good, making friends, carrying on in their own little corner.
Participant 5	I was scared. These people are serious people in there. You don't mess with them. Everything I did, everything the cops had me reveal, it got me in trouble, because there are certain things you don't do when you're on the outside that put you on the inside.
Participant 6	None but it was when I became homeless when I got out and became depressed. I was in control before, I thought.
Participant 7	There's a lot of things going on in the CDC system. I have a lot of respect as law enforcement, but our system is a punishing system, and it's hypocritical, because it doesn't restore justice or a community's balance. They think it's hilarious that everyone is high on drugs in these state prisons. I've been strapped in chairs, I've been electrocuted, I have had them shut off the cameras and do whatever they want.
Participant 8	I don't like people. Over the past couple of years, being around a lot of people around me. As long as I sleep, I don't have to deal with anybody and that's what Seroquel was for. Incarceration is depressing. It's depressing a lot. Anxiety. I did once hear voices. If I take proper medication, I can pretty much be around people.

One of the main themes of contributors to recidivism was that of being unemployed following release from jail or prison as well as finances which often led to the aforementioned obstacle of homelessness. The last participant interviewed stated that he was “not used to” being employed, which added to his depression. One of the participants reported that he lost his section 8 voucher while he was incarcerated and because of his felony, he was no longer eligible for the program upon release. Similarly, one of the participants who reported not being assisted with income following release and struggling to find a job reported that he was able to obtain supplemental income, however, he is most interested in working. He stated:

> I only get 910 dollars a month and when a person gets off the streets in California, they take 100 out of his check. Social security needs to be increase because I’m eating at 200 dollars a month. When I pay for rent, bus pass, and phone, I barely have enough, so I’ll steal food when I need to and things like that.

When asked about what he needs to stay in the community, he replied:

> I need a job that can pay me extra couple of hundred bucks a month. If I had a job, I would be really good. I would be able to eat and the internet so I can go back to school and buy shoes so I can continue running, the enjoyable things, go to the movies once in a while.

Similarly, another participant discussed the challenges of the increase in cost of groceries, which he highlighted as his biggest barrier, sharing that housing and money

are his main needs to stay out of a locked setting. Also sharing commonalities is another individual who shared that he attempted to get a truck driving job; however, it did not work out and reiterated that he had to travel out more trying to find prospective jobs, in which he ended up homeless because of not finding employment willing to work with his record. “I was homeless for a long time, I spent most of my life being homeless.” He elaborated working with Department of Rehabilitation for employment and was still unsuccessful in which then he decided to enroll in school, which has increased his desire to do well in the community. Likewise, another participant who struggles with PSTD as a result of his time spent in prison had gone to college to become a drug counselor but was not able to obtain a job which “began his downward spiral.” He continued to elaborate in his interview that lack of employment negatively impacted his overall functioning. He currently does not have any income and is working with outpatient provider on obtaining SSI. He detailed:

> They offered employment. They would offer you trucking, but you can’t go more than 15 miles out of your parole. Cooking, but you can’t be around knives and sharp utensils. Forestry, but there were no jobs. They do offer a program called PIA Prison Industry Authority, it’s for their benefit to get the clothes made and furniture made for the state and things like that, but there is no follow up or transition from things like that to the streets. I couldn’t get a job even though I had all the experience. I had a letter and hours and everything.

Another participant agreed with the unemployment barrier but is currently employed with an outpatient mental health program as a peer support coordinator. He had expressed his gratitude and highlighted that if they did not employ consumers, he "probably wouldn't get employed" with other agencies or companies, because of his felony history. Lastly, two participants claimed their physical health issues as barriers, as they have prevented them from working and expressed their desires to work. One stated not working was causing his depression, and another stated:

> A decline in physical health which caused the depression. That is my biggest hang up right now. Because of my health, it's too easily for me to call in this depression, and I stay in it, because I become comfortable in it. Stress that impacted my physical health issues.

