2016

Clinician Perspectives on Community Reentry for Mentally Ill Offenders in New York

Lauren C. Meath
Antioch University, New England

Clinician Perspectives on Community Reentry for Mentally Ill Offenders in New York

by

Lauren C. Meath

B.A., State University of New York at Plattsburgh, 2006
M.A., John Jay College of Criminal Justice, 2009
M.S., Antioch University New England, 2012

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2016

Keene, New Hampshire

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

CLINICIAN PERSPECTIVES ON COMMUNITY REENTRY FOR MENTALLY ILL OFFENDERS IN NEW YORK

presented on March 17, 2016

by

Lauren C. Meath

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Kathi A. Borden, PhD

Dissertation Committee members:
Dean Hammer, PsyD
Christina Roth, PsyD

Accepted by the

Department of Clinical Psychology Chairperson
George Tremblay, PhD

on 3/17/16

* Signatures are on file with the Registrar's Office at Antioch University New England.

Table of Contents

Abstract

The prevalence of individuals with serious mental illness (SMI) in prisons has risen in recent years. While incarcerated, individuals with SMI face many challenges, such as difficulties with peers and staff, and potential exacerbation of mental health symptoms. These difficulties do not subside when reentering their communities upon release. These individuals encounter unique challenges upon release, such as facing the difficult task of finding mental health services and other resources, housing, and health insurance. This study aimed to gather the perspectives of clinicians who worked for the Office of Mental Health in New York State regarding community reentry for inmates with SMI. Participants included two groups: (a) prerelease coordinators who worked in prisons throughout the state and (b) clinicians who worked at an urban outpatient clinic. Interviews with nine participants were completed to gather provider opinions on the unique challenges faced by offenders with SMI reintegrating into society. A goal of this study was to encourage enhanced resources during the reentry process and improved community resources for mentally ill offenders. Thematic analysis was used as the method of data analysis. The results found primary themes related to discharge planning and community reentry for inmates with SMI. Identified themes included: (a) inmate psychosocial risk factors, (b) issues of access to community resources, (c) problems in the discharge planning process, and (d) factors that facilitated the discharge planning process (all included additional sub-themes). The results were generally consistent with those of prior research, noting the challenges in finding necessary community resources and the myriad issues these inmates face upon release. The findings are discussed further, highlighting interfering and facilitating factors to reentry, and comparing the perspectives of the prison prelease coordinators and the community-based clinicians.

Keywords: community reentry, mentally ill offenders, serious mental illness, prison

Clinician Perspectives on Community Reentry for Mentally Ill Offenders in New York

Chapter 1: Literature Review

Inmates with serious mental illness (SMI) face numerous challenges while in prison and even greater concerns upon reentering the community.[1] The purpose of this study was to gain outpatient and prison provider perspectives on the topic of reentry for these inmates. This study begins with a review of the relevant literature on the topics of mental illness in prisons, community treatment for individuals with mental illness, mental health treatment in prisons, and community reentry.

Prevalence of Mental Illness in Correctional Settings

The prevalence of mental illness in prisons, including SMI, is much higher than in the general population. Prevalence rates of mental illness in prison inmates have ranged in the literature, but generally continue to show higher rates than in community populations (Prins, 2014). Fazel and Danesh (2002) found in their review of prison population surveys that individuals in prison were seven times more likely than those in the general population to have a psychotic disorder or major depression. The National Commission on Correctional Health Care (as cited in Lamb & Weinberger, 2005) reported rates of SMI in jails and prisons as ranging from 16 to 24 percent. Torrey (1995) reported that the highest numbers of institutionalized individuals in the United States are no longer in psychiatric hospitals, but in correctional settings, and inmates diagnosed with SMI face multiple problems. In New York State, the number of inmates receiving mental health services almost doubled between 1990 and 2008, and there was a 21.7% increase in the presence of SMI between 2004 and 2008 (Way, Sawyer, Lilly, Moffitt, & Stapholz, 2008). A study completed in New York State prisons found that 6% of inmates

[1] Please see Appendix J for an alphabetical list of acronyms that will be used throughout this document.

entering the state prison system during a one-month period received a SMI diagnosis. This same study found that many of these inmates had a history of multiple suicide attempts and multiple psychiatric hospitalizations (Way et al., 2008).

The high rate of mental illness in prison reinforces the stereotype that all individuals with a mental illness are criminals (American Psychiatric Association [APA], 2004). A study completed in Massachusetts that followed individuals with SMI receiving state mental health services found that 27.9% of these persons were arrested over a 10-year period, with more being a result of public order crimes than violent offenses (16% versus 13.6%; Fisher et al., 2006). A survey completed in the 1990s found that more of the general public associated mental illness with dangerousness than in previous survey data (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). A more recent study focusing on stigma of mental illness in 16 countries also identified that people generally were wary about whether or not they should fear violence when encountering mentally ill individuals (Pescosolido, Medina, Martin, & Long, 2013). A high rate of mental illness in prisons is not only problematic for those inmates, but also problematic on a societal level for the reinforcement of mental illness stigma and overgeneralizations that correlate crime and mental illness.

Vulnerabilities for Mentally Ill Inmates

While this study related to community reentry and release planning, understanding the specifics of the prison experience for inmates with SMI can help provide a framework for what they might have experienced prior to entering the community. An increase in mental illness in prisons has been well documented, and individuals with SMI are vulnerable to various forms of harm in prison (APA, 2004). A recent study that included interviews to gain perspectives of former inmates found that it was a very stressful environment that often worsened their

psychiatric symptoms (Pope, Smith, Wisdom, Easter, & Pollock, 2013). Inmates with a mental illness have more difficulty adapting to prison than those without. For instance, inmates with mental illness are more likely to break prison rules and be involved in verbal or physical assaults, as well as being much more likely to be physically assaulted by other inmates than inmates without a mental illness (Blitz, Wolff, & Shi, 2008; Olley, Nicholls, & Brink, 2009).

Prisons maintain order through rules that may be difficult for inmates with SMI to follow due to psychiatric symptoms and a lack of appropriate coping skills (O'Connor, Lovell, & Brown, 2002). Generally, inmates with mental illness are more likely to engage in problematic behaviors that require disciplinary action (MacKain & Mueser, 2009). Inmates can have time deducted from their sentences for following the rules and exhibiting good behavior; this is commonly called "good time." An increase in disciplinary infractions can cause an inmate to lose "good time." Frequent episodes of misbehavior, often due to psychiatric symptoms, can lead to inmates with mental illness losing "good time" and serving longer sentences than non-mentally ill inmates (O'Connor et al., 2002).

Inmates who are acutely psychotic may at first appear as hostile and disagreeable to correctional staff, due to possible aggressive or disruptive behavior and difficulty following rules (Lewis, 2000). Within the prison system, inmates who are disruptive or exhibit problematic behaviors often get placed in isolation and segregation in an effort to separate them due to safety concerns (Kupers, 2008). Unfortunately, spending lengthy amounts of time in segregation can have negative effects on these individuals, such as psychiatric decompensation and isolation from social connections (Kupers, 2008).

Inmates with SMI are also likely to be exposed to stress by nonmentally ill inmates and correctional staff and may act out as a result. In a study comparing inmates with schizophrenia

and nonmentally ill inmates, the inmates with schizophrenia demonstrated poorer overall adjustment, with more violations involving violence, more medical or disciplinary moves throughout the system, and less ability to maintain a job in prison (Morgan, Edwards, & Faulkner, 1993). Additionally, the stress of incarceration could lead to a worsening of symptoms (APA, 2004). Furthermore, it is not only difficult for these inmates to understand formal prison rules, but it is also difficult to follow informal rules that exist within prisons (O'Connor et al., 2002). Inmates with SMI often have inadequate social skills and are unable to understand cultural rules among other inmates.

Suicide. Suicides in correctional settings far outnumber suicides in the general public (Tartaro & Lester, 2005). A study completed in New York State found that 84% of inmates who died by suicide between 1993 and 2001 had received mental health services at some point during incarceration (Way, Miraglia, Sawyer, Beer, & Eddy, 2005). Slightly more than half of these inmates had a prior suicide attempt and many had undergone recent prison stressors. A risk factor for suicide in correctional settings has been found to be residing in a single-cell, as opposed to a dormitory setting. In single cells, inmates are housed alone, as opposed to dormitories, which include beds in a large open area (Smith, Sawyer, & Way, 2004). Conviction for a violent crime has also been found as a risk factor (Way et al., 2005). Regarding psychiatric disorders and suicide, a study in New York prisons found that schizophrenia, personality disorders, and adjustment disorders were risk factors for suicide (Way et al., 2005). A qualitative study based on the prison system in Oregon found that the most frequent diagnosis among inmates who attempted suicide was major depressive disorder (Suto & Arnaut, 2010). Additionally, mental health issues, relationship issues, and prison factors appeared to be related to suicide attempts among inmates (Suto & Arnaut, 2010).

Disciplinary segregation. Inmates are expected to abide by formal prison rules and when inmates violate prison rules, disciplinary action is taken. Inmates may receive disciplinary action or be placed in disciplinary segregation for breaking prison rules, such as assault on another inmate or staff (Way, Sawyer, Barboza, & Nash, 2007). Placement in single-cell disciplinary housing may relate to deterioration of mental health and, as previously stated, can also be a risk factor for suicide (Way et al., 2007). In the previously mentioned study completed in Oregon, inmates who had attempted suicide reported that placement in restrictive housing was related to their attempt, noting deterioration of mental health while there (Suto & Arnaut, 2010). Some states have shown that there is an overrepresentation of inmates with mental illness on segregation units (Fellner, 2006). Additionally, even inmates with no history of mental illness may experience depression, anxiety, and hallucinations as a result of prolonged isolation (Fellner, 2006). A review of disciplinary housing suicides in New York State found that the average number of days in segregation before suicide was 63, leading the authors to note that increased observation may be necessary during the first two months of segregation (Way et al., 2007). Way et al. (2005) found in their study of suicide risk factors that 23% of prison suicides in New York in a nine-year time frame occurred in the Special Housing Unit (SHU), which is a disciplinary cell in which inmates are in confinement for 23 hours of the day. While placement in SHU may be a risk factor for suicide, inmates who are known to be actively suicidal typically are not placed in SHU (Way et al., 2005). Additionally, a policy was implemented which states that any inmate with an "S" designation and a SHU sanction of longer than 30 days will be referred for special programming (Central New York Psychiatric Center, 2015).

Relations with correction officers. Correction officers frequently respond to any acting out behaviors with punishment; however, this behavior may often be a result of an inmate with

SMI lacking appropriate coping methods (Morgan et al., 1993). Research has indicated that inmates with mental illness commit more assaults on staff than inmates without a mental illness (McShane, 1989). However, correction officers and mental health professionals in prisons often have conflicting goals, which can make appropriate treatment of mentally ill inmates difficult. For instance, correction officers will often respond to disorderly behavior in a punitive way consistent with their procedures, but for inmates with mental illness who often lack appropriate coping, this can worsen their stress (Morgan et al., 1993). Correction officers may not always be sufficiently trained to work with inmates with mental illness and therefore may have difficulty separating purposeful acting out from behavior related to SMI. Also, correction officers may have difficulty agreeing to alter security or make exceptions for individuals with significant mental health needs (Fellner, 2006).

Deinstitutionalization and Criminalization

The rise of individuals with SMI entering the prison system is often referred to as criminalization of mental illness, with several reasons commonly cited. Deinstitutionalization is often named as a contributing factor to increases in the numbers of inmates with mental illness (Prins, 2011). When the number of state hospital beds began to decrease beginning around 1955 due to treatment shifting from psychiatric hospitals to the community, many of these individuals may have moved into the correctional system due to the lack of appropriate community services once discharged from the hospital (Prins, 2011; Torrey, 1995). As a result of deinstitutionalization in the United States, there were over 400,000 fewer state psychiatric hospital beds available in 1990 than in 1960, according to the National Institute of Mental Health (as cited in Markowitz, 2006). Deinstitutionalization stemmed in part from to the Joint Commission on Mental Illness and Health's attempt to reduce lengthy inpatient hospitalizations

and provide community mental health treatment to individuals with SMI (Baillargeon, Hoge, & Penn, 2010). The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 was passed to help provide states with funding to develop these community programs, but funding was insufficient (Baillargeon et al., 2010).

Several additional contributing factors to deinstitutionalization have been noted. First, the introduction of medications, such as Thorazine, to treat chronic mental illnesses allowed individuals who had resided in institutions to return to the community, where follow-up was often inadequate (Markowitz, 2006; Mechanic & Rochefort, 1990). Second, many states created stricter criteria for involuntary hospitalization, namely that one must be an imminent danger to self or others. This made it more difficult for families to get their loved ones who were exhibiting psychiatric symptoms into a hospital for care (Markowitz, 2006; Mechanic & Rochefort, 1990). Of note is California's Lanterman-Petris-Short Act of 1967, which contributed to these stricter criteria, with other states following their lead in the years after (Baillargeon et al., 2010). Third, federal control of mental health funding, through programs like Medicaid, led to decreased funds for mental health services (Markowitz, 2006). One of the primary hopes with deinstitutionalization was that individuals who had been hospitalized for long periods of time would be able to lead more fulfilling lives in the community. However, many of these individuals transitioned to other institutional settings (McGrew, Wright, Pescosolido, & McDonel, 1999). When these formerly hospitalized individuals could not access the appropriate community services, many came to the attention of the criminal justice system due to untreated mental illness (Baillargeon et al., 2010).

Some potential factors that lead to criminal justice involvement for individuals with SMI, in addition to deinstitutionalization, include limited treatment access and police mishandling

(Hartford, Carey, & Mendonca, 2006). There are often insufficient resources for treatment in the community for individuals with chronic and severe mental illnesses (Lamb, Weinberger, & Gross, 2004). In most communities, supports available are not numerous enough for the number of individuals needing intensive community services for mental illness. On the other hand, some people report that deinstitutionalization was not rapid and did not place as many individuals immediately on the streets as is commonly stated. Many former residents of state psychiatric hospitals were transferred to nursing homes and other hospitals, not the community (Prins, 2011). However, opponents of deinstitutionalization often cite transinstitutionalization as occurring, resulting in large numbers of individuals with mental illness in jails and prisons (Prins, 2011). Transinstitutionalization occurs when the decreased number of state hospital beds results in some individuals with mental illness decompensating in the community, and without appropriate outpatient mental health services, their behaviors bring them to the attention of the police and criminal justice system (APA, 2004). Law enforcement officers may be unable to identify a person who is mentally ill, as they have not always had sufficient training in this area. Additionally, police officers may encounter mentally ill individuals and believe them to be under the influence of drugs and alcohol, instead of suffering from a mental illness. Further, resources are scarce in many communities (APA, 2004), so police may not have sufficient options regarding where to bring mentally ill individuals. When mentally ill individuals end up in the criminal justice system for non-violent, perhaps nuisance or mischief crimes, it reinforces the stereotype within the general public that individuals with mental illness are also criminals.

Some have also argued that the "war on drugs" (Baillargeon et al., 2010, p. 365) has contributed to an increased number of individuals with mental illness being incarcerated. Comorbid substance use is high among individuals with mental illness and is often noted to be

higher than in the general population, according to Mueser, Bennett, and Kushner (as cited in Hartwell, 2004). With the rise of the "war on drugs," Hoge reported that mentally ill individuals who abuse substances were being arrested for drug related offenses (as cited in Baillargeon et al., 2010).

Community Treatment for SMI

Specialized mental health treatment services have been developed in the community for individuals with SMI. While therapy and psychiatry appointments at general mental health clinics remain a viable option for this population, some individuals may need a higher level of care, especially as they transition out of hospitalization or incarceration. Individuals with SMI typically require psychoeducation and tools for symptom management, as these types of mental illness can be chronic in nature (Drake, Green, Mueser, & Goldman, 2003). These factors point to the beneficial aspect of specialized treatment programs for individuals facing these illnesses.