Another theme explored in the research related to recidivism was that of alcohol and substance abuse issues. For one participant, his substance abuse began as a child. He shared, "I'm from a Christian home, but I was ADD as a kid, and then I discovered speed and that solved the problem. I would go in and out, and the cycle continued. Then I became hooked on meth for many years." He also reported being involved in a dysfunctional marriage, and his wife was also using at the time. Another participant related to this response of negative influence and association with others. He shared a similar response to his criminal justice history and what factors played a role in his criminal justice history and stated:

> I had a drug problem. I had an authority problem….The people I live around, the people you go to school around, and live around. It's peer pressure. I fell

> into peer pressure easily. I'd rebel against authority. I knew right from wrong, but I was gonna do it, because I wanted to and not because I wanted to. I do what I wanted to do.

Another participant highlighted his location and associates as an "easy lifestyle to get into" which he felt was a major factor in his criminal justice history, also placing much emphasis on family issues. He discussed how he relocated to a new environment to disassociate from and although he declared it "so very hard," he found "the strength to leave that addiction alone." Whereas others are highlighting their associations with others, family hardships, and developmental issues as factors that played a role in their negative circumstance and likelihood of going back to jail or prison, another participant discussed his history of sexual abuse and early childhood trauma. This participant shared that there was drug abuse in his family, sexual abuse, and the trauma of his sister committing suicide. He highlighted his eventual cocaine addiction as his barrier to maintaining placement in the community. He continued that he is currently sober and regularly goes to the Methadone clinic.

Lastly, another theme in the category of recidivism is the bureaucracy of services. Half of the participants had complaints of the county mental health system including barriers to getting adequate medications to fit their needs, unjust policies and procedures of some of the programs, and not getting the services they feel that they needed.

One of the most common factors contributing to their perspectives of not getting the support they need is the issue of medications. Two of the participants felt

a lack of trust between provider and patient. One of the participants who had overcome addiction to heroine highlighted his experiences with the methadone clinic and county services. He stated:

> I have to talk to a counselor every week at the methadone clinic. They don't have anything else to offer to the community like housing or mental health. They only have what the clinic has. They should be able to reach out, and the county should be much more involved. Services should be more integrated. I don't think it's right at all. They tell you there's an opioid crisis, but then they don't have these services in jail where you go when you get locked up. It's bullshit. If it weren't for that methadone clinic, I wouldn't have gotten out of probation or parole.

He also discussed his experience with not qualifying for other services and feeling that there is a lack of communication on why he does not quality for particular services stating, "There is not enough dialogue to let you know what qualifies and what doesn't." When asked about what had made it difficult to maintain placement at his apartment, he continued to elaborate on the lack of trust between provider and patient, the participant reported:

> Have some good medications to get passed the depressive states. They work, they don't work as good as I want them to work. The medications I want, the doctors aren't willing to prescribe which leads me to go on out to search for myself. There are not real good relationships with the practitioners and providers… It's just a matter of services that I need is just to feel comfortable.

> I think that's the major barrier, it seems once you always get something working, it's always forgotten and quiet. Like the medications I was on, Xanax, like for the anxiety and the pain pills I need, and I can't get them anymore.

Two of the participants emphasized their needs for therapy but being unable to obtain therapy, in which one identified as a barrier and is something that he is currently unhappy about. He reported:

> The one thing that I asked, I have to get rid of these unresolved issues that I have about people who have passed away that I never got over. My brother, my grandmother. I never got over. My relationships with my mother, that's probably never gonna change, that is the way she is, and it does bother me,, but I can't talk to her about it. You can give me all the medications all you want, but it's not gonna happen (referring to need of therapy)."

The participants shared differing views of the services that they have been a part of and the services they currently receive.

Improvement in Outpatient Mental Health Services

Participants of the research were each asked if they were offered services once released from jail and prison, to rate the services they have participated in, how the services meet their immediate needs, and to self-reflect on what services do they feel have assisted them the most. After reflection, they were asked what services they felt they needed the most but were not able to obtain in order to maintain placement in the

community. Lastly, they were asked how they could improve their own role in their mental health recovery.

When asked about the services upon release, three out of the eight participants reported that they were not offered any services upon being released from jail and or prison since their last incarceration. Of the five who did, most received assistance with psychiatric care including medications, counseling, and anger management, while others received assistance with housing and being partnered with a program that has mandated groups and assistance with getting linked with SSI. These participants shared that they have continued outpatient services since being released and had mixed ratings of the services they have participated in; however, the average rating (on a scale of 1-10) was an 8.5.