Assertive Community Treatment. Assertive Community Treatment (ACT) provides mental health services to individuals with SMI in their own environment, such as having treatment providers go to clients' homes (Mueser, Torrey, Lynde, Singer, & Drake, 2003). ACT was developed to provide community-based services to individuals with SMI in an effort to help them function in the community and avoid hospitalization (Lamberti, Weisman, & Faden, 2004). It is an intensive approach for individuals in need of the most comprehensive services, from which some individuals can eventually be discharged to less intensive programs (Bromley, Mikesell, Armstrong, & Young, 2015). McGrew and Bond (1995) interviewed ACT experts and among the results they reported on several key factors leading to ACT being successful. These included using a team approach with small caseloads for case managers, providing outreach in the community so as to help individuals meet basic needs, and helping clients avoid

hospitalization and remain in the community. They also found that most experts believed that psychiatrists, social workers, and nurses would make ideal team members (McGrew & Bond, 1995). Many studies have been completed since ACT took shape in the 1970's that demonstrate its effectiveness at helping people remain successfully in the community (Mueser et al., 2003).

Psychiatric rehabilitation. Psychiatric rehabilitation is a longstanding, comprehensive community treatment for individuals with SMI and is focused on recovery and tailoring treatment to building upon strengths (Drake et al., 2003). Psychiatric rehabilitation can provide intervention at various levels, and focused on improving overall functioning and enjoyment of life (Corrigan, 2003). This can be accomplished by helping in many areas, including increasing social supports, social skills, housing, daily living skills, or even employment (Corrigan, 2003; Drake et al., 2003). Individuals with SMI can face chronic symptoms, so psychiatric rehabilitation is focused on improving overall functioning in addition to symptom management. Services are best offered to individuals with SMI when they are inclusive of clinical and psychosocial needs, and are client-centered, thereby focusing on each individual's needs (Drake et al., 2003). Individuals with SMI in later recovery stages might also make positive members of a multidisciplinary psychiatric rehabilitation team, as they can provide a peer support role that could be beneficial (Corrigan, 2003).

Cognitive-Behavioral Therapy (CBT). Versions of CBT have been adapted for use with SMI, and, more specifically, are commonly used for schizophrenia and other psychotic disorders. CBT can provide useful cognitive and behavioral strategies and interventions for managing SMI, as well as provide helpful psychoeducation to better inform individuals about their illness. Studies have shown that when compared to other treatment, individuals with schizophrenia who had CBT showed better long-term outcomes in terms of symptoms (Dickerson, 2004), including

negative symptoms (Rector, Seeman, & Segal, 2003). Dickerson found in a review of relevant research that studies of CBT efficacy found effective programs had several elements in common, including psychoeducation about the illness and potential stigma and strategies for managing symptoms. Cognitive approaches been found to be helpful in cognitive restructuring, such as challenging thought and beliefs, specifically related to delusions and hallucinations (Gould, Mueser, Bolton, Mays, & Goff, 2001).

Personalized Recovery Oriented Services (PROS). PROS is a newer form of treatment for individuals with SMI that is recovery oriented. PROS programs offer comprehensive services to increase recovery for these individuals, including the components of community rehabilitation and support, intensive rehabilitation, ongoing rehabilitation and support, and clinical treatment (New York State Office of Mental Health [NYS OMH], n.d.-b). According to the Office of Mental Health (OMH), the goal of PROS programs is to "improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing" (NYS OMH, n.d.-b). This can provide a good alternative to day treatment in the community, as they may offer a variety of services throughout the day, but in a recovery oriented manner in that the individual can choose the services that apply specifically to their needs.

Treating Mental Illness in Prison

Understanding prison treatment options will provide a framework for understanding what skills or illness management strategies inmates with mental illness would have acquired in prison and may have upon entering the community. With such large numbers of inmates with SMI, tailoring treatment to the needs of that population is important. Applebaum reported that some individuals may receive a thorough mental health evaluation and subsequent treatment for the

first time while incarcerated (as cited in Soderstrom, 2007). Proper mental health treatment in prisons is crucial, given the aforementioned challenges faced by inmates with mental illness.

Psychiatric rehabilitation, as previously mentioned, has shown potential during early implementations as a positive treatment method in prisons (MacKain & Mueser, 2009; Morgan et al., 2012). A meta-analysis by Morgan et al. found that programs in correctional settings with the most positive outcomes treated both mental illness and criminality. Additionally, treatment programs that utilized homework assignments and behavioral exercises had better treatment outcomes than other programs. Positive treatment effects included increased coping and a reduction in distress, as well as improved behavior within the correctional environment (Morgan et al., 2012). These results indicated that positive treatment effects can occur within prison settings for inmates with mental illness.

Consistent with research that shows it is most helpful to treat mental illness and criminality, a survey of mental health providers in prison settings indicated that clinicians in correctional settings do indeed attend to both areas (Bewley & Morgan, 2011). More specifically, clinicians provided treatments with the following areas of focus: (a) mental illness, (b) skill development, (c) behavioral functioning, and (d) criminogenic needs. Criminogenic needs, as defined for this survey, consisted of antisocial thoughts, behaviors, and peers, as well as substance abuse (Bewley & Morgan, 2011).

New York State Prison Mental Health Treatment

In New York State, mental health treatment within state prisons is offered through OMH, working in conjunction with the Department of Corrections and Community Supervision (DOCCS). Through the services of Central New York Psychiatric Center (CNYPC), an OMH facility, mental health treatment is offered within prisons via outpatient CNYPC sites. CNYPC is

a maximum-security hospital that provides inpatient psychiatric services to inmates incarcerated in NYS prisons. According to Smith et al. (2004), CNYPC has approximately 800 admissions per year, with 71% having an Axis I diagnosis of schizophrenia or other psychotic disorder. Outpatient clinics exist in 28 of the 70 prisons in New York, and services are provided to approximately 8,500 inmates within prisons across the state (NYS OMH, n.d.-a). In addition to clinic services, there are 15 full satellite units (NYS OMH, n.d.-a) and other specialized outpatient prison mental health services include the Residential Mental Health Unit (RMHU), the Residential Crisis Treatment Program (RCTP), Intermediate Care Programs (ICP), and basic mental health services which are offered in SHU (Smith et al., 2004).

CNYPC outpatient treatment. Most prison systems in the United States employ the method of screening new inmates for mental health needs and then transferring them to an appropriate facility and program (Baillargeon et al., 2010). This is what occurs in the New York prison system, with inmates being sent originally to a reception facility, of which there are four in the state. Once there, each inmate meets with a mental health clinician for an evaluation to determine the need for mental health services (Smith et al., 2004). This includes review of previous mental health records and an interview to determine mental health history and any current symptoms. Inmates will typically begin receiving mental health services at the reception facility before being transferred to another facility to serve the remainder of his or her sentence, though inmates can be opened to mental health services at any point during their incarceration if there is a need. An inmate's next destination in part depends on his or her mental health needs. When inmates enter the New York prison system, they are assigned mental health levels ranging from 1 to 6. These levels can determine prison assignments, as not all prisons offer all levels of services (Smith et al., 2004). Inmates in need of the most comprehensive mental health services

will be assigned to Level 1 and sent to a prison offering services seven days per week. Level 1 indicates the presence of SMI with active symptoms (New York State Commission on Quality Care and Advocacy for Persons with Disabilities, 2010). Level 2 also indicates a diagnosis of SMI, but without active symptoms or severe impairment. Level 3 inmates are in need of mental health services including medication management, but can function in a facility offering part time mental health services. Level 4 inmates receive mental health services for milder disorders and are not in need of medication. Level 5 is not currently used at any of the facilities. Lastly, level 6 inmates do not receive mental health services (New York State Commission on Quality Care and Advocacy for Persons with Disabilities, 2010). There is also an "S" designation, which can be added to a level 1 or level 2 to signify that the person has a SMI diagnosis, such as schizophrenia, psychotic disorders, or major depressive disorder. An "S" designation is required for an inmate with any of these diagnoses (New York State Commission on Quality Care and Advocacy for Persons with Disabilities, 2010). Levels to which inmates are assigned may change as their needs change (Smith et al., 2004).

Regarding specialized mental health services, the RMHU was designed to serve as a residential program for inmates with SMI and who have disciplinary infractions that typically would warrant 30 days confinement in SHU or 60 days in keeplock housing, where inmates are confined to their cells. Instead of spending time in SHU, inmates who meet these criteria now spend time in RMHU where their segregation time will continue to run (NYS OMH & New York State Department of Correctional Services [NYS DOCS], 2009). RCTPs were developed for inmates who are in crisis and in need of immediate services, primarily stabilization and evaluation services (New York State Commission on Quality Care and Advocacy for Persons with Developmental Disabilities, 2010; Smith et al., 2004). ICPs provide mental health services

to inmates who have difficulty functioning in the general population due to their SMI. ICPs were designed for inmates who require more care than the usual outpatient services, but do not require inpatient hospitalization (Condelli, Bradigan, & Holanchock, 1997). As of 2010, there were 743 total ICP beds in the state (Wlock, Lilly, & Moffitt, 2011).

Recidivism

Recidivism rates among nonmentally ill offenders have ranged in the literature, but studies have typically reported high rates of recidivism (Stahler et al., 2013). A recidivism study of 15 states using release data from 1994 found that within three years of release, 67.5% of individuals had been rearrested (Langan & Levin, 2002). A study completed in Utah found that inmates with SMI returned to prison nearly a full year sooner than inmates without mental illness, as the median number of days until reincarceration was 381 versus 728 days (Cloyes, Wong, Latimer, & Abarca, 2010). For adults with psychotic disorders and criminal histories, typical community mental health services alone often do not prevent future incarcerations (Fisher, Packer, Simon, & Smith, 2000). Constantine, Robst, Andel, and Teague (2012) conducted research in two counties in different states, and found that receiving outpatient mental health services decreased the likelihood of recidivism in the short term; however, results were more mixed as time went on. Lovell, Gagliardi, and Peterson (2002) reported that many individuals with SMI in their study did recidivate, but most were for far less serious offenses than they had previously committed. They also found that the SMI population had a slightly higher felony recidivism rate than offenders without mental illness who were released into the community during the same period, though those with SMI rarely committed violent offenses (Lovell et al., 2002). However, rates of felony offenses for the entire sample decreased after one year. Although not statistically significant, the authors noted that individuals who committed

new felonies had fewer and later post release encounters with mental health systems than those who did not commit new felonies (Lovell et al., 2002). A study completed in New York found a recidivism rate for a follow-up period of 22 to 46 months in individuals with SMI of nearly 50%, but only 11% were for violent offenses (Hall, Miraglia, Lee, Chard-Wierschem, & Sawyer, 2012).

Risk factors for recidivism. Andrews and Bonta (2010) have reported on a set of risk factors that are commonly associated with recidivism in general criminal populations; they refer to these major risk factors as the central eight. These risk factors are (a) history of antisocial behavior, (b) antisocial personality pattern, (c) antisocial cognitions (including beliefs supportive of crime), (d) antisocial associates, (e) problems in family and/marital relationships, (f) problems in school and/or work, (g) problems in leisure and/or recreation (including lack of non-criminal activities), and (h) substance abuse (Andrews & Bonta, 2010). Elevated problems in any of the above areas have been associated with criminal recidivism, and many of these same problems are often present for offenders with mental illness. Research has shown that offenders who are young, male, and homeless are at increased risk for recidivism (Constantine et al., 2012). In a study of prison release of mentally ill offenders, Lovell et al. (2002) identified the same recidivism risk factors, along with the finding that having committed previous violent felonies was associated with increased risk of future violence. Specifics of mental health history in a sample of individuals with SMI, such as diagnosis or history of psychiatric hospitalization, was not identified as a recidivism predictor in one New York study (Hall et al., 2012), though level of symptomatology at time of release may be a factor in community success. For offenders with mental illness, a meta-analysis revealed that prior criminal history and antisocial personality

were most strongly predictive of both general and violent recidivism (Bonta, Law, & Hanson, 1998).

Community Reentry

As incarceration rates have risen, including for inmates with SMI, many individuals are returning to their communities from prison (Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005). Community reentry is generally a challenging experience for all inmates. These individuals often face housing and employment challenges, and they are often released from prisons with few resources (Baillargeon et al., 2010). However, release from prison is even more challenging for inmates with SMI. Community reentry from prison is different than from jail, as being in prison typically means more time spent out of the community and serving longer sentences. Therefore, when released from jail, an individual has not spent as much time separated from the community and reintegration into the community may be a smoother transition (Draine et al., 2005). Due to longer stays in prisons and lengthier separation from their communities, more adjustment is usually needed to successfully transition, as individuals may have adapted to the prison lifestyle.

Community reentry challenges. Individuals with SMI face many challenges upon prison release. In addition to the specific obstacles that are listed below, these individuals often face the stigma of both being an offender and having a mental illness, which are two challenges that can lead to rejection by their community (Draine et al., 2005). These individuals are often poor, can make others feel frightened, and are seen as undesirable candidates for services by community agencies (Draine et al., 2005). However, community support is needed to help these ex-offenders successfully reintegrate into society.

Hatcher (2010) conducted a qualitative study to determine inmate and staff views regarding elements of community reentry that are of primary importance to offenders, as there

can be a separation between what staff finds important and what offenders find important. The author found that inmates believed that caring for daily living and successfully integrating into the community were most important, while recreational activities such as going to the movies were least important. They also believed that stereotypes about offenders could negatively impact their reintegration. Hatcher found that staff areas of importance were very similar to those of inmates, with the exception of criminal justice, with staff members placing more importance on factors related to the criminal justice system. However, the groups differed in many areas regarding feasibility of obtaining services and getting needs met, with a conclusion that staff do not find as many feasibility issues as inmates and do not perceive reintegration to be as difficult as inmates.

Probation and parole. Individuals who are released from prison often have requirements for community supervision upon release. When granted parole, individuals are released from prison early to serve the rest of their sentence in the community. In New York, parole is part of the DOCCS agency, as are the state prisons. Those who are sentenced to probation are monitored by a probation agency in the community, sometimes after a brief jail sentence or often instead of incarceration (Bureau of Justice Statistics, n.d.). Individuals with mental illness often have increased difficulty complying with rules of community supervision, and have additional conditions that those without mental illness do not face, such as mandated mental health treatment. Some probation/parole officers will carry specialized caseloads of offenders with mental illness, which would include having smaller caseloads and officers with special mental health training (Skeem, Emke-Francis, & Eno Louden, 2006). Research has found that as specialty agency caseloads increased, the way that treatment was enforced became similar to that of traditional agencies, i.e., threatening incarceration (Skeem et al., 2006). Previous research has

found that specialty officers are more likely to encourage rehabilitation, whereas traditional officers are primarily focused on community safety (Skeem, Encandela, & Eno Louden, 2003). However, the relationship between probationers and officers in either type of agency was found to impact outcome (Skeem et al., 2003). Additionally, officers in specialized programs have been found to more frequently meet with individuals with mental illness and meet as part of a mental health treatment team than traditional officers who work with mentally ill offenders (Eno Louden, Skeem, Camp, & Christensen, 2008).

Obtaining services. Individuals with mental illness who are released from prison are faced with the challenge of establishing new mental health services, including obtaining medications that might be necessary to maintain psychiatric stability (Hall et al., 2012). Many community programs are ill equipped to deal with the unique needs of individuals with mental illness and previous involvement in the criminal justice system. Due to the lack of appropriate community mental health services, many offenders with SMI may receive intermittent mental health care (Baillargeon et al., 2010). Community mental health settings may not have experience dealing with probation and parole, and also may be concerned about staff safety when working with previous offenders (Haimowitz, 2004).

Housing and employment. Individuals released from incarceration with SMI have been found to have higher rates of homelessness than those without mental illness, according to Solomon et al. (as cited in Baillargeon et al., 2010). Additionally, it has been posited that individuals with SMI who are homeless may not receive appropriate treatment and may become involved with the criminal justice system (McNiel, Binder, & Robinson, 2005). Research has shown that many people with mental illness were homeless prior to incarceration (McNiel et al., 2005), so the risk of being homeless after release is a realistic concern. Additionally, incarcerated

individuals who have been homeless previously have shown a greater likelihood of being diagnosed with a substance abuse or mental disorder, as well as more likely to be dually diagnosed, than individuals who had not been homeless (McNiel et al., 2005). Difficulty finding employment is also usually more profound for offenders with mental illness than for their non-mentally ill peers (Hall et al., 2012). Solomon et al. (as cited in Baillargeon et al., 2010) found that accessing and maintaining employment was difficult for offenders with mental illness who were both male and female.