Each participant is part of an outpatient mental health program contracted through the county. As part of their engagement in services, they routinely see a psychiatrist at least every 3 months, and they meet with a service coordinator for face to face social rehabilitation monthly, checking in on their progress and barriers in goals. They also have the opportunity to participate in groups. Half of the participants take part in weekly groups. When asked how services meet their immediate needs and how services offered helped to prevent their chances of incarceration, 6 out of the 8 participants had a positive response to the services they are currently engaged with. One of the participants reported, “Counseling, medication, and housing helped my stability, mentally, spiritually. They would tell me just cry it out,” and continued to

emphasize getting his needs met by having someone to talk to, as he did not identify a support system outside of treatment. Another participant shared:

> It's taking care of my psychiatric, it's seeing a psychiatrist every 3 months. They do updates. We do assessments every year, and it's both the psychiatrist as well as the service coordinator. So there is 2 assessments being done. It helps me to identify areas that I need to work on. I see my service coordinator about once a week usually if there is not anything that screws it up.

Although one participant was not satisfied with getting the medications he felt he needs, he appeared to agree with the support of having a service coordinator and face to face meetings "gets him through the moment." Another participant agreed that the ongoing assessments were helpful for him maintaining his stability. He reported:

> Structure process. In all honesty, the way the program progresses. In order to allow the transition. Going to board and care, to a room and board, to independent living and taking the time to process this through. They actually review whether you should or should not progress along the way, depending on how you're performing. That's probably the best way to see how you're doing and assess yourself as well as how to be able to manage in the community.

Another participant agreed that the services are assisting him with "rebuilding structure," and others shared that assistance with maintaining housing was imperative as well, particularly those who were homeless at the time of being connected with services.

Lastly, participants were asked what services they feel that they need but do not have in order to not return to prison or jail. Half of the participants shared that they felt they were already getting the support that they needed and referred to assistance with maintaining housing, medications, groups, psychiatric assessments, and face to face social rehabilitation, whereas the other half felt that there was more that could be obtained. Among those that were asked how services could be improved to meet needs, two of the participants shared the need for financial stipends. These particular individuals live in subsidized apartments and are on a fixed income.
One participant disclosed, "I'm close to starving as it is," whereas the youngest participant in the sample stated on top of lack of natural support system, his physical health issues also contribute to his inability to take advantage of available resources in the community:

> Transportation. It would be nice if there was some kind of 20 dollars in food card so I can get the food that I need to eat. I have a bad ulcer and serious issues with my intestines, so I can't go to foodbanks all the time. I can't get food stamps if you don't have kids or you're not an old person.

Consistent with his response was another participant who was in need of support with navigating the community and highlighted transportation. Lastly, another participant who has a history of substance abuse and alcoholism as well as family hardships shared the need for therapy upon request and reported:

> The one thing that I asked, I have to get rid of these unresolved issues that I have about people who have passed away that I never got over. My brother,

> my grandmother. I never got over. My relationships with my mother, that's probably never gonna change, that is the way she is, and it does bother me,, but I can't talk to her about it. You can give me all the medications all you want, but it's not gonna happen (referring to need of therapy).

After self-reflection, each participant was asked how they could improve their roles in their mental health recoveries, keeping up with the social work value of self-determination. Their response are provided below:

Table 3

How Could You Improve Your Role in Your Mental Health Recovery?

Participant 1	You know for some reason, I couldn't see, but there were so many people that have came to me that have came to me at my worst and commend me and say how I am a role model. For some reason, people say I have been an example of them. I don't know how to answer that. That's the man from above.
Participant 2	Stay on track the way I've been doing. Self-care.
Participant 3	Just continue to do what I'm doing, making it to meetings, taking my meds, I have days that I isolate, but I know I have to get her out to a walk (emotional support pet), and she usually rolls with me on most appointments. Part of my therapy, I go to Arden mall with my dog and go window shopping. Recycling. I find good items in the trash, sell them to others who need it. We have a park nearby, and I give when I have it.
Participant 4	Well I have to stay motivated to stay in school. The major barriers are to be active, and I'm always pushing to be active.
Participant 5	I'm doing it. I'm attending the meetings. The meetings, we discuss issues, a subject is come up with, subjects are limited. Taking my medications. I have an alarm that reminds me.
Participant 6	Keep up with it all. Not neglect it. Don't put off what you can do today tomorrow. Don't procrastinate. I need change. I don't like it, but I know I need it.
Participant 7	Go to school.
Participant 8	To be honest with you, I don't think medicine works. I have a girlfriend who recognizes that I'm more withdrawn when I take medications. When I'm not on it, I'm more active. I get things done. Drugs are not the answer. How do I fix that I don't know. I'm so used to working. This is my problem. I want to find a job that I'm happy with.