Dual diagnosis. Previous research has shown high rates of comorbid substance use and SMI in both male and female offender samples (Abram, Teplin, & McClelland, 2003; Hartwell, 2004). In a study of female offenders, those with SMI were found to be 1.5 to 4.9 times more likely than women without SMI to have substance abuse disorders (Abram et al., 2003). Additionally, James and Glaze (2006) have noted that more than half of inmates in their state prison, federal prison, and jail samples with a mental illness reported using substances within the month prior to their arrest. These authors also found that inmates with mental health issues had higher rates of substance abuse and dependence (James & Glaze, 2006). Individuals with SMI who also use drugs or alcohol can become involved with the criminal justice system due to their substance use. Their ability for appropriate decision making can be compromised both by their mental illness and substance use (Hartwell, 2004). The previously mentioned challenges, such as housing and employment, can be exacerbated by comorbid substance abuse. Offenders who are dually diagnosed have been found more likely to be homeless upon release from incarceration when compared to those without substance abuse disorders (Hartwell, 2004). Additionally, dual diagnosis has been associated with recidivism (Hartwell, 2004). When inmates with dual diagnosis are released into the community without adequate services in place, this can lead to

mental health symptom and substance abuse relapse (Draine et al., 2005). It can be difficult for offenders with dual diagnosis to access appropriate services, as finding services to attend to both substance abuse and mental health can be complicated. Substance abuse agencies will sometimes have difficulty appropriately treating the psychiatric disorder and mental health services may not appropriately treat the substance abuse (Hall et al., 2012). Additionally, while released offenders with dual diagnosis are likely to engage in community services in the short term, they are also often lost to service providers and return to incarceration or hospitalization in the long term, due to the often chronic nature of substance abuse problems (Hartwell, 2004). Release from prison can be a stressful time, especially for some inmates who have been incarcerated for lengthy periods of time and may be unfamiliar with current society; this can also contribute to relapse of substance use, or involvement in criminal activity (Stephens, 2011). Successful placement of dually diagnosed offenders in outpatient substance abuse services has been found to be associated with engagement in other services and activities as well, such as obtaining health insurance and joining social clubs (Hartwell, 2004).

Antisocial attitudes and incarceration culture. Many individuals with a history of incarceration have developed attitudes and behaviors that were adaptive in prison or jail, but are no longer adaptive for successful community reintegration or mental health treatment (Rotter, McQuistion, Broner, & Steinbacher, 2005). Some examples include not wanting to disclose problems and intimidating others (Hall et al., 2012). While keeping problems to oneself in prison is adaptive so one can appear strong, this may lead to an inability to get help due to reluctance to share needs with mental health staff (Rotter et al., 2005).

In addition to being skilled at interventions specific for SMI, clinicians working with individuals with a criminal justice history should be aware of cognitive and behavioral

interventions appropriate for antisocial traits (Allen, Mackenzie, & Hickman, 2001; Lamberti, 2007). A survey conducted with staff members of diversion and other community based programs for offenders with SMI found that staff members reported most of their clients exhibited criminal thinking styles (Wolff et al., 2013). Examples of these thinking styles included ignoring thoughts that deter crime, believing that they can avoid the negative consequences of their behaviors, and externalizing blame as a way to rationalize their behaviors. Typical community mental health centers may not be equipped to deal with the antisocial nature of some ex-offenders, and community mental health providers may not know how to respond to such thoughts and behaviors (Rotter et al., 2005). The Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) approach was designed to help community providers understand and intervene better with ex-offenders, by better understanding the prison culture to which they have become accustomed (Rotter et al., 2005). Within this approach, staff members are trained to recognize and appropriately respond to criminalized attitudes or behaviors. The client component of this approach is a group treatment called Reentry After Prison/Jail (RAP), which focuses mainly on psychoeducation and social skills. This approach has been used in diversion and reentry programs (Rotter et al., 2005). As of 2011, there had not been any controlled studies of program efficacy (Rotter & Carr, 2011).

Transition Planning

It is crucial that jails and prisons provide assistance with reentry planning to inmates with SMI due to the above mentioned challenges that they face. Increasingly, states have been implementing transition planning services for inmates with SMI, including assistance with obtaining mental health services, supplying medication, and developing an individualized discharge plan (Baillargeon et al., 2010). The American Association of Community Psychiatrists

[AACP] (2001) recommended that discharge planning begin soon after admission for inmates with mental illness, as it may take time to establish the appropriate services. Discharge plans should be comprehensive and cover many areas, such as mental health, medical, and social services (AACP, 2001). Getting input from the inmates about their discharge plan, and allowing them to feel some autonomy in the process, will serve them well as they may be more prone to continue with outpatient treatment if they were involved in the plan (AACP, 2001). If family members are available and willing to support the inmate, their involvement is also encouraged (AACP, 2001). Haimowitz (2004) also recommends some strategies for combating potential reentry challenges. An important component can be a clear discharge plan that is established collaboratively by community and correctional staff, so that the individual has an understanding of what to expect upon release and can experience continuity of care. This process should be done long before discharge, so that different agencies have an understanding of their roles in the reentry process. Similarly, community correctional agencies, such as probation, parole, and mental health staff should have a clear understanding of each agency's role. For instance, providers will need to establish who will be in charge of case management activities and who will be in charge of making visits to the offender's home. Community providers should also discuss any potential barriers to effective collaboration (Haimowitz, 2004). As previously stated, it is often the case that correctional and mental health agencies have divergent goals, so steps should be taken to deal with any barriers and to enhance successful communication. As such, mental health and correctional agencies may benefit from attending trainings at which they can learn about what the other does (Haimowitz, 2004). This can be helpful in encouraging collaboration toward the common goal of helping individuals with successful community reentry.

The federal government has provided funding for some programs to assist in community reentry for ex-offenders who pose the greatest risk to society. An example is the Serious and Violent Offender Reentry Initiative; according to the U.S. Department of Justice, this provides funding for reentry programs in all states (as cited in Draine et al., 2005). Several authors have reported that there is a lack of empirical evidence to guide reentry programs (Blank Wilson & Draine, 2006; Osher, Steadman, & Barr, 2003), but several models and programs have been developed in an attempt to fill this gap and provide important transition services. Blank Wilson and Draine collected survey information about community reentry programs for offenders with mental illness nationwide and found 50 established programs with details of their offerings. The authors found that the majority of these programs were implemented by criminal justice, not mental health agencies. Further, the programs that were run by criminal justice systems engaged in more agency collaboration than the programs run by mental health (Blank Wilson & Draine, 2006). Just as successful reentry depends on an individual's willingness to live prosocially in the community, it also depends on the community's ability to receive the individual and appropriately serve him or her (Draine et al., 2005). Plans for reentry can only be as effective as the collaboration among agencies, so effective collaboration is critical (Osher et al., 2003).

Draine et al. (2005) posit that successful community reentry for ex-offenders is reliant on both the individual being willing to participate in the community prosocially, and the community being willing to accept the individual. Based on this concept, they have developed a model of reentry that relies on both the community and the individual doing their part to make successful reintegration possible. While many reentry models are service-focused, this model is driven by the social process as well. Individuals who are released from incarceration have had their needs met through the criminal justice system during the period of their incarceration, so they often

need support when trying to find structure in the community. Whether or not someone can acquire this support may depend on what social connections one has in the community. Often either the community is unwilling to provide resources to an offender, or it does not have the appropriate resources to give. The model reported by Draine et al. described how an individual and the community can come together after inmate release, which can happen most successfully when the community is willing and able to accommodate the inmate's needs. The authors posit that as the gap between an individual's needs and community resources narrows, the individual's needs can be met in a prosocial way and community integration can then be successful (Draine et al., 2005).

New York State and transition planning. As previously mentioned, mental health services in New York prisons are implemented under the auspices of CNYPC; this includes prison reentry services for inmates with mental illness. According to Hall et al., New York employed 25 prerelease coordinators who help establish services such as Medicaid and Supplemental Security Income (SSI), as well as find mental health treatment prior to release. These prerelease coordinators help inmates access medications and insurance, as well as community treatment providers (Hall et al., 2012).

New York also has established several specialized reentry programs to assist qualified inmates with reentry. These programs include the Community Orientation and Reentry Program (CORP) for male inmates with SMI and the Safe Transition and Empowerment Project (STEP) for females (Hall et al., 2012). Upon release from prison, individuals most commonly receive treatment at community mental health settings. Inmates with SMI returning to New York City may be eligible to enroll in the Parole Supported Treatment Program (PSTP). This program originated in 2002 and was designed for inmates with SMI and a history of substance abuse.

Parole officers who work in this program are specially trained to work with this population and collaborate with community treatment providers (Hall et al., 2012). The released individuals are also assigned an Intensive Case Manager or a Supportive Case Manager during the first three months post-release to further help obtain appropriate services. Treatment services are in the style of assertive community treatment, which is an evidence-based community treatment model for individuals with SMI (Cusack, Morrisey, Cuddeback, Prins, & Williams, 2010). The program includes providers such as nurses, psychiatrists, and peer specialists. Individuals enrolled in PSTP also have access to supported housing and apartments (Hall et al., 2012).

Community Reentry Models

Descriptions and research regarding various models for community reentry have been published, with several being reviewed here. While there are likely more programs and models than could be described here, these provide a sampling of some current efforts toward successful community reentry for inmates with SMI.

Regarding community reentry models for individuals with dual diagnosis, Osher et al. (2003) developed the APIC model, which is currently considered a best practice for reentry from jails. The model is dependent on effective communication among systems, such as criminal justice, mental health, and substance abuse agencies. The APIC model stands for assess, plan, identify, and coordinate (Osher et al., 2003). The authors posit that if these components are completed, alone or in combination, community reentry can lead to better outcomes for inmates with SMI and co-occurring substance abuse. The stages of this model are relevant for mental health, criminal justice, and substance abuse treatment agencies to consider when working with an individual returning to the community from jail. Developing a coordinating committee can be helpful in building this collaboration of systems (Osher et al., 2003). The assessment stage

includes the need to assess the inmate's clinical and social needs, as well as assessing any public safety concerns. The main components of this stage are hearing from the inmate what his or her needs are, and in addition to establishing clinical services, helping the inmate acquire insurance and public assistance so that he or she can pay for services. The planning stage is designed to plan services that are most appropriate to a specific inmate's needs. Some important services include housing, mental health and substance abuse treatment, medical care, medication, and others (Osher et al., 2003). The identify stage refers to the need to identify specific programs of need for the inmates, and establish which programs will be responsible for services after the inmate is in the community. Lastly, the coordination stage involves coordinating the plan so that the inmate has the greatest chance for success and does not experience lapses in care (Osher et al., 2003). The authors note several differences between community reentry from jail and from prison. Jails hold inmates with shorter stays, either still unsentenced and awaiting court, or those who have brief sentences, often under one year (Osher et al., 2003). While APIC has not specifically been evaluated in regard to reentry from prisons, it seems that the underlying model could be applicable to anyone returning to the community from incarceration (Stephens, 2011).

The state of Connecticut has developed the Connecticut Offender Reentry Program, which is a specialized program for offenders with violent offenses and co-occurring SMI and substance abuse issues (Kesten et al., 2012). After realizing that these inmates were not having their needs adequately met by the state's programming, this program was developed to help them transition to the community. This program begins while inmates are still incarcerated, with inmates who have 6 to 12 months left on their sentence being included. The Connecticut Offender Reentry Program has three components, the first of which is a "Life Skills Reentry Curriculum" (Kesten et al., 2012, p. 22) that occurs while participants are still incarcerated. This

curriculum centers on issues pertinent to this specific population, focusing on various mental health and substance abuse topics. The other two components involve collaborative reentry planning and implementation of the plan. Staff members in this program remain in contact with released individuals until connections are made to services. Housing assistance is also provided. The authors completed a study that compared inmates receiving mental health services as usual in the correctional system to participants of the Connecticut Offender Reentry Program, finding that program participants had a lower recidivism rate up to six months after release (Kesten et al., 2012).

Another approach to reentry is the ACTION approach, which aims to bring together different community systems to work toward successful reentry. Specifically, mental health, substance abuse, and criminal justice systems collaborate to bridge any service gaps for offenders returning to the community (Vogel, Noether, & Steadman, 2007). The ACTION approach is multidisciplinary and includes an educational cross-training program for providers working in substance abuse, mental health, and criminal justice agencies, with an emphasis on systemic change and collaboration to help improve individual reentry. An important component of the training is developing a Local Cross-Systems Map, which describes visually an individual's movement through the criminal justice system, such as court proceedings and jail. This can highlight possible places for intervention, diversion, or community collaboration. Additionally, an Action Plan is developed as part of the training, which outlines steps that the agencies can take toward systems change and how to effectively make the changes (Vogel et al., 2007). Vogel et al. also reported that an evaluation was completed after the training, to assess perceived strengths and weaknesses of the program. An outcome evaluation showed that agencies involved in the training have implemented systems changes to make transition to the

community a more successful process for offenders. Some of these changes included better preparing the community for inmate return, hiring employees to be liaisons between the community and the jail, and developing and maintaining a task force to sustain the plan (Vogel et al., 2007).

Critical Time Intervention (CTI) is a program that coordinates community providers and builds supports for individuals with mental illness during community reentry from prison (Draine & Herman, 2007). The program lasts nine months and is time-limited so that the person can establish connections with CTI support and then continue with community services after the program is complete. This model was originally created for use with individuals transitioning out of homeless shelters, but it has since been used for release from psychiatric hospitalization and prison. The model's two components are to deepen community ties to establish long-term supports for individuals, and to provide emotional support and advocacy during early transition into the community (Draine & Herman, 2007). A recent study of CTI in England found that those individuals engaged in CTI were better connected to services upon release from prison than those in treatment as usual (Jarrett et al., 2012). While studies have been done looking at CTI as related to homelessness and psychiatric hospitalizations, the aforementioned study by Jarrett et al. (2012) is the only one known to me that looks at CTI with an offender population.

Alternatives to Incarceration

A more recent approach to the problem of mental illness in criminal justice settings has been to use diversion programs as an alternative to incarceration. These programs arose when it became apparent that some individuals involved with the criminal justice system do not benefit from the typical prosecution method. This was first discovered in the case of drug offenders and these alternatives to incarceration began with drug courts in the 1980s, which offered treatment

resources as opposed to the punishment of incarceration (DeMatteo, LaDuke, Locklair, & Heilbrun, 2013). Constantine et al. (2012) reported that the outcomes for such programs have been mixed, with some research citing positive changes in rearrest and jail stays, and others showing that diversion programs may not be effective at reducing recidivism for mentally ill offenders. Wolff et al. (2013) refer to a variety of programs established to assist individuals with SMI and involvement with the legal system. They refer to programs such as jail diversion, drug and mental health courts, specialized probation, and Forensic Assertive Community Treatment (FACT) as "first generation interventions" (Epperson et al., 2011, p. 3; Wolff et al., 2013, p. 2). These programs adhere to the principal that providing these individuals with mental health treatment reduces involvement with the criminal justice system. Research has been mixed regarding the efficacy of these "first generation interventions" to reduce criminal justice involvement and psychiatric symptoms, with most studies showing at least minimal effectiveness (Wolff et al., 2013). Diversion programs can be differentiated as either prebooking or postbooking, which has to do with the stage in the criminal justice process at which individuals are engaged with a diversion program. As the names imply, prebooking programs connect with individuals when they are arrested, and postbooking programs connect upon release from the court system (Lamberti et al., 2004). A study of both pre- and post-booking jail diversion programs found that while offenders spent less time in jail, they had arrest rates comparable to offenders not in a diversion program (Steadman & Naples, 2005). Hartford et al. (2006) reported about several prebooking programs in various states, specifically noting the success of the Crisis Intervention Team in Memphis, TN with lower arrest rates and more individuals being taken to treatment instead of jail. They also found, in a review of literature on pre-arrest diversion programs, that 70% of police departments that responded to the survey provided mental health

training to their police officers. From their literature review, they found that programs perceived to be successful had several features in common, including mental health and criminal justice agencies being involved in development, the agencies involved having regular group meetings, having a person whose role was to coordinate between mental health and criminal justice agencies, and having a mental health drop-off center that could not refuse police cases (Hartford et al., 2006).

The Nathaniel Project is an alternative to incarceration program in New York City offered to offenders with mental illness and serious criminal charges that would typically call for time in state prison (Haimowitz, 2004; National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2002). Individuals can be referred to this program before a case disposition has been reached and, if accepted, they can be released from jail to the custody of the Nathaniel Project, instead of serving prison time. Program length is two years and if an individual fails to complete the program, he or she may be sentenced to serve time in prison (National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2002). As previously mentioned, finding appropriate community mental health services for ex-offenders can be challenging, and the Nathaniel Project acknowledges that this is also a challenge for them. In addition to mental health services, participants are provided housing opportunities and case management services. Outcomes have been positive, with the program reporting decreased rates of rearrest, successful engagement in the program and treatment, and a decrease in homelessness (National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2002).

FACT. FACT programs are a forensic adaptation of the previously described treatment approach ACT. Both ACT and FACT offer comprehensive services, including psychiatry, are often comprised of a team and mobile approach, and are available at any time of the day (Cusack

et al., 2010; Lamberti et al., 2004). FACT is an example of a pre-booking strategy (Baillargeon et al., 2010). FACT differs from ACT in that it is appropriate for individuals who have been involved with the criminal justice system, and collaboration with the criminal justice system is a crucial component of FACT (Lamberti et al., 2004). In addition, FACT programs often have a supervised housing component as part of the program, and ACT programs do not (Lamberti et al., 2004). FACT may be a way to get appropriate outpatient services to individuals involved with the criminal justice system, as these services are often difficult to find. While FACT programs have begun developing in recent years and are commonly used, there has been little empirical evidence describing their efficacy (Cusack et al., 2010). One survey of FACT programs found that 16 programs in nine states were being implemented differently and there was not a consistent FACT protocol (Lamberti et al., 2004). In one of the first randomized clinical trials examining whether FACT reduced psychiatric hospitalizations, interaction with the criminal justice system, and offender costs, Cusack et al. found positive effects of the FACT program in a California community. Participants in the FACT program had fewer interactions with the criminal justice system and fewer psychiatric hospitalizations than a treatment as usual group. While the outpatient cost was slightly higher for the FACT participants, there was less of a financial burden from inpatient psychiatric hospitalizations, as well as incarceration (Cusack et al., 2010). Erickson et al. (2009) found that recidivism risk factors for individuals with SMI who received FACT were the same as for the general offender population. Significant recidivism risk factors were found to be antisocial traits, being asked to leave housing during treatment, and history of violent crime arrests (Erickson et al., 2009).

Mental health courts. Mental health courts are an example of a postbooking strategy (Baillargeon et al., 2010) and have been developed across the country as a way to re-route

offenders with SMI through the criminal justice system. This is one type of problem-solving court that arose and was designed after the success of drug courts (DeMatteo et al., 2013). These courts differ from regular courts in that the focus is on treatment and an effort to move the individual away from the criminal justice system (McNiel & Binder, 2007). There have been increasing numbers of mental health courts and the breadth of their services has been expanding (Castellano & Anderson, 2013). While mental health courts originated for offenders with non-violent misdemeanor charges, more recently, mental health courts have been developed for offenders with violent or felony charges (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). There is typically a specific mental health court judge, and criminal justice and mental health systems usually work together to make appropriate determinations for an offender. To be eligible for participation in mental health court, most courts would require a diagnosis of SMI and that the individual voluntarily agree to go through the mental health court (i.e., treatment and court hearings about same) instead of the regular court process (Castellano & Anderson, 2013). Further, most mental health courts take place post-adjudication and require an offender to plead guilty in order to participate (Castellano & Anderson, 2013). A study that included interviews of offenders going through mental health court found that most participants had a positive experience with the actual court process and with the therapy component (Kennedy, 2012). Participants spent less time in jail, attended scheduled therapy appointments, and were generally more engaged in treatment than before they became involved with the mental health court (Kennedy, 2012). One California study comparing recidivism rates of mental health court participants and other offenders with mental illness entering the criminal justice system found that the individuals going through mental health court had longer time periods without any new involvement with the criminal justice system (McNiel & Binder, 2007).

Community Outpatient Treatment

As previously mentioned, standard outpatient mental health treatment approaches may not be appropriate for individuals with SMI and prior criminal justice involvement, as typical outpatient mental health programs are ill-equipped to deal with the special needs of this population. When these individuals cannot access appropriate treatment, they may engage in high-risk and problematic behaviors, such as becoming assaultive or engaging in some other behaviors that may bring them to the attention of police (Lamberti, 2007). While it is important to provide treatments that are appropriate for mental health symptoms, it is also necessary to utilize techniques, such as cognitive and behavioral approaches, that are relevant to intervene with antisocial cognitions and behaviors (Allen et al., 2001; Lamberti, 2007). Additionally, integrating the various outpatient services that individuals may be receiving and helping to coordinate care is important. In addition to needing mental health or substance abuse services, these individuals may also face criminal justice services that can be difficult to navigate. Further, the risk factors referred to above, as discussed by Andrews and Bonta (2010), could be at play in these individuals' lives and may require clinician attention.

Many communities also offer assisted outpatient treatment (AOT) for individuals with mental illness who are also at risk for criminal behavior (Appelbaum, 2005; Markowitz, 2011). These individuals may be mandated into mental health treatment in the community if they are unable to care for themselves, and this may be another way for these individuals to receive appropriate outpatient treatment. This could mean a court order requiring that an individual receive intensive case management services while under AOT (Gilbert et al., 2010). An alternative approach is that individuals agree to sign a voluntary agreement to participate in the same services that a court order would mandate, but a formal court order is not given. A study in

six New York State counties looked at arrest rates for individuals with AOT or voluntary agreement involvement versus those with SMI and criminal justice histories who were not under AOT. Results showed that individuals under an AOT court order were less likely to be arrested than those without AOT involvement; significant differences were not found for those who had signed the voluntary agreement, perhaps indicating that the court order provided advantages that the voluntary agreement did not (Gilbert et al., 2010).

Current Study and Rationale

The goal of the current study was to understand the perspectives of providers involved in the treatment and service planning of inmates with mental illness, both in prison and in the community. The purpose of conducting interviews with these participants was to gather the opinions of the employees involved in this process and see what strengths as well as shortcomings and challenges they see in terms of helping inmates with SMI transition to the community. This study employed a qualitative design, as it was intended to add to the qualitative literature in the area of community reentry for offenders with SMI, as there seem to be few studies. A potential gain from a qualitative investigation was to obtain an open-ended narrative that might not have been possible with quantitative research.

Two prior mixed methods studies provided relevant background research to this investigation. Wolff et al. (2013) completed a nationwide study that included the use of interviews of community and corrections-based providers working with inmates with SMI to determine their perceived difficulties regarding needs and challenges. The participants reported that they were concerned about the lack of funding and resources. They also noted having difficulty placing individuals into services, as well as the need for more integrated services. Participants also felt that increased effort needed to go toward treating these individuals

respectfully and altering the philosophy toward their recovery (Wolff et al., 2013). Another recent study obtained outpatient provider perspectives regarding working with clients who have SMI and prior criminal justice involvement (Pope et al., 2013). The participants noted that it was particularly difficult to coordinate with parole for the purposes of planning appropriate treatment. Some participants also noted the challenging nature of working with a population that is mandated to treatment, commenting on the lack of motivation for some clients to engage in services. Some providers also spoke about their own thoughts toward these clients as additional barriers, noting that they were sometimes fearful of clients with criminal justice involvement (Pope et al., 2013).

The current study was exploratory with no specific research questions, other than simply obtaining open descriptions and opinions of providers. A goal of this study was to contribute to the literature advocating for improvements in the reentry process, as well as enhanced resources in the community for this population. In hearing from providers in the prison and in the community, we can learn valuable information about community reentry and how it might be improved to facilitate successful reintegration.

Chapter 2: Methods

The intention of this study was to contribute qualitative data to the area of community reentry for inmates with mental illness, particularly SMI. Specifically, learning from providers directly involved in working with this population, both incarcerated and formerly incarcerated individuals, may help us learn about changes that can be made to provide smoother community reentry experiences. This study focused specifically on community reentry from prisons in New York State, providing an in-depth look at one state system, including the views of providers in prisons and in the community about what was working, what challenges clinicians faced, and what changes might be considered to improve the system. The broad objective of this study was exploratory, to simply find out about staff experiences in working with these inmates and clients and to identify what emerged about the community reentry process. This study utilized qualitative methodology, specifically thematic analysis, which was used to generate themes about what participants conveyed.

Participants

Participants were six prerelease coordinators employed by CNYPC and working in the New York prison system, and three outpatient clinicians employed by Hutchings Psychiatric Center. Both agencies are part of OMH. Participation was voluntary and no compensation was provided. Prerelease participants were CNYPC employees working in prisons across the state, and outpatient participants worked at an urban mental health clinic providing services to individuals with SMI.

Prerelease recruitment. Prior to the study, the forensic unit chief of the Division of Diversion, Reentry, and Community Education for the Division of Forensic Services stated that she would provide contact information for select prerelease coordinators. Contact information for

all prerelease coordinators could not be provided due to limited staffing resources. Upon receiving IRB approval from Antioch University New England, I contacted the forensic unit chief who then provided names and contact information for eight potential participants who were currently conducting prerelease services in their job roles. These 8 potential participants were out of a total of approximately 25 prerelease coordinators employed in the prisons, according to Hall et al.'s study. The unit chief knew who was contacted and asked to participate, but she was not made aware of who ultimately decided to participate. Upon receiving contact information for the potential participants, I sent an initial email with an invitation to participate (Appendix A). The email contained a brief study description, including the study purpose and what participation would entail. The informed consent form was attached for their review (Appendix B). Those who had not provided any response were contacted two weeks later with a follow-up email (Appendix C) and were again provided the informed consent form. All eight prerelease coordinators initially responded to one of the two emails with interest in participating. One of these individuals returned the informed consent form, but ultimately declined participation due to difficulty finding time to schedule the interview. One other individual also initially responded with interest in participating, but ultimately decided not to participate. Of the eight invited to participate, a final total of six prerelease coordinators participated.

Outpatient recruitment. Upon receiving IRB approval from Antioch University New England, the chief psychologist and IRB chair at Hutchings Psychiatric Center contacted all adult outpatient clinicians (29 potential participants) on my behalf via email (Appendix D). The email contained my contact information and included the informed consent form (Appendix E). Outpatient clinicians were instructed to contact me if interested in participating. One individual initially responded to me, and one responded directly to the Hutchings Psychiatric Center IRB

chairperson. The IRB chairperson forwarded the email to me, and the participant was then contacted separately; the IRB chairperson had no further knowledge about the individual's involvement in the study. All outpatient clinicians were sent another email two weeks later on my behalf (Appendix F), providing them another opportunity to participate and again provided the informed consent form. All clinicians were included in the second email as to not make known to the IRB chair the identities' of those who had already responded. An additional clinician responded at this time with interest in participating. There was a final total of three outpatient clinician participants.

Participant demographic information. Participants ranged in age from 32 to 61, with a mean age of 47. Participant race included Hispanic, Caucasian, and African American. Participants were primarily female, with there being only one male participant. Participant disciplines included social work, nursing, and psychology. Length of employment at their current positions ranged from 1 to 15 years. Five participants had previously worked within a correctional setting, and four had no prior correctional experience.

Procedures

Ethical principles were followed in accordance with the standards of the American Psychological Association's code of conduct (American Psychological Association, 2010).

Informed consent. Two informed consent forms were developed for use in this study (Appendices B and D). The prerelease coordinators' names were provided by a supervisor, so there was a small risk that they could be identified. They were assured that no identifying information would be provided in the final report. Two consent forms were used because the same risk of being identified was not an issue with the outpatient clinicians since all clinicians were invited to participate. All participants were sent a copy of the informed consent form at the

time of first email contact, as previously described. Both sets of participants were offered an opportunity to speak to me via telephone at this time, if they wanted to further discuss their participation prior to signing the informed consent form, to which all declined. Informed consent forms were either printed, signed, scanned and sent back via email, or mailed to a post office box that was used solely for collection of informed consent forms. I reviewed the informed consent paperwork verbally with each participant before the interview began and time was allotted for any questions. Participants were informed that their involvement was voluntary and that they could withdraw at any point prior to data analysis. Participants were also informed that the interview would be recorded. Possible limits of confidentiality were discussed, including possible use of deidentified direct quotes in the final report, though no names or work locations would be written in the description. Additionally, the participation of specific employees would not be made known to other OMH or DOCCS employees. I would be the only one with knowledge of who participated. Participants were informed that an employee of OMH was on the dissertation committee, but she would not have access to the names or work locations of participants, or any other identifying information.

Confidentiality. Participants were assigned numbers that were used in place of their names on all transcripts, theme tables, and in the final results. Their initials were written with their corresponding numbers in a password protected word document, which was deleted after data analysis. Informed consent forms, which contained identifying information, were kept in a locked safe. Communication was conducted via participants' work email, and when it came time to send individual themes for member checks, they were allowed an opportunity to provide a personal email address if they had concerns about confidentiality. Direct quotes have been utilized in this document, though they are deidentified to maintain confidentiality.

Interviews. Semistructured interviews were used as the method of data collection. A predetermined set of open-ended interview questions was used for each participant population (Appendices G and H). Clarifying and follow-up questions were used as needed, but otherwise interview questions did not deviate from listed questions. These questions were primarily derived from a review of the literature on this topic. Interviews were offered either by telephone or in person, and ultimately all interviews were conducted by telephone. As a requirement of the site, all prerelease interviews were conducted during business hours while participants were at their work location. Outpatient clinician interview times and locations of participants varied. Interviews were recorded for subsequent transcription. The recording device was kept in a locked safe in my home. Raw data from interviews were transcribed for ease of coding and developing themes. The transcripts were kept in a password protected document on my computer and labeled only with participant code numbers.

Thematic Analysis

Data were analyzed using the process of thematic analysis. Thematic analysis is a process that allows for interpreting qualitative information and discovering themes among the qualitative data (Boyatzis, 1998). Additionally, themes demonstrate patterns across the data, and in the case of this study, patterns were ideas and perceptions that were repeatedly cited by the participants regarding community reentry (Braun & Clarke, 2006). Prior to performing the analysis, I chose which approach, as outlined by Braun and Clarke, would be used to identify themes and at which level the themes would be found. This study follows an inductive, or "bottom-up," approach (Braun & Clarke, 2006, p. 83), meaning that the analysis was data-driven. Instead of coding for a specific research question, I was trying to link the codes directly to the data (Braun & Clarke, 2006). Regarding coding level, I was coding for themes at the semantic, or explicit, level. This

means that themes were generated from a surface understanding of the data (Braun & Clarke, 2006).

The steps that were followed in this thematic analysis have previously been described in six phases by Braun and Clarke (2006): "familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report" (p. 87). Codes were developed prior to themes as a way to organize the interview data. These codes were narrower and then led to broader themes within participants' responses (Braun & Clarke, 2006). In this study, codes were initially created for each interview, by reading every interview in its entirety and taking detailed notes about elements that could potentially be interesting for thematic development. Throughout this stage, I reflected and observed emerging patterns of interest. Codes were generated for each individual interview, then typed and printed to sort into potential themes at the level of individual interviews. This process was completed for each interview and a table of themes was created from each interview. These tables were printed and used in creating a thematic map, as a way to organize the themes at the individual level into themes representative of the entire data set. Thematic maps create a visual representation of the data and use of them was a helpful strategy in deciding if potential themes were appropriate (Braun & Clarke, 2006). Themes representative of the entire dataset were generated combining the outpatient clinician codes and the prerelease coordinator codes, as the aim of this study was not to make a comparison between the two, but to generally gather the perspectives of clinicians involved in community reintegration. Furthermore, the two sets of participants had theme results that were similar and generally represented opinions that could fit well into candidate themes together. At this stage, some themes were combined and some subthemes were compiled to create a larger candidate theme. The thematic map was reviewed and altered several times to

ensure that subthemes were in the appropriate place and that the map of themes accurately described the entire data set (Braun & Clarke, 2006), including reviewing codes that were initially found but left out in earlier stages of theme development. The themes were eventually collapsed into the categories that will be presented in the results below. The process of organizing subthemes was meticulous to ensure that they were placed within themes that accurately captured the underlying meaning. The themes were given names that seemed to best encapsulate what the subthemes were describing.

Two raters were utilized for the initial coding of individual interviews. A second rater, a recent graduate from the Psy.D. program at Antioch University New England, and I separately coded the individual interviews for themes and then compared results. Similarities and discrepancies were discussed until agreement was reached and then individual interview codes were combined to develop themes.