Summary

Overall, the qualitative data collected in this study suggests that outpatient mental health programs have the necessary resources to assist their consumers with maintaining stabilization in the community, as each of the participants have been incarcerated since being linked with services. Most of the participants gave positive response to services including medications, housing, counseling, and groups; however, this did not appear to take away from the issues faced outside of the agency and into the community such as financial issues, substance abuse, barriers to employment, physical health issues, and lack of natural resources.

CHAPTER V

DISCUSSION

Overview

The purpose of this study was to explore the individualized experiences and perceptions of people who have current mental health diagnoses and have at least once been incarcerated for purpose of exploring ideas and thoughts to consider that could reduce likelihood of re-incarceration. Additionally, the study explored whether or not experiences were similar. The design of this study was created to interview adults who met the criteria of having a mental health diagnosis and a history of at least one incarceration. For this study, face to face interviews were completed with the 8 participants, all whom identified as a male, have at least 1 incarceration, and currently engaged in outpatient mental health services. The goal for this chapter is to explore the major findings, connect findings to the research, compare and contrast with existing literature, expose limitations of the research study, discuss implications for policy and practice, and explore ideas for future research..

Overview of Major Findings

The data collected in this study provided answers to the guiding research questions. The findings revealed patterns and similarities in the participants' experiences that helped identify factors in their social environments that influenced successes and barriers of community functioning. The results further provided insight into the perceptions of the current and historical services that each participant has

received and how these services have helped or have not helped and how they could potentially be improved.

Findings and Existing Literature

Success in the Community

One of the major themes identified in this study for success in the community for participants was the importance of a support system, specifically having someone to talk to. Several participants identified the rewards of being able to open up to someone, whether it is a natural resource or treatment provider with counseling. This information is congruent with a study previously identified by Abracen, Gallo, Looman, and Goodwill (2016) in which the amount of individual therapy received was inversely associated with recidivism. Participants who have histories of trauma and who perceive socialization as a barrier in the community highlighted the need for therapy and or counseling as essential to stabilization in the community, which is consistent with research completed by Barranger, Draine, Angell and Herman (2016) essentially pressing a need for emotional support and guidance following adjustment to community settings. This demonstrated a continuous need to offer counseling and therapy services in programs to address trauma and social factors that trigger symptoms and stressors.

Not only for counseling and therapy, connection to services was highlighted by most participants in this study as being essential to maintaining placement, as they highlighted their needs for assistance with housing which is also mirrors findings of a study done by Wikoff, Linhorst, and Morani (2012). Although participants were not

part of mental health court, a study completed by Burns, Hiday, and Ray (2013) noted that a group of individuals experiencing homelessness who were a part of a mental health court did not graduate and returned to jail. In this study, many of the participants identified their current housing as a factor that continues to help them maintain community placement. Participants in this study revealed that self-motivation was imperative to successful community functioning and affiliated some affiliated their self-motivation with education. This is consistent with the same study completed by Wikoff, Linhorst, and Morani (2012), which highlighted the significant of education in association with reduce rates of conviction and a study by Ellison (2017) which addressed education in prison settings as having a positive impact on reducing recidivism. Self-motivation is congruent with self-determination value within social work profession and will continue to persist as an essential for stabilization.

Barriers to Community Placement

One of the barriers to community placement identified by participants was substance abuse issues. Several of the participants highlighted records with criminal charges on drug charges that contributed to returning to jail or prison, which directly relates to previous study by Balyakina et al. (2014) in which those with co-occurring substance use were more likely to engage in future crimes and return to jail or prison. Participants in this study found that family hardships and developmental issues as factors that played a role in their negative circumstance and life of alcohol and other drugs, some identified associations with others. This is consistent with

aforementioned research study done by Barrenger, Draine, Angell, and Herman (2016) in which participants highlighted the importance of avoiding negative influences, acquaintances, and new associates. This issue continues to persist as those transitioning out into the community often do not have the resources to relocate and often return to the lives they left behind.