Quality Checks

When conducting qualitative research, it remains important to conduct checks on research quality, though the methods are different than one might find in quantitative research. Guba and Lincoln outline what they call parallel criteria for judging quality in qualitative research, including how to check for validity and reliability equivalents. These are meant to match the conventional criteria of validity, reliability, and objectivity (Guba & Lincoln, 1989). In addition to these measures, described below, I also maintained awareness about any personal reactions and biases throughout the data collection and analysis process. For instance, I was acquainted with some of the outpatient participants due to predoctoral internship placement, and it was important not to let a personal relationship interfere with analysis. Furthermore, I had personal knowledge of working within the CNYPC system in prisons, as well as personal opinions about

the rising numbers of individuals with SMI who have become incarcerated. It was important to be aware of these thoughts and feelings and maintain a level of objectivity during analysis.

Member checks. Credibility is referred to as a parallel of internal validity, and one of the specific methods used included member checks (Guba & Lincoln, 1989; Mertens, 2010). Member checks can be informal or formal, and occur at different points throughout the research (Cho & Trent, 2006; Mertens, 2010); for this study member checks occurred after data analysis. This provided participants an opportunity to correct any mistaken information and to give any additional information once they heard their opinions as an outsider heard them (Guba & Lincoln, 1989).

After determining themes for individual interviews, each participant was contacted by email to obtain permission to send a copy of his or her themes to the email that had been used for correspondence (a work email). They were also provided the opportunity to provide an email not affiliated with work, or to discuss the themes by phone. All nine participants responded, some after a follow-up email, and tables of their themes, associated codes, and potential quotes for inclusion were provided. All provided permission to send themes to their work email. Six participants responded about the themes, three reporting that the themes reflected what they were trying to convey. One participant failed to clearly specify if the themes were all in accordance with what he or she wanted to convey. Two participants provided detailed feedback about the themes and made some alterations; these clarifications were noted and taken into consideration in the results. The remaining three participants received their themes, but did not respond with any feedback, despite one follow-up email. Length of time that passed between interview and contact about themes varied, as interview dates varied by several months. The length of time between interview and follow-up email ranged from seven to ten months. This delay may have

had an impact on participants' points of view, or there may have been coder misunderstanding, though the specific impact of this delay is unclear.

Thick description. Guba and Lincoln (1989) also described the concept of transferability paralleling external validity. The researcher can provide a "thick description," as originally described by Geertz (as cited in Mertens, 2010, p. 259), of the specifics of the situation being researched, such as culture and environment, and leave it to the readers to decide if the results can be generalizable to their situations (Guba & Lincoln, 1989; Mertens, 2010). By providing a thick description to provide context to the participants' perspectives, such as the correctional mental health system in New York State and the process of discharge, readers were able to determine how the results might relate to them. The literature review provided a detailed understanding of mental health treatment, described how a mentally ill offender might function in the prison system, and informed the reader about what community options were available upon release. Further, the general prison culture was discussed both in the literature review and results, providing additional context for the study.

Dependability and confirmability. Dependability is related to stability of data over time and has been cited as paralleling the concept of reliability. Confirmability is related to the assurance that the research is reality based and relevant to context, and not something that makes sense only to the investigator; this parallels the concept of objectivity (Guba & Lincoln, 1989). Dependability and confirmability audits were conducted as to detail the research process so that someone else could easily identify the steps taken throughout data collection and analysis, and confirm that the process followed was appropriate for the purposes of the study. During both data collection and analysis, I outlined the research process; this audit should limit the amount of research subjectivity (Mertens, 2010). For instance, the processes used for data analysis and the

steps taken from raw data to theme development were clearly documented for anyone else to follow if needed. Further, as previously stated, the steps outlined by Braun and Clarke (2006) were followed closely, in an effort to increase the ease with which other could follow the data analysis. In doing so, another person could review the data and the subsequent themes, and be able to trace the steps to see how the conclusions were made. The second thematic rater was also used to confirm that the conclusions reached were appropriate given the data and process of analysis.

Chapter 3: Results

Four broad themes were generated from the data set and represent participants' opinions about their experiences with community reentry for mentally ill offenders: (a) Inmate Psychosocial Risk Factors, (b) Issues of Access to Community Resources, (c) Problems in the Discharge Planning Process, and (d) Factors that Facilitate the Discharge Planning Process. The first three themes represent primary challenges that clinicians face, including inmate-specific and prison or community system-specific factors that impact reentry. Amid such challenges, clinicians also mentioned factors that aided in community reentry and discharge planning processes, which are addressed in theme four.

The themes of this study were identified based on both the frequency with which participants discussed them, as well as the level of significance a participant placed on a specific issue. To make the data more meaningful, the themes have been presented in a manner that has organizational significance. Each primary theme is also comprised of sub-themes, which help to further structure the more complex theme and provide a "hierarchy of meaning within the data" (Braun & Clarke, 2006, p. 92). As such, the themes and sub-themes are presented sequentially, such as they may arise during the reentry process. For ease of readability, the term inmate will be used throughout the results section, even though it might not typically be used to describe mentally ill offenders upon release. Please see Appendix I for a table outlining the themes and sub-themes.

Inmate Psychosocial Risk Factors

The first theme includes internal or external factors specific to the inmate that could impact transitioning to the community. These issues are broadly referred to as psychosocial risk

factors for these purposes, indicating various issues that participants perceived as impacting an inmate's discharge.

Attitudes and beliefs that interfere with reentry. Participants noted certain attitudes and beliefs that could impact release planning. For instance, participants suggested that some inmates lacked insight into their mental illness and had a history of treatment or medication noncompliance, which made planning community services challenging. Some participants reported that they have seen individuals gain insight into their mental illness and not return to prison, which was rewarding. Others noted how lacking insight could be a barrier to treatment adherence and finding appropriate treatment services in the community.

Additionally, inmates may have developed attitudes and beliefs that were adaptive in the prison culture, but could impede discharge planning. One such maladaptive strategy included manipulation, where it might be difficult to ascertain the community-based needs of an inmate who has a history of lying or withholding accurate information. The barrier of prison culture can also extend to inmates' feelings toward mental health treatment. Participants spoke about the different inmate perspectives they saw regarding mental health treatment in prison, including viewing mental health services as a burden, viewing mental health services as a resource that could help them be successful in the community, or viewing it as a system to manipulate and use in order to acquire something they desire, such as assistance with disability supports. In discussion of inmates' views of mental health, some participants noted that at times inmates felt frustrated by the mental health system in general and had trouble trusting mental health agencies. The range of mental health stability was also a varying factor, as inmates might refuse assistance with discharge planning or hide that they were psychiatrically unstable. Some actually had worsening symptoms in prison, such as increased paranoia, but were motivated to hide it.

Additionally, participants noted that perceived mental health stability within the highly structured setting of a prison does not necessarily translate to the same or comparable degree of psychological stability upon release. One participant said, "…okay they're doing well here, well they're doing well here because we're taking care of all those basic needs" (Prerelease Coordinator). Regarding stability in prison, while some participants spoke of it being a false promise of community stability, other participants spoke of easier community linking due to prison stability: "Easy to place means stability. It means guys who are showing a track record, in here, of doing the right thing" (Prerelease Coordinator). According to participants, inmate-to-inmate misinformation about mental health treatment, as a byproduct of prison culture, often posed as either a barrier or false motivation for mental health treatment. For instance, participants noted inaccurate, shared beliefs among inmates, such as engaging in mental health services would stall their prison release date or, on the other hand, would increase their eligibility or processing of SSI.

Personal impairments. Many participants described mentally ill offenders as a complex population facing myriad issues, including personal factors that could make for even greater challenges transitioning back into the community. To highlight these impairments, participants noted that inmates often faced medical problems, some of which they may have acquired in prison, and other unique needs that require specialized discharge planning, such as a traumatic brain injury. Some participants mentioned frequently seeing intellectual deficits in this population, in addition to much illiteracy. Some participants also noted that often illiteracy goes undocumented or unnoticed throughout the inmates' term of incarceration, which can then pose a challenge with setting up appropriate discharge services:

> Some of them don't read or write and that's not always apparent or it hasn't always been identified. And so then I'm trying to make sure that they're linked appropriately and yet they haven't really been identified in the DOCCS system as being illiterate, and that's a problem sometimes. (Prerelease Coordinator)

Another personal challenge participants noted was having a language barrier, as some inmates do not speak English as their first language. Community navigation could be challenging when speaking a different language. Many inmates also have a history of trauma, which could impact their vulnerability for re-victimization if they are in the community without adequate support.

Substance use history. Participants identified a history of using substances as a risk factor once released into the community, and how risk of substance abuse relapse was of concern for many inmates upon release from prison. As such, some participants spoke about the relationship between mental illness and substance use, and how the combination might correlate with increased criminal activity. Despite risks of substance use and relapse, participants did not believe that a history of substance abuse necessarily negatively impacted planning for community services due to the availability of Mentally Ill Chemical Abuser (MICA) programs. However, some participants reported that issues of drug use while in prison further complicated prison discharge. One participant discussed setting up inpatient drug treatment for an inmate upon release due to ongoing drug use in prison:

> So generally I don't pursue inpatient rehab, but I really felt it was very important, I knew this guy was not going to function in the community…I worked very hard with Medicaid actually in helping him go to an inpatient rehab…you know, this guy probably would've went into withdrawal when he was released and obviously if he was having withdrawal

> he would've found drugs. So I don't think he would've lasted out there 24 hours. (Prerelease Coordinator)

Lack of family support. Participants identified varying levels of family support and how the presence or absence of family support could impact community reentry. Prerelease coordinators reported contacting the family prior to release for all inmates with an "S" designation, which sometimes led to positive family involvement if the family was supportive of the inmate. However, the degree to which the family might become involved in release varied. Participants opined that family support could often increase an inmate's success in the community, but that support was not often seen for reasons frequently attributed to family dysfunction and disconnection. Prerelease participants reported that it was often helpful for discharge planning purposes if an inmate could reside with family upon release, but the family environment might not always be an ideal environment for the inmate's well being. Family members might be able to provide emotional support, but might not be able to provide discharge support, such as a place to stay.

Issues of Access to Community Resources

Another primary theme relates to issues with access to community resources. The associated sub-themes are discussed regarding how they can impede an inmate's access to community-based services, as well as a clinician's ability to connect them with services to fit their needs.

Lack of resources in the community. The majority of participants spoke broadly about challenges due to the lack of community resources, and barriers associated with establishing services for someone directly from prison. They stated that many mental health agencies have different referral processes for individuals coming from prison, which could lead to waitlists:

> I think the hardest thing for me to understand at times and one of the most difficult things is that outpatient providers will have a completely different referral process for an individual who's incarcerated compared to an individual in the community. If you were just in the community, you call for an outpatient appointment somewhere they just schedule it. If you're incarcerated they say oh, you need to send us this, this, this, this, this, this, and then we have the clinical director review it, and then we'll let you know if they can go there… the patient would be in the community so if he had just like called when he was out, it would be a completely different referral process for the same exact individual. (Prerelease Coordinator)

As described, waitlists could force the community providers to prioritize who will receive services, and individuals in the community may take priority over inmates. Prerelease coordinators often faced the challenge of establishing appointments in the timeline needed for release. Some community programs face cuts to resources, are closing altogether, or are generally overwhelmed by the need in their county for services. Waitlists occur for clinic appointments, but it was also a significant challenge when there were waitlists for case management, as participants described case managers as being crucial to the community reentry process. Some clinics also were unwilling to make an appointment for an inmate until he or she had active Medicaid, which was frequently still pending upon release:

> A lot of the community providers tell us that they cannot schedule an intake appointment unless Medicaid is active and when a person is incarcerated Medicaid is not active. Medicaid gets shut off when they become incarcerated, so we reapply for them about 2 months before they go home so the 45 day processing period happens while they're in here so hopefully their card is waiting for them when they get out. But, I mean the truth

> of the matter is that counties can back bill Medicaid up to 3 months and patients should still be allowed a sliding fee scale, but…we have a lot of problems with counties saying that they won't even schedule an appointment unless the patient has active Medicaid. (Prerelease Coordinator)

Diagnostic limitations. A frequent message among participants was that diagnosis could significantly impact an inmate's qualification and eligibility for community services, about which participants reported feeling frustrated. Comprehensive community services (e.g., case management and supportive housing) were generally only available for inmates with SMI (i.e., those with an "S" designation). It was therefore important that inmates received appropriate diagnoses, so that they might get the community services that most fit their needs. However, participants spoke about the desire for community agencies to take functional deficits into consideration as well when establishing services, as prerelease coordinators desired to help inmates access services based on functioning and not just diagnosis. For instance, an inmate might not be able to navigate the community independently, but if there is no "S" designation, he or she may not be eligible for case management to support establishing resources. Participants felt as though some inmates fall through the cracks of the system due to not fitting the mold in terms of service eligibility. Additionally, it was mentioned that an inmate may have been considered SMI in the community, but has not been assigned an "S" in prison:

> …I have people who have been SPMI [serious and persistent mental illness] in the community for 10, 20 years and they haven't been designated an "S" here because they're compliant with meds and they're doing well. Well that doesn't mean they can take care of themselves in the community. Like I just got one…he's never lived anywhere but a group home, he's been homeless or there, he's been SPMI in the

> community for years, most of his life, and…he was scared, he's like I can't go to a shelter… (Prerelease Coordinator)

Participants expressed frustration when seeing inmates who they believed needed more comprehensive community services, but for which they were ineligible:

> So the difference is like he can be an "S" and not necessarily need my help and I have to give it to him. And sometimes they're not an "S" and clearly they need it, but because they haven't been designated it I can't, and to me that's ridiculous… (Prerelease Coordinator)

Some participants reported that it was actually easier to establish community services for inmates with SMI, as opposed to those without SMI. Inmates not labeled with an "S" generally only received an appointment at a community mental health clinic, yet participants reported this as more challenging because sometimes community providers did not see their need as clearly. When an inmate had SMI, the need for community assistance was often apparent, so getting responses from the community might be easier.

History of violence and SMI. Most participants reported challenges finding community services for inmates with a violence history. Some participants spoke about general violence (e.g., an assault history), but many individuals reported specifically about the difficulty when an inmate has a history of sexual offending or arson, due to difficulty establishing housing and mental health treatment. Participants reported that many housing services would not take them due to risk of dangerousness. One participant spoke about the challenges associated with sex offenders being held past their release date due to housing issues:

> …the biggest challenges for us right now are patients who are being held past their release date because they are leveled sex offenders, who either are a level 1, level 2, or

> level 3, and there is no, legally, there is no approved housing in their community. So they are held in prison in what we call RTF status, residential treatment facilities, but they are still actually in prison until parole can find them an address that meets the legal guidelines of them to be in. (Prerelease Coordinator)

Housing to which these inmates are discharged might be temporary, such as a motel or shelter, and unstable, likely not lending to successful reintegration:

> …let's say the people are sex offenders, they end up going in places where they're permitted but typically these are really, really, horrible places…they're not placed in my opinion in, often, with supports that can help them be successful. More likely they're placed in places where they're likely to be vulnerable, either as a victim or as somebody who is susceptible to using substances, or doing petty crime, something like that. (Outpatient Clinician)

Additionally, participants reported that mental health clinics serving families and children often would not allow someone with a sex offense history to also receive treatment there, which poses a challenge when inmates cannot access needed community treatment.

Housing issues. A recurring theme among the outpatient clinicians and prelease coordinators who participated in this study included problems with access and availability of community-based housing for mentally ill offenders; some participants reported this as the biggest challenge they faced. Participants reported frequent waitlists for housing programs due to statewide shortages. One Prerelease Coordinator stated, "I literally had someone…he came back on a parole violation, came back again and he was still the same place on the housing list." Poor community housing lends to a host of risk factors and may contribute to an inmates' vulnerability in the community for things such as victimization, relapsing on substances, or

engaging in criminal activity. Former inmates are also prone to face homelessness, and participants reported that they have seen many individuals come through their system with a history of homelessness.

If housing was not available at release, many inmates would go to shelters. However there are issues with shelters, including that they may not provide a safe or supportive environment, and rural counties often do not have them. One participant said the following about these housing issues:

> …he's like 'well when I got out they pretty much sent me to a crack house' and I was like (laughs) I was like it was a shelter sir, and he's like 'well I went back to parole' and he's like 'I told them I wasn't staying there.' So they put him back in the county jail for 60 days until there was a bed available at a residential place…But that to me is ridiculous, like he did his time, he should've been linked right to that from the get go, and not waiting 64 days somewhere in limbo. (Prerelease Coordinator)

If an inmate does not have housing or other basic needs met, then mental health treatment might fall on the list of priorities. Prerelease coordinators reported that they only assist with housing for inmates designated SMI, though some reported the belief that all inmates could benefit from assistance with housing upon release. There were also noted challenges with the housing referral process, as referrals can be cumbersome and complicated, though this varied by county.