Another major theme in barriers to community placement identified by participants was lack of employment and financial support. Many of the participants discussed how this affected housing as well as money for everyday items including transportation and groceries. Many of the participants supported themselves with SSI and were not employed and few discussed their desire for employment but not being able to obtain due to arrest records. Lack of employment as a common barrier to recidivism is consistent with previously mentioned study by Barrenger, Draine, Angell, and Herman (2016) in which participants faced struggles with securing employment, and not making enough, which essentially created tensions, financial burdens, and increased risk of re offending. Lack of employment and opportunity for adequate wages continues to persist because of socioeconomic conditions as well as discrimination against those who have a criminal background regardless of circumstances and context.

Improvement of Outpatient Services

One of the main findings in how to improve outpatient services within the eyes of the participants was needs for assistance with transportation. Many of the participants highlighted financial burden as a barrier and few discussed improvement

of services by a cash stipend. This is congruent with a qualitative study by Wilson, Bonfine, KFarkas, and Duda-Banwar (2017) in which participants highlighted needs for assistance with transportation and incentives for participation. In that study, a need for a variety of group schedules was important to increase engagement, whereas a participant in this study did report the importance of a more variety of group times being that work schedules are conflicting. The desire of cash stipends for participants continues to persist because of low wages in the community and lack of employment opportunities for this population as previously mentioned. In that same study, participants found a need for more comprehensive assessments at intake, whereas this small sample did not mention a change in assessments at intake and annually, potentially because they do not find the intake process as an issue or barrier.

Lastly, another major theme identified in their perception of services was positivity about the interventions they receive involving medication support, therapy, groups, case management, social rehabilitation, and housing. Their positive responses mirrored that of a study by Eschbach, Dalgin, and Pantucci (2018) that participants received relatively same services that the structure of the services were helpful. Although in that same study, they emphasized peer support in the community, AA groups, and recovery support, as having a positive impact, whereas the participants in this study are not offered those services through this program. Integration of community services continues to be an issue that could continue to be room for improvement.

Limitations

There are limitations of the study that may have prevented additional responses to the guiding research questions. One of the major limitations of the study was that the sample size was small. Because of the time constraints on the study, the interviewer resorted to conducting research with a small sample size of 8 participants. The interviewer was also limited in navigating potential resources, having to rely on service coordinators of an agency for referrals for purpose of protecting confidentiality of the participants. Since there was a strict time schedule, the interviewer was not able to be selective of the participants that were referred. The sample also minimized diversity, as the majority of the interviewees were older, heterosexual, unemployed, Caucasian males. Had there been more time spent on finding adequate participants, there essentially could have been a more broad range of cultures and backgrounds, which could have provided a more broad understanding of how mental health affects individuals of different race, class, and gender.

Another main limitation of the study was that the sample size included individuals who are considered to have a mental illness who may all be a part of different programs; however, they are all a part of the same outpatient mental health services. Although the different programs meet the specific needs of individuals, interventions and services provided are similar. Therefore, reflections on services provide a limited response in comparison to an essential broad range of services and programs within the county the interviews were conducted in, representing a small sample of the mental health community.

Implications for Social Work Practice and Policy

The information found in this study is meaningful to direct social work practice in policy in a number of ways, because this study keeps up with social work core values as it focuses on individuals' perceptions and validates their experiences. The participants in the study described facing their challenges and barriers in maintaining placement in the community and achieving stability in their lives following struggles in different domains in their lives and in community functioning. These protective and risk factors were a direct result of circumstances in their social environments that are significant and place an emphasis on services within the community that could be tailored to meet the needs of each individual. These factors discovered in this study should be evaluated when designing and implementing effective interventions to reduce recidivism in mental health services.

One of the findings in this study included substance abuse as a significant barrier to maintaining individual placement within the community. Currently in Sacramento County, for example, alcohol and other drugs (AOD) services are separate from mental health services and integrating these two services could be crucial for stabilization. Although mental health services within the county assess for AOD issues, there is a lack of follow up with co-occurring substance abuse disorders. Social workers could develop programs that could have an integration of services such as a "one stop shop" where the individuals could receive care for both disorders simultaneously in the same location, where there is familiarity with treatment providers, the way the program is structured, and the building of a peer support

system. All of these elements are consistent with protective factor identified by participants that have assisted in success and stabilization. As previously mentioned in the literature, mental health courts have proven to be successful in reducing recidivism, offering more opportunity for individuals with co-occurring mental health and substance abuse.

Another finding in this study was self-motivation being a factor in maintaining placement in the community. There were different perspectives on what motivates each individual; however, another theme was that of not having adequate finances to fund for transportation, groceries, and activities. Currently, the Mental Health Service Act, MHSA, provides counties within California with funding to run programs and to provide participants with basic needs with a priority on assisting with subsidies for housing. This funding is limited and withheld within each program. Since finances were an issue, small stipends could be granted to those who successfully attend appointments and do well in meeting treatment plan goals, furthermore increasing self-motivation, which has the capacity to greatly reduce the risk of recidivism and returning to criminal activity. Federally, more funding could be granted to include this intervention in nationwide programs.

As social workers fulfill roles of service providers, it is imperative that social workers are trained and educated in maintaining and upholding values of social work practice. It would be imperative for social workers to consistently uphold the belief that participants have ability to personally grow and be the experts in their own lives. It would also be important for social workers to believe in the recovery model,

highlighting that each individual has the capacity to reach their full potential and achieve stabilization. It would be significant for social workers to also maintain an ecological perspective when performing assessments and listening to participants' stories. Being culturally competent as well would be essential for best practice.

Since few participants reported not being offered services upon release from prison, it would be imperative for prisons and jail to implement a policy whereby all offenders reentering the community are offered referrals to community service programs. Referrals could include community reentry programs, diversion programs or mental health programs, especially for offenders who are released without supervision of parole or probation officials. Social workers could also propose and develop community programs specifically aimed to support this population in a smooth transition back to the community, creating a more integrative approach between these locked settings and community settings.

These findings are connected to past and current policies in a number of ways. While one of the major findings of this study were the barriers of lack of employment and bureaucracy of county mental health services, these are current barriers that are inevitable to recidivism and relapse in mental health. Specifically, barriers identified to maintain placement include the unemployment because of arrest record which trickles down to lack of adequate finances and further more putting housing in jeopardy, which are other barriers described by participants. Currently, policy states for subsidized housing through HUD by the government does not qualify for individuals who have a history of a felony. A number of these individuals are then not

able to afford a place at current rates due to not being able to find adequate employment, which has the potential to lead to homelessness as well as exacerbate mental health symptoms. If more collaboration between employment agencies and places of employments can be made to be more mindful of felony record, this could be a solution to lack of employment. Also, implementing mandated integrated community services in conjunction with employment plan could potentially show success. If the policy to subsidized HUD housing not providing vouchers to felony offenders could be altered as a case by case situation or potentially and or include a plan to work with a case manager on successful independent living, this could increase likelihood of stabilization as well as reinstate hope for individuals who are experiencing discrimination and barriers to employment and housing.

Future Research

This study focused on a narrow sample of the criminal justice and mental health community in Sacramento County. The findings in this study are significant and display a picture of the factors that determine how individuals who have a mental illness and criminal justice history interpret their experiences in the community, the challenges the have faced and continue to face as well as their perceive strengths and protective factors. This study also highlighted their perception and experiences of the mental health services they have received and are currently receiving. Although findings in this study are significant and add to limited knowledge base, future research could include a more in depth, comprehensive understanding of the services

they receive inside a jail or prison and living conditions within the prison and focus on their return to the community following extensive incarceration.

Future research could also include a larger, more diverse sample of the population including a broader age group as well as inclusion of females. Future research could provide insight into the experiences of women of different backgrounds and cultures and see how experiences of men and women differ. Being that women at state and national levels are increasingly entering the criminal justice system and the female prison population is increasing at a faster rate than males (Wikoff, Linhorst, and Morani, 2012), it would be important to highlight their perceptions in dealing with mental health issues while incarcerated to increase level of understanding and validation of their experiences.