Geographic factors. Participants reported variations in the quality of services and the gaps in services by county and geographic region. Participants spoke about challenges and strengths of each setting. Regarding an urban setting, one participant reported, "I just think it's easier, if somebody's motivated to go to treatment, it's going to be easier for somebody in an

urban setting than it would be for somebody in a rural setting" (Prerelease Coordinator). On the other hand, there could be challenges to navigating a city; one participant noted, "with the city, it's so big and so overwhelming and again making a referral is pretty easy but patients they tend to get lost in the system down there" (Prerelease Coordinator). Many participants reported that rural counties often have fewer resources to offer. However, some participants felt that a benefit of a rural area was that the treatment providers might already know the inmate and be willing to provide services where the inmate formerly received treatment. Another barrier in rural areas could be transportation issues and difficulty attending appointments due to services being more spread out with less transportation options.

Problems in Discharge Planning Process

The following fall under problems specifically related to discharge planning, and establishing community services.

Inadequate diagnostic assessment. It can be difficult to get a thorough diagnostic assessment in prison, as many inmates present with complex dynamics. Participants opined that inmates might come into the state system from county jail with a diagnosis that does not give an accurate or complete picture of an inmate. They may also enter prison on medications that do not align with that diagnosis, and the same medications and diagnosis will remain throughout their prison term. For instance, diagnoses could be vague or an inmate might be on medications that do not necessarily seem to match, which could provide an unclear diagnostic picture. One participant reported that issues of misdiagnosis or mismedication were a reflection of low resources and systemic issues that may prevent a thorough assessment in prison, as opposed to mental health staff not caring. To address this need, participants expressed a desire for more comprehensive assessment, which they believed would then aid in prelease coordination of

services. According to the participants, they believed thorough assessment could be helpful if it were done at reception, meaning an assessment done when an inmate first entered the state prison system:

> The other thing is that if we had that initial assessment right from the get go, a real one, we would know that they were SPMI before they're 6 weeks out…and now I'm scrambling to see what kind of other things I can get in place for them. (Prerelease Coordinator)

An assessment of an inmate's psychiatric status completed at reception might not match an inmate's situation at release. Outpatient clinicians reported the opinion that inmates might at times leave prison with insufficient treatment planning for the community, and some outpatient participants also believed that mental health treatment in the prisons was not always adequate.

Clinician burden. Factors related to challenges in release planning might also stem from the lack of internal resources. Prerelease coordinators consistently reported about the clerical burden associated with their job. They reported that there was a substantial amount of paperwork associated with coordinating community services, such as faxing and scanning applications and relevant inmate information. Participants identified potential benefits of having designated administrative staff who work solely on prerelease clerical needs, as it could be difficult to attend to clinical needs due to the large paperwork demands:

> I would like for discharge planning to have a full administrative staff, you know, so that discharge planners didn't have to do a lot of the paperwork because it's very paperwork driven now. And it really, it really does take away from the clinical work that we could be doing… (Prerelease Coordinator)

Additionally, participants reported that they typically had high caseloads, which limited their attention to only the essentials of the discharge plan. As such, participants reported that they typically did not have time available to offer inmates extra assistance with services that were not required, but may have been beneficial. The prerelease coordinators might have multiple inmates being released at one time, which could be challenging to manage. As one participant discussed, "…when you've got 12 people leaving, there's not time for four people to really have issues…" (Prerelease Coordinator).

Lack of psychological preparedness. Many participants noted the strong emphasis on establishing community referrals and the paperwork burden, which could cut back on time available to support an inmate's emotional processing and psychological preparedness for re-entering the community. Many participants noted that the process of community reintegration could be frightening and produce anxiety in all inmates, but those with SMI might be particularly vulnerable to change. While participants believed that all inmates would likely benefit from programming designed to support reentry preparedness, they believed that SMI inmates could especially use increased support to deal with the transition. One participant reported the following about the ideal discharge scenario:

> Yeah I think maybe like within the system here… people could probably benefit from a discharge specific group, whether they're active with mental health or not, but maybe especially for the SMIs as far as really processing the emotions that come along with going home because I think we have a couple SMIs who 6 months out are okay with going home and then they decomp enough that they actually have to go to a hospital just because of the nervousness and the, the anxiety has led to some psychiatric decomp, so I

think maybe more support along the way in helping them deal with that would be helpful. (Prerelease Coordinator)

Some participants suggested increased processing of inmates' emotional reactions, as well as the need for daily living skills to help with successful re-integration into society.

Inmates could become accustomed to the highly structured prison environment and might lack the resources (e.g., job skills, long-term plans, coping skills) to prepare for life in the community. A recommendation among participants was to have group therapy focused specifically on these aspects, as well as increased focus on processing emotions, prior to discharge.

Barriers to coordinating resources. The following barriers consisted of both practical (e.g., internet limitations) and communication barriers that might impact community resource coordination. Correctional settings lack standard internet access, beyond agency email and intranet, due to security issues. Many participants discussed how this contributed to challenges when trying to establish community services for inmates being released from prison. For instance, it can be difficult to access information about community resources without the internet, especially when attempting to access geographically-specific resources for an inmate. Additionally, prerelease coordinators reported that they have access to an intranet website with information about community resources, which many thought of as an asset. However, these resources appeared to be infrequently updated, therefore consisting of out of date information, which ultimately made them less useful. Prerelease coordinators also reported that community providers sometimes want to send electronic applications, or links to websites, but they are unable access the information they need to establish appropriate community services. One participant reported the following about these issues:

> I don't have access to the internet which really is a difficulty, just trying to find information…I have like the OMH listing for outpatient providers but a lot of it is not up to date, the phone numbers may be wrong, addresses are not always accurate…That and like a lot of places do an electronic referral form, if we had a, like a listing of referral forms for every place that we call, it would save time instead of calling, waiting for that person to call you back, then saying you need to submit this referral form… (Prerelease Coordinator)

Regarding other coordination barriers, as OMH employees, participants identified challenges collaborating with DOCCS, though they reported that they routinely made an effort to establish positive working relationships with DOCCS employees. Both agencies played a role in the discharge process and participants felt that both were doing their best, but sometimes the different agency goals conflicted. For instance, some prerelease coordinators reported that at times they felt the need to educate DOCCS staff about the role that prerelease coordinators play in the release process. They reported that there has been a need for role clarification so that DOCCS and OMH staff are not spending time working on the same resource for an individual. Some participants reported that it was difficult to get accurate release dates, which are decided by DOCCS, but could impact planning for mental health services. For instance, DOCCS might change the county to which an inmate was being released, which means the prerelease coordinator would need to switch services that are determined by county, such as Medicaid and mental health appointments. Due to these issues, prerelease coordinators described needing to adapt and have enough flexibility to alter discharge plans with very limited notice:

> Sometimes DOCCS doesn't really get the information until the last minute, especially the ORCs [Offender Rehabilitation Coordinator] here, they have to wait for, like, housing

> approval and PO [parole officer] assignments from field parole…so it's a multi-level process that's time consuming and you know it's up to us prerelease coordinators to be flexible and…to just leave ourselves a little bit of wiggle room just in case there are any…anything that comes up that we would need to dedicate time towards. (Prerelease Coordinator)

Additionally, if an inmate was being released under parole supervision, DOCCS would ultimately be responsible for approving the release plan, not OMH, which means that prerelease coordinators can only do so much advance coordination:

> Department of Corrections, sometimes staff see that someone is mentally ill and they take a step back and wait for OMH to take the lead when all we can do is make referrals, we can't guarantee that the county is going to have anything available. So it's a lot of us having to make sure Department of Corrections is working with parole and that both agencies understand that they are responsible for finding housing for the patient because they're the ones that have the final approval, and that we will work with them in doing the necessary referrals, but sometimes they see it's SMI and they just kind of take a step back. (Prerelease Coordinator)

Factors that Facilitate the Discharge Planning Process

While many challenges arose from the interviews, participants also reported many factors that were working well to facilitate community reentry. They were able to note their personal strengths and those of their programs to recognize what facilitates the discharge process.

Clinician characteristics that positively relate to treatment. Participants noted the general importance of taking a non-judgmental approach to working with inmates, especially regarding their crimes:

> …you can't do your job if you take things personally and you're looking at that person like okay they don't deserve treatment. You just can't work in here having those types of opinions. You really have to come to terms with whatever you might think about certain crimes. You have to find a way to treat the person and not the crime. (Prerelease Coordinator)

Some participants noted difficulty working with inmates who had engaged in specific, aversive criminal activities (e.g., sexually abusing children), and some also noted that it could be hard to work with someone who committed a crime with which they had personal experience. Participants also provided examples of hearing other staff talk badly about an inmate due to his or her specific crime. However, generally they reported attempts to be non-judgmental. Even if the nature of the criminal behavior was difficult to comprehend, they found it important to focus on an inmate's need for treatment:

> Some of these crimes you read, honestly, sometimes a lot of them will bring tears to your eyes…but they're going to the community, and if they're going to the community I want them to have the treatment they need. (Prerelease Coordinator)

Furthermore, inmates with SMI often faced stigma due to being in prison and having a mental illness, so being nonjudgmental could be particularly helpful to combat the stigma:

> I think really just like understanding where the patient is coming from in that sense…they kind of have a lot of stigma stacked against them because, you know, mental health treatment, substance abuser, and you now have the criminal record, that really just trying to understand and maybe asking them, being like what was it like for you, you know I'm just trying to understand. Just not really placing any judgment because I think there is a lot unfortunately placed on that. (Prerelease Coordinator)

The importance of being open and honest, and not taking inmate behaviors personally was also highlighted, "I feel that because of my experience I know that I'm not responsible for people's behaviors. I think that's the biggest thing. Because these cases can consume you" (Outpatient Clinician). Additionally, participants noted that different clinicians have different approaches, such as some being more hands on than others. Participants also discussed the importance of remaining flexible in their roles as prerelease coordinators due to the systemic demands that place limitations on their job.

Reintegration to a community of prior connection. Prerelease coordinators reported the benefits of being able to discharge an inmate to a clinic with which the inmate already had a prior relationship. They reported that this often occurred in rural settings. Participants noted that having a prior relationship might make a clinic more likely to take an inmate, and also help the inmate transition into the community more easily:

> I love when they come in and they say 'well I would like to go to treatment here, and I used to go here and they were helpful to me and maybe I could, you know, I hear the housing over here is good.' I love when I call a place and they'll say 'oh we know him, I'm so glad he's coming back out' and they're ready for him and they'll send him a message probably like, 'hey looking forward to seeing you,' that kind of thing, then they feel like, and I feel like, somebody's going to be watching them when they get out... (Prerelease Coordinator)

Collaboration. The importance of collaboration was a common topic, including interagency and intra-agency. Participants discussed the importance of the support they received from working in a treatment team, and the benefits of getting support and ideas from colleagues. Prerelease coordinators also discussed the assistance they received from OMH central office and

their administrators when needed, to coordinate discharge. These individuals might provide help with a challenging referral or even help simply by looking up resources on the internet, of which the OMH central office employees have more access since they are not prison based. In addition to interagency collaboration, participants felt it was important for agencies to collaborate, such as mental health and DOCCS staff in the prison and parole officers in the community, to coordinate transition planning. Prerelease coordinators noted the utility of video teleconference equipment to connect a patient with providers prior to release, which has several reported benefits, including building an advance relationship. It could be difficult for community providers to get an accurate portrayal of an inmate while he is still incarcerated, but increasing communication as release nears might make an inmate feel more connected to community supports. Regarding an element of the ideal discharge:

> I think probably, maybe more regular contact with community providers the closer it is to the discharge date. I think when somebody [the inmate] feels connected to the person they're going to work with there's a better opportunity for them to actually stick with the services we've put in place. (Prerelease Coordinator)

Participants also emphasized the important role the case manager plays in an inmate's successful community reintegration, as case managers help with numerous resources in the community. In addition to these types of collaboration, participants also discussed the importance of collaboration among community agencies, of which they reported seeing varying levels. Finally, it was noted to be helpful to collaborate with informal supports, such as family and a community network. These individuals, if stable and supportive, can be just as useful for reintegration as formal support systems.

Creating individualized treatment plans (being person-centered). Participants felt that it was important to plan for community services that would set the inmates up for success, which would mean setting up an individualized plan. One outpatient Participant spoke about the concerns of not planning for success, stating "…very often folks just end up back where they're from and that's what happens, that's just the way of life." Individualized plans mean paying attention to specific needs; participants mentioned several services that they look for depending on the inmate's needs, such as day treatment, PROS programs, MICA treatment, or even seeking AOT if someone has a history of noncompliance. Alternatively, the necessary discharge plan might be to send someone to a psychiatric hospital upon release if he or she was not psychiatrically stable enough to be in the community. A potential risk for some inmates is recidivism: "a number of them come right back because things don't work out smoothly, and they lose patience, and they just kind of give up" (Prerelease Coordinator). This participant spoke further about the necessity for an accurate assessment at discharge:

> So we kind of look at each person individually and work with the, you know, our central office as far as discharge planning goes. They review everything and if they approve of what we're doing or do they say…let's get an AOT on this guy or…would he be better off being hospitalized initially. We kind of just look at everything possible to get the best plan. (Prerelease Coordinator)

It could often be difficult for inmates to navigate the various community agencies and supports with which they are involved (e.g., parole and case management) and as such, participants thought it would be ideal to set up services that make for easier accessibility. Specifically, some participants believed that providing inmates with a structured and comprehensive discharge plan would offer them the best opportunity for success.

The above themes provide meaning to the participants' opinions regarding community reentry, and the subthemes have provided added significance. As can be seen, participants were willing to openly discuss challenges in various areas, as well as areas in which they feel reentry goes well. Despite challenges, the results indicate a commitment to helping this difficult population successfully transition out of prison and into the community.

Chapter 4: Discussion

Major Findings

As has been outlined throughout this study, mentally ill offenders, especially those with SMI, face issues of marginalization upon release and have difficulty accessing needed community services, which could contribute to difficulties successfully reintegrating back into society (Baillargeon et al., 2010). The findings of this study have been generally consistent with those of prior qualitative research that highlighted the issues that providers and inmates face related to release from prison. Participants in the current study discussed many challenges, including systemic issues and characteristics of the inmates or clients that were perceived barriers to reintegration. Participants also discussed strengths, including in themselves and in their agencies, which were an important element of their work. Major findings will be highlighted, specifically focusing on both interfering and facilitating factors related to reentry, as well as a discussion of outpatient results as compared to prerelease participant results. Findings will be addressed as related to prior relevant research.

Interfering factors. Factors that were identified as interfering with reentry will be discussed below, to include a lack of resources, limitations with discharge planning, and restrictions for violent offenders.

Widespread resource shortages. A major factor that participants identified as interfering with reentry was the lack of resources, which was noted in many areas. Participants repeatedly discussed issues with diminishing or nonexistent resources in different settings, which had an impact on many individuals, including providers, inmates, and communities. Community and prison staff felt burdened due to low resources, but resource issues also largely impacted inmates. When faced with limited resources, unstable housing situations, and ongoing mental

illness, inmates' abilities to reintegrate into the community and remain out of prison were compromised. Resource issues were cited frequently, including resource issues within the prison, with community mental health treatment, with case management, and with housing. These will be discussed further below.

Within the prison, clinicians felt frustrated with being encumbered by paperwork, being short on time, constantly being assigned new cases, and generally feeling as though there were not enough staff, resulting in high caseloads. This in turn impacted the inmates, because staff might not have sufficient time to dedicate toward assisting each inmate as they had desired. Participants also reported the need for increased administrative staff to help relieve some of the paperwork burden. Pope et al. (2013) found that mentally ill offenders felt as thought they had inconsistent meetings with mental health staff in prison, and few felt as though they had an opportunity to establish a strong therapeutic relationship. It could be challenging to meet all the needs of every inmate with a high workload.

Participants typically reported that there were waitlists in the community for many necessary services, including mental health treatment and case management. Exacerbating the problem with waitlists, participants also reported that some community programs were closing due to resource issues. Some community mental health programs were also unwilling to take a client directly from prison. The report of shortages in community services in the current study was consistent with prior qualitative research, which found a general lack of resources for mentally ill offenders (Wolff et al., 2013). As with the current study, most participants in previous research reported a need for increased community resources (Wolff et al., 2013).

A shortage of safe and supportive housing was a reported challenge, which was also consistent with prior research. Pope et al. (2013) found that mentally ill offenders felt as though

having unstable housing at release negatively impacted many areas of their lives (e.g., difficulty attending mental health appointments). Providers in the same study also noted the challenges with finding housing for mentally ill offenders. A lack of adequate housing can have a far-reaching impact on the lives of inmates upon release.

Discharge planning limitations. An issue related to that of not having enough resources was the issue of only having the ability to help inmates with discharge necessities. For SMI inmates, necessities typically meant housing, Medicaid, and mental health treatment. For non SMI inmates receiving mental health treatment, this was more limited to mental health treatment. Participants reported the desire to help inmates in other areas of their lives as well, such as with daily living and appropriate coping skills, but often faced barriers due to the aforementioned resource shortages. Hatcher (2010) found that inmates believed one of the most important areas of focus for community reentry was daily living, and participants in the current study agreed, yet these needs could not always be met.

Participants discussed how not meeting basic needs could interfere with inmates attending mental health treatment after release. Recent research confirms this, showing that upon release from incarceration, mentally ill offenders prioritize other basic needs above mental health or substance use treatment, due to having lost many basic necessities when incarcerated (Blank Wilson, 2013). Maslow originally wrote about the hierarchy of needs in 1970, reporting that humans have five innate needs and if the lower needs are not met, one cannot focus on accomplishing higher needs (Schultz & Schultz, 1998). These needs, in order, are physiological needs, safety needs, belongingness and love needs, esteem needs, and self-actualization needs (Schultz & Schultz, 1998). This hierarchy applies to what the current results and other research

have shown, as offenders will need to fulfill basic needs, such as having housing, food, and clothing, before they will be motivated to seek higher-level needs.

In addition to not meeting daily living needs, participants felt generally unable to spend time helping inmates develop coping skills and focusing on other personal inmate factors that could impact reentry. Wolff et al. (2013) found other factors in offenders' lives that often conflicted with treatment and parole supervision, according to providers. Some of these factors included criminal attitudes, impulsivity, and poor insight and judgment as associated with their mental illness. Wolff et al. found that providers frequently reported that their mentally ill offender clients lacked the tools to manage stress effectively. Participants in the current study also felt as though inmates might lack the proper coping skills when leaving prison, which could hinder community success.

Participants also reported frustration regarding diagnostic limitations, indicating that inaccurate diagnoses could impact eligibility for various services. Completing an assessment of needs, symptoms, and diagnosis closer to prison release could help prerelease coordinators find the services that best match an inmate's needs.

Restrictions for violent offenders. A major finding in this study that interfered with reentry involved the difficulties encountered when an inmate had a history of violence, particularly sex offenses. Nearly all participants, outpatient and prerelease, discussed how this history complicates community reentry for inmates. More specifically, prerelease coordinators reported how this history hindered their ability to find adequate, safe housing and appropriate treatment services for offenders. Participants seemed disheartened about the instances when they had to release an inmate to a temporary motel or shelter, or even when inmates were held past their release dates due to the lack of adequate accommodations in the community.

The housing challenges for individuals with a violence history are paramount, since finding housing is a high priority for providers and inmates. Staff and offenders have noted the importance of housing in prior research (Blank Wilson, 2013), which was consistent with the current findings; securing this basic necessity can help with developing control and responsibility over one's life (Blank Wilson, 2013). While the reasons for residence restrictions for sex offenders are clear, including the goal of increased community safety, offenders have reported that restrictions on housing have led them to feel greater isolation and instability (Levenson & Cotter, 2005). Ideally there would be increased appropriate, or even supervised, housing options for violent offenders that could still provide community safety.

In addition to housing, access to mental health treatment was also noted to be difficult for mentally ill offenders with a violence history. It is important to provide the structure of ongoing treatment for mentally ill offenders with a violence history, as to effectively monitor factors that could impact their likelihood for violence (Dvoskin & Steadman, 1994). Receiving appropriate treatment is an important element for community success, yet it was noted in the current study to be difficult for violent offenders to attain because some mental health clinics are unwilling to take individuals with a sex offense history. This history then makes societal reintegration even more difficult for a population that already faces many barriers.

Facilitating factors. In addition to obstacles, participants discussed factors that facilitated release planning. First, participants spoke about their passion for helping individuals with SMI function successfully in the community. Their motivation and hard work to help inmates succeed is a tremendous asset to the system. They noted the stigma that the individuals they worked with faced due to having SMI and being involved with the criminal justice system. Participants discussed their jobs in a way that was indicative of wanting to make a difference for

individuals with SMI, so that these offenders would have the best chance to remain safely in the community. The participants' passion was notable, given that this population can be challenging. The providers' desire to help likely served inmates well as they worked to reenter the community.

Connection and collaboration. A primary finding related to facilitating discharge was the importance of connection and collaboration in working both within the prisons and the community. Planning and follow through were noted as more successful when collaboration and connection occurred. This came up in many ways for the participants.

Participants discussed their reliance on collaboration among professionals, such as with colleagues and other agencies, and their frustrations when there was not as much collaboration as desired. They reported relying on colleagues to help feel supported in their work, both emotionally and practically. Additionally, working closely with other agencies made for easier community transitions for inmates. Participants emphasized the important role that case management played in reentry, highlighting how case managers can help inmates access needed services in the community. It was especially useful when inmates could connect with community case managers while still incarcerated, as a relationship could begin forming prior to release and might increase the chances of follow through in the community.

Pope et al. (2013) reported that providers faced many barriers in trying to coordinate care, specifically with parole. Participants in this study also felt as though there were barriers to coordination among providers, including DOCCS, which sometimes proved challenging for planning community services. Despite challenges, participants reported working diligently to make efforts at collaboration, as they realized that this would lead to the best plans for inmates.

Conversely, there were dangers when there was a lack of effective collaboration among agencies, resulting in difficulty providing comprehensive services. Wolff et al. (2013) found that providers reported a lack of integrated community services and that this made it difficult for clients to access all their needed services. Clients are the ones who ultimately suffer when there are not comprehensive and integrated services, due to difficulty navigating systems. When agencies are siloed in this way, it impedes collaboration and can make it harder for inmates to access services upon release from incarceration (Blank Wilson, 2013). Case managers can play an important role in helping inmates navigate services in their community. Regarding collaboration, it was interesting to note that both participant populations reported that they lacked follow-up with the other agency, meaning that outpatient participants denied having contact with prison providers, and prison providers denied having any follow-up with outpatient providers upon release. It seems likely that increased communication that lends to follow-up and bridges care could provide helpful feedback and be efficacious for all parties.

In addition to collaboration among providers, participants placed emphasis on their own connection with inmates, specifically maintaining an honest and nonjudgmental stance. It was encouraging to hear providers discuss their attempts at connection with the inmates or clients. Research has highlighted the importance of a therapeutic relationship, noting that empathy and connection can be one of the primary change agents during therapy (Ottens & Klein, 2005). Mentally ill offenders are a vulnerable and challenging population. Genuine connection has often been lacking in their lives, and is not often seen within the confines of prisons.

Related to wanting to develop working alliances with inmates was the desire to develop individualized release plans. Not every inmate can benefit from the same plan for reentry, and the participants felt it was important to emphasize this in their work. When a positive

relationship exists, inmates might feel more comfortable discussing their ideal plans for community treatment. In addition, this connection might allow space for the provider to make suggestions if the desired plan would not be efficacious.

Contrasts between outpatient and prerelease results. While comparing the two populations was not a focus of this study, reflections and observations based on the comments of each participant group will briefly be shared. There were many similarities in opinions and perceptions between the two populations, as discussed in the results, but there were also areas where a participant population might have reported an opinion more strongly, or spoken about a topic as more specifically applicable to their population.

Prerelease participants. Prerelease participants consistently discussed various challenges with community programs, such as resource shortages and lack of collaboration, which have been discussed in detail in above sections. Prerelease participants also reported challenges that they experienced within their own work settings, more so than outpatient participants. Outpatient participants discussed some issues collaborating with other agencies, but it was less frequent than the prerelease coordinators. Additionally, outpatient participants did not report facing as many challenges within their own work setting. A hypothesis about this could be that since prerelease coordinators worked in the prisons, their clientele were exclusively mentally ill offenders. However, the outpatient participants worked at a community mental health center, with mentally ill offenders representing only a portion of the clients whom they served. Due to this, outpatient participants may have spent less time facing the challenges specific to mentally ill offenders and leaving prison than did prerelease coordinators.

Prerelease participants also placed more emphasis than outpatient participants on accurate assessment and diagnosis in prison, since having the correct diagnostic labeling can be critical

for acquiring needed services upon release. Participants discussed at times being discouraged by SMI diagnoses and labeling, in that an inmate had to have the appropriate diagnosis to be eligible for specific community services. Acquiring an accurate diagnosis and planning community resources based only on that could be difficult, as has been referenced above with the lack of resources. Participants reported the belief that the community places a large emphasis on diagnosis and this puts pressure on prison providers to make an accurate assessment, with limited time and resources to do so. It is worth noting that this issue of SMI diagnosis and labeling was specific to prerelease participants, as the clinic where the outpatient participants worked exclusively served clients with SMI.

Outpatient participants. Since the outpatient clinicians worked with mentally ill offenders after release from prison, those participants discussed the issues that these clients dealt with that were viewed as specifically related to having been incarcerated. For example, one outpatient participant reported seeing mentally ill offenders in the community who he or she believed did not have an adequate release plan. Another outpatient participant felt as though some mentally ill offenders who returned to the community after long incarcerations did not have adequate community providers or supports. Prior research has generally found that mentally ill offenders do face issues related to having been in prison. Mentally ill offenders often have difficulty establishing community treatment, and can have more difficulty transitioning back to their communities from prison than inmates coming from local jail (Baillargeon et al., 2010; Draine et al., 2005). Other participants in the current study reported that they had seen clients whose mental health symptoms worsened while in prison. This is generally consistent with prior research wherein mentally ill offenders reported that being incarcerated was highly stressful and many felt as though their symptoms worsened (Pope et al., 2013). Outpatient participants also

reported having clients who were witness to or victims of violence in prison, an observation consistent with prior research that has shown that inmates with mental illness are more likely to face assaults in prison (Blitz et al., 2008). Prison can be a frightening experience for individuals with SMI, as discussed in the review of the literature, and outpatient clinicians have seen the negative impact of prison on their clients. Outpatient providers were able to confirm prior findings regarding the issues and aftermath of incarceration within this population.

Outpatient clinicians also all spoke generally about the clinician's role in treatment, and more specifically the concept of accepting the current stage of treatment at which the client presents. They spoke about being client-centered and utilizing approaches to put the responsibility for treatment on the client. While collaboration, connection, and individualized care were discussed above, as reported by all participants, the outpatient participants consistently spoke about it with an increased focus on recovery oriented care. The recovery model is an approach to mental health treatment that highlights the need to focus on strengths, connection, and empowerment, as opposed to diagnostic labeling and having an expert tell the client what is best (Barber-Rioja & Rotter, 2014; Jacobson & Greenley, 2001). This is in stark contrast to the often held beliefs and practices within psychiatric care, where the viewpoint has been that patients with SMI have lifelong battles and will likely have long-term suffering due to their illness and need an expert to lead them to health. It is possible that clinicians working in outpatient treatment have a greater ability to let the client take the lead and tailor treatment directly to clients' needs. As much as prison providers may strive for this approach, there will always be an inherent lack of control for the inmates, as prisons implicitly and explicitly promote the message that inmates do not have control. Additionally, I had personal knowledge of the environment in which the outpatient providers' worked, and recent efforts to incorporate

recovery-oriented and client-centered care into their practice. However, there have been promising findings for the use of the recovery model and forensic settings. Previous research found that both staff trained in recovery and those who had not been trained in it thought positively about the use of this approach with a forensic population (Gudjonsson, Webster, & Green, 2014). Additionally, participants in the study by Wolff et al. (2013) largely reported believing that recovery was possible for mentally ill offenders, and did not judge them based on their SMI or criminal justice involvement.

In sum, an observation of the results showed that prerelease coordinators had greater awareness of challenges within their own work setting and with acquiring community resources, as well as issues with the emphasis placed on diagnostic labeling. Outpatient participants were able to highlight the prison related stressors for their clients and their use of recovery oriented care.

Clinical Recommendations

The results of this study highlighted several areas in which systemic changes could be made to improve the reentry process for mentally ill offenders, particularly as related to systems and resources that would benefit inmates with SMI.

Increased reentry resources. Participants discussed widespread issues with lacking resources, as has been discussed. Systemic issues with lacking resources can have implications at various levels, and results suggested the need to put time and money into increased resources to assist mentally ill offenders in returning to their communities.

Heavy caseloads imply that increased staffing resources would be beneficial both in the prisons and in the community. More prerelease staff and administrative staff in prisons would help lighten the burden on clinicians, thereby allowing more time to help each inmate.

Additionally, this could allow for time put toward reassessment of inmate needs and diagnoses closer to discharge. Reassessment could help determine if an inmate's needs might have changed during incarceration and could benefit discharge planning. Providing increased staff in community programs is also necessary to adequately assist this population, as community resources are key to having successful reentry and participants reported a lack of appropriate programs and ongoing issues with waitlists. There has been an increase in specialized reentry programs. Several were mentioned in the review of the literature, including probation and parole officers who specialize in working with mentally ill offenders (Skeem et al., 2006) and CTI, an intervention which offers increased supports to this specific population upon release from prison (Draine & Herman, 2007). Developing increased specialized reentry programs might lend to a smoother transition into the community after incarceration, as some participants discussed the need for comprehensive reentry teams to help mentally ill offenders transition into the community.

Housing is another area where increased safe and supportive options are needed, according to the results. Participants spoke frequently about the lack of housing options, and research has shown that homelessness can expose individuals with SMI to vulnerabilities (McNiel et al., 2005). These inmates are not being set up for success if they do not even have an appropriate place to stay upon release. Additionally, financial stressors could make obtaining or maintaining housing difficult. Helping offenders access resources to assist with finances, or with finding employment, might better prepare them to manage financial stressors that arise in the community.

While creating new programs and resources for this population is not likely to occur instantly, there are small steps that might be taken. For example, adding additional staff members

or new services to existing programs might benefit everyone involved in the care of mentally ill offenders.

Training. Implementing trainings for professionals who are routinely involved with mentally ill offenders would help provide better care and support to these individuals in prison and in the community. One such group who could benefit from training would be those who are often first responders to mentally ill offenders, such as law enforcement (e.g., correction, parole, and police officers). Research has shown that correction officers can have difficulty determining whether inmates' behaviors might be related to their psychiatric symptoms (Fellner, 2006; Morgan et al., 1993). Inmates and staff might all be safer if officers were trained to detect the potential signs of psychiatric decompensation or behavior indicating an inmate should see a mental health provider. The same can be said about offering training to law enforcement in the community, as police officers often respond to incidents involving individuals with SMI and might not have had sufficient training about mental illness (APA, 2004).

Another area for potential training would be to ensure that community providers have knowledge and adequate skills to address non mental health needs, such as risk factors for criminal behavior and criminal thinking. Research has shown that mentally ill offenders require help with other general risk factors, such as antisociality, in addition to their mental illness, if they hope to stay out of the criminal justice system (Skeem, Winter, Kennealy, Eno Louden, & Tatar, 2014). Community mental health centers might not be equipped to deal with the specific needs of this population upon their release from prison. Providing community clinicians with the skills to attend to criminal risk factors in treatment of mentally ill offenders could help with successful reentry and decreased recidivism (Bonta et al., 1998; Skeem et al., 2014).

Reentry related group treatment in prisons. The results have also indicated that it would be beneficial to implement group treatment within the prison system that would focus on two different but important areas: daily living skills needed for community reintegration and emotional processing related to release. It should be noted that CNYPC currently has relevant programs that were mentioned in the literature review: the CORP program, which is a reentry program for male inmates with mental illness as they near release, and the STEP program for females (Hall et al., 2012). These are positive programs for helping inmates prepare for reentry, and there could be increased benefits if there were additional programs or specialized groups to help with these needs, as even more inmates would receive the needed services. As of 2011 CORP had a 31-bed unit for inmates within 90 days of release (NYS DOCCS Bureau of Mental Health, 2011), and it seems there would be additional inmates that could benefit from the services of specialized reentry treatment.