Future research could zone in on single research studies of each protective factor that individuals with a mental illness and criminal justice experience and how this particular factor aids in maintaining placement in the community. For example, whether education, self-motivation, employment, connection to services, or a support system consistently proves to be significant. Studies could be designed solely to showcase each factor in a way to increase depth and understanding of the experiences surrounding these factors. Other studies could focus solely on risk factors and how they continuously pose barriers in the community for this population as a way to increase depth and understanding of the negative experiences this population continues to face. Information collected in these studies could have significant impact on alteration of services already in place.

As previously mentioned, there is limited research that focuses on the experiences of individuals with mental illness and history of incarceration. It is recommended that future studies continue to build this knowledge base by exploring their experiences to identify what their needs are in maintaining placement in the community and reducing risk for relapse in mental health and recidivism. Identifying these needs can continue to be integrated into current and future services, current and future policies and programs in order to support this population as well as reduce stigma and rebuild connection with the community.

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APPENDICES

APPENDIX A

IN DEPTH INTERVIEW QUESTIONS

1) I want to examine your views of your current placement in the community defined as not in locked setting.
   - Tell me about your current living situation.
   - What factors have assisted you in maintaining placement?
   - What factors have made it difficult to maintain this placement?
2) What are your views of the mental health services that were offered to you upon release?
   - What services were offered to you upon release?
   - Describe your experiences with the services.
   - How would you rate the services on a scale of 1-10?
   - What do you think influenced your response?
3) What services offered do you feel would have helped to prevent your chances of re-incarceration? Or what services do you feel have helped with remaining in the community?
   - In what ways would these services have helped you? or How have these services helped you in reducing re incarceration?
   - How would you define stability in the community?
   - What do you feel you need to maintain stability in the community?
   - How do these services meet your immediate needs?

4) What factors do you feel contributed to your incarceration?
    - Tell me about your criminal justice history.
    - In what ways do you feel these factors played a role?
    - Describe your experiences with mental health challenges while incarcerated.
5) What are some perceived barriers you have faced or anticipate facing since/upon your release?
    - How have these barriers impacted your overall functioning?
    - What situations were occurring or may occur in your life that contributed to these barriers?
    - What situations were occurring in your life that assisted you in overcoming barriers?

6) What services do you feel you most need but are unable to obtain to maintain placement in the community?
    - How would these services assist you in maintaining placement in the community?
    - How could you continue to improve your role in your mental health recovery?

APPENDIX B

INFORMED CONSENT

Dear Participant:

You are being asked to participate in a research project that is being done to fulfill requirements for a Master's degree in Social Work at CSU Stanislaus. We hope to learn and gain insight into themes that could aid outpatient support and reduce likelihood of re-incarceration. If you decide to volunteer, you will be asked to participate in an approximately 45-60 minute interview that consists of semi-structured questions where you will voluntarily answer preset open-ended questions related to your perceptions of treatment in your history of mental health services upon release from jail and or prison and focusing on what you felt was successful, what was not successful, and or what could have been successful while considering strengths and barriers of your social environment that may have contributed to success or lack of success. The study will include 8-10 participants.

Risks involved in the study include potential harm that could result from the questions being asked, which may or may not trigger unwanted thoughts and feelings. If this results, the researcher will stop the interview process and offer a break or to reschedule the rest of interview at another time. You will also be advised that you could stop answering questions altogether at any given point of the interview.

It is possible that you will not benefit directly by participating in this study. Others may benefit from this study by the knowledge gained for your experiences that could contributed to improved strategies for supporting persons to avoid re-incarceration. . The information collected will be protected from all inappropriate disclosure under the law. All data will be kept in a secure location, specifically in a locked file cabinet, in a secured room during and after completion of study. The data collected will not include names of the participants.

If you agree to participate, please indicate this decision by signing below. If you have any questions about this research project please contact me, Jessica Echeverria at (**916) 539-3623** or my faculty sponsor, John Garcia at (**209) 667-3769.** If you have any questions regarding your rights and participation as a research subject, please contact the IRB Administrator by phone (209) 667-3493 or email IRBAdmin@csustan.edu.

Sincerely,
Jessica Echeverria
MSW Student

I have read and understand the information provided above. All of my questions, if any, have been answered to my satisfaction. I consent to take part in this study. I have been given a copy of this form.

Signature ____ Date ____________________

Name (printed) ____

Signature of person obtaining consent _________________________ Date _______

Printed name of person obtaining consent __________________________________