Daily living skills groups. The majority of participants felt the lack of focus on daily living was a major gap, and an area in which meaningful change could actually be made. There are some daily living skills, such as preparing meals for oneself or utilizing public transportation independently, that inmates might not have the capacity to perform on their own, perhaps because they never have or because they have had a lengthy incarceration. Group treatment prior to release could focus on providing inmates with the needed skills to function in their communities upon release. In addition to daily living, the group could focus on coping with common environmental stressors and tools for prosocial functioning, such as finding employment. One participant mentioned that inmates often lack job skills, as they may have been supporting themselves through crime. Offering skills for finding legal employment could help offenders avoid resuming antisocial behaviors in the community. If they can learn necessary job

skills, this may reduce some environmental stressors, such as financial stress. Groups of this nature would be positive for all mentally ill offenders, but it could be especially helpful for those who have been incarcerated for lengthy periods and might be unsure of what to expect outside of prison.

Process groups. Another area that requires attention prior to release is emotional processing. Many participants reported that for inmates with SMI, it could be frightening or anxiety producing to experience the changes associated with release, and participants felt as though there was not adequate time to attend to these issues. A process group provides inmates with SMI a safe space to discuss any concerns or feelings regarding their impending release. Not only would this allow them to explore their feelings with mental health clinicians, but they might also be able to connect with other inmates who feel similarly.

Implications for Future Research

The current study provided outpatient clinician and prison prerelease coordinator perspectives within one state system. The results of this study have opened the door to additional areas of inquiry that could add to the literature on community reentry for inmates with SMI. There seems to be a particular need for further qualitative studies, as there were fewer qualitative than quantitative studies covering this topic. Qualitative studies can provide a rich narrative and provide participants an opportunity to speak openly and at length about their experiences. Several potential research ideas are mentioned here.

The prerelease coordinators in this study worked hard to link inmates to appropriate community services, and the outpatient clinicians on the receiving end made efforts to ensure successful community reintegration for mentally ill offenders. Future research could follow offenders with SMI after they reenter the community from prison to determine whether former

inmates remain connected to the community resources with which they were linked upon prison release. Quantitative methods could be utilized to identify the numbers of individuals who have followed through with treatment, housing, or case management. Interviews could also be conducted to gather offender perspectives about how well the services met their needs, as well as facilitating factors and obstacles to receiving services. This would help identify the effect of steps that providers take on long-term outcomes for clients, as well as what challenges and unmet needs offenders have found once trying to function in the community.

While the current study focused on mental health professionals, a suggestion for future studies would be to also gather the opinions of the other community providers involved in an offender's care. In addition to mental health, this could include parole officers, case managers, or staff at supportive housing programs. Given the plentiful results that have stemmed from the current study, obtaining perspectives from other community providers could highlight additional areas for growth and change in the realm of community reentry. Participants in the current study spoke about the important role that case managers played in assisting inmates with SMI once in the community, so it would be particularly interesting to obtain their perspectives on community resources. Interviews with case managers might be able to further assess other areas that the current study did not place as much emphasis on but are related to community reentry, such as employment difficulties. An added area of interest in a study such as this would be to gather opinions on the level of communication and collaboration that these providers feel occurs among them, as these factors were noted to be important in prior research.

Limitations

As with all research, there were limitations to the current research study. A major study limitation was that an OMH administrator selected potential prerelease participants and

participation was not open to all prerelease coordinators. While all outpatient clinicians were invited to participate, that was not possible with the prerelease coordinators, due to limited access. This is a limitation because there is no way to know if the opinions of those who were chosen to participate also represented the opinions of those who did not have an opportunity to participate. Furthermore, the selected prerelease coordinators may have been chosen for a specific reason, and there was no way for me to know if this was the case. Early in data collection, two additional prerelease coordinators expressed interest in participating. They were informed that they could contact the administrator if interested in participating, but this put up a barrier and would have made their identities known. Therefore, there were others who wished to participate, but were unable to do so with ease or anonymity.

The current study had a small sample size, given that there were only nine participants representing two total populations. There was also an underrepresentation of outpatient participants, as there were half as many outpatient participants as there were prerelease participants. Moreover, the participants in this study only represented one state, and more specifically, one overarching organization within the state, as the New York State Office of Mental Health employed all participants. Results of this study therefore might not be generalizable to other prisons or mental health systems, or other states. However, one might argue that the issues faced within systems would likely be similar across agencies and states, as the issues common to community reentry are not specific to New York. This was further validated by the similarity of these results to those from other studies and other states. Further research should be conducted with larger populations, as increasing the sample size could also help the reader determine the generalizability of the results.

Another study limitation could be the length of time that passed between interviews and participant member checks. The length of time between interview and follow-up contact varied, though it was several months for all participants. This lapse in time may have led participants to forget what they reported during the interview, or even change their opinions during the passing months. Several participants provided feedback making alterations to their themes or indicating that they had difficulty recalling what they reported. It is not known with certainty that the time gap contributed to these effects; participants might have desired to make changes even if that amount of time had not passed. However, it is at least worth considering that the gap in contact with participants might have had some impact.

Additionally, an inherent limitation in the qualitative design of this study could be the subjective nature of generating themes. However, efforts were made to minimize this potential limitation by utilizing a second rater and following explicit steps for data analysis, as outlined by Braun and Clarke (2006). Additionally, the above mentioned audits and quality checks should have reduced the impact of subjectivity.

Summary

This qualitative study gave voice to outpatient clinicians and prerelease coordinators through semi-structured interviews during which they could provide their opinions about community reentry for inmates with SMI. Results identified themes pointing to challenges that these clinicians and the inmates faced, as well as highlighting what facilitates clinicians' work with this population. Findings identified pervasive resource issues across multiple settings, which could have a large impact on clinicians and inmates. There was also a need for increased collaboration and comprehensive services, as it might be challenging for individuals with SMI to navigate the various systems through which they receive services. The need for attention to

individualized treatment and needs at release was also found, as well as providing treatment focused on challenging antisocial attitudes and increasing prosocial beliefs and supports. This population has unique needs and providing mental health treatment alone likely will not help them stay in the community; clinicians need appropriate training to attend to criminogenic needs, with increased collaboration and follow-up among providers. Addressing the needs of mentally ill offenders in terms of community reentry could help the individuals have increased psychiatric stability, and it could also help everyone to see less crime and homelessness in their communities.

Final Thoughts

I have learned through this study that the world of discharge planning and community reentry for inmates with SMI is not uniform. Every offender has different impairments, strengths, and needs when returning to his or her community. Community and prison providers should have the time and ability to make individualized plans and help inmates or clients with all areas in which they struggle, or all needs they may be facing. Additionally, providers should be able to have ongoing transitional collaboration after release, and ideally, there would be time to engage in follow-up to coordinate care. When programs try to group mentally ill offenders together and offer the same services for all, a disservice is done, because people are diverse, and will likely respond differently to the same approaches and programs. There could be long-term positive effects to making changes to community reentry, such as having more community treatment and housing resources, and having increased resources within the prison. This might improve inmate psychiatric stability, as well as decrease involvement in criminal behavior following release. If we can help with successful reentry, we can help offenders learn to live prosocially, and

ultimately lead to a reduction in the number of inmates with SMI returning regularly to our criminal justice system.

The subject of SMI in prison is one about which I am passionate. I have worked with individuals with SMI in the prison setting, and worked with individuals with SMI in the community who were formerly involved with the criminal justice system. I went into this study thinking that there would be challenges for participants to report, based solely on my personal knowledge of this difficult population. While there were challenges, there were also people who cared and persevered with and for a complicated population, despite frustrations. And there were strengths in connection, as well as the ability to work together despite what can be a bleak environment. These were rewarding personal findings.

It seems as though there are far too many individuals with SMI in our jails and prisons, and the trend does not seem to be decreasing. I am hopeful that the community can adequately prepare to serve these individuals. The emergence of reentry programs and diversion programs is encouraging; these are exciting initiatives to help this underserved and stigmatized population. Most of those incarcerated will be released at some point. We should prepare them for that day, and in doing so, we could build safer communities and help individuals with SMI lead more productive and fulfilling lives. It was refreshing to find that participants in this study shared my passion for finding solutions for successful community transitions. One participant spoke poignantly about the desire to make a difference, which summarizes well the parting message of this study:

> …I'm really passionate about discharge planning. I wanted, when I came into prison I wanted to do discharge planning because I think people deserve a fresh start when they get out but sometimes those resources are just not there, and sometimes the real life

> issues that people are faced with when they get out, we don't help to really fill those gaps. …I just invest all my time and energy into trying to make things better. (Prerelease Coordinator)

References

Abram, K.M., Teplin, L.A., McClelland G.M. (2003). Comorbidity of severe psychiatric disorders and substance use disorders among women in jail. *The American Journal of Psychiatry, 160,* 1007-1010.

Allen, L., Mackenzie, D., & Hickman, L. (2001). The effectiveness of cognitive behavioral treatment for adult offenders: A methodological quality-based review. *International Journal of Offender Therapy and Comparative Criminology, 45,* 498-514.

American Association of Community Psychiatrists [AACP]. (2001). *AACP position statement on post-release planning.* Retrieved from http://www.communitypsychiatry.org/publications /position_statements/postrelease.aspx.

American Psychiatric Association [APA]. (2004). *Mental illness and the criminal justice system: Redirecting resources toward treatment, not containment.* Retrieved from http://archive.psych.org/edu/other_res/lib_archives/archives/200401.pdf

American Psychological Association. (2010). *Ethical Principals of Psychologists and Code of Conduct, 2010 Amendments.* Standard 8: Research and Publication.

Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Cincinnati, OH: Anderson Publishing Company.

Appelbaum, P.S. (2005). Assessing Kendra's Law: Five years of outpatient commitment in New York State. *Psychiatric Services, 56,* 791-792.

Baillargeon, J., Hoge, S.K., & Penn, J.V. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology, 46,* 361-375.

Barber-Rioja, V., & Rotter, M. (2014). A therapeutic approach to jurisprudence: A differential thinking model of sanctions and rewards. *International Journal of Forensic Mental Health, 13,* 272-278.

Bewley, M.T., & Morgan, R.D. (2011). A national survey of mental health services available to offenders with mental illness: Who is doing what? *Law and Human Behavior, 35,* 351-363.

Blank Wilson, A. (2013). How people with serious mental illness seek help after leaving jail. *Qualitative Health Research, 23,* 1575-1590.

Blank Wilson, A., & Draine, J. (2006). Collaborations between criminal justice and mental health systems for prisoner reentry. *Psychiatric Services, 57,* 875-878.

Blitz, C.L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry, 31,* 385-393.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123,* 123-142.

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, California: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Bromley, E., Mikesell, L., Armstrong, N.P., & Young, A.S. (2015). "You might lose him through the cracks": Clinicians' views on discharge from assertive community treatment. *Administration and Policy in Mental Health, 42,* 99-110.

Bureau of Justice Statistics. (n.d.). What is the difference between probation and parole? Retrieved from http://www.bjs.gov/index.cfm?ty=qa&iid=324.

Castellano, U., & Anderson, L. (2013). Mental health courts in America: Promise and challenges. *American Behavioral Scientist, 57,* 163-173.

Central New York Psychiatric Center. (2015). Special Housing Unit services in MHSL 1 facilities. Marcy, NY: Author.

Cho, J., & Trent, A. (2006). Validity in qualitative research revisited. *Qualitative Research, 6,* 319-340.

Cloyes, K.G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior, 37,* 175-187.

Condelli, W.S., Bradigan, B., & Holanchock, H. (1997). Intermediate care programs to reduce risk and better manage inmates with psychiatric disorders. *Behavioral Sciences and the Law, 15,* 459-467.

Constantine, R.J., Robst, J., Andel, R., & Teague, G. (2012). The impact of mental health services on arrests of offenders with a serious mental illness. *Law and Human Behavior, 36,* 170-176.

Corrigan, P.W. (2003). Towards an integrated, structural model of psychiatric rehabilitation. *Psychiatric Rehabilitation Journal, 26,* 346-358.

Cusack, K.J., Morrisey, J.P., Cuddeback, G.S., Prins, A., & Williams, D.M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46,* 356-363.

DeMatteo, D., LaDuke, C., Locklair, B.R., & Heilbrun, K. (2013). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice, 41,* 64-71.

Dickerson, F. B. (2004). Update on cognitive behavioral psychotherapy for schizophrenia: Review of recent studies. *Journal of Cognitive Psychotherapy: An International Quarterly, 18,* 189-205.

Draine, J., & Herman, D.B. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services, 58,* 1577-1581.

Draine, J., Wolff, N., Jacoby, J.E., Hartwell, S., & Duclos, C. (2005). Understanding community reentry of former prisoners with mental illness: A conceptual model to guide new research. *Behavioral Sciences and the Law, 23,* 689-707.

Drake, R.E., Green, A.I., Mueser, K.T., & Goldman, H.H. (2003). The history of community mental health treatment and rehabilitation for persons with severe mental illness. *Community Mental Health Journal, 39,* 427-440.

Dvoskin, J.A., & Steadman, H.J. (1994). Using intensive case management to reduce violence by mentally ill persons in the community. *Hospital and Community Psychiatry, 45,* 679-684.

Eno Louden, J., Skeem, J., Camp, J., & Christensen, E. (2008). Supervising probationers with mental disorder: How do agencies respond to violations? *Criminal Justice and Behavior, 35,* 832-847.

Epperson, M.W., Wolff, N., Morgan, R.D., Fisher, W.H., Frueh, B.C., & Huening, J. (2011). The next generation of behavioral health and criminal justice interventions: Improving outcomes by improving interventions. *Monograph Series.* New Brunswick, NJ: Center for Behavioral Health Services & Criminal Justice Research, Rutgers University.

Retrieved from https://ssascholars.uchicago.edu/sites/default/files/m-epperson/files/2011__next_generation_monograph_0.pdf

Erickson, S.K., Lamberti, S., Weisman, R., Crilly, J., Nihalani, N., Stefanovics, E., & Desai, R. (2009). Predictors of arrest during forensic assertive community treatment. *Psychiatric Services, 60,* 834-837.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359,* 545-550.

Fellner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights – Civil Liberties Law Review, 41,* 391-412.

Fisher, W.H., Packer, I.K., Simon, L.J., & Smith, D. (2000). Community mental health services and the prevalence of severe mental illness in local jails: Are they related? *Administration and Policy in Mental Health, 27,* 371-382.

Fisher, W.H., Roy-Bujnowski, K.M., Grudzinskas, A.J., Clayfield, J.C., Banks, S.M., & Wolff, N. (2006). Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. *Psychiatric Services, 57,* 1623-1628.

Gilbert, A.R., Moser, L.L., Van Dorn, R.A., Swanson, J.W., Wilder, C.M., Robbins, P.C.,…Swartz, M.S. (2010). Reductions in arrest under assisted outpatient treatment in New York. *Psychiatric Services, 61,* 996-999.

Gould, R.A., Mueser, K.T., Bolton, E., Mays, V., & Goff, D. (2001). Cognitive therapy for psychosis in schizophrenia: An effect size analysis. *Schizophrenia Research, 48,* 335-342.

Guba, E.G., & Lincoln, Y.S. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Gudjonnson, G.H., Webster, G., Green, T. (2014). The recovery approach to care in psychiatric services: Staff attitudes before and after training. *The Psychiatrist, 34,* 326-329.

Haimowitz (2004). Slowing the revolving door: Community reentry of offenders with mental illness. *Psychiatric Services, 55,* 373-375.

Hall, D.L., Miraglia, R.P., Lee, L.G., Chard-Wierschem, D., & Sawyer, D. (2012). Predictors of general and violent recidivism among SMI prisoners returning to communities in New York State. *Journal of the American Academy of Psychiatry and the Law, 40,* 221-231.

Hartford, K., Carey, R., & Mendonca, J. (2006). Pre-arrest diversion of people with mental illness: Literature review and international survey. *Behavioral Sciences & the Law, 24,* 845-856.

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15,* 84-99.

Hatcher, S.S. (2010). Recognizing perspectives on community reentry from offenders with mental illness: Using the afrocentric framework and concept mapping with adult detainees. *Journal of Offender Rehabilitation, 49,* 536-550.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52,* 482-485.

James, D.J., & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates* (Bureau of Justice Statistics Special Report NCJ 213600). Washington, DC: National Criminal Justice Reference Service.

Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C.,…Shaw, J. (2012). Continuity of care for recently released prisoners with mental illness: A pilot ramdomised

controlled trial testing the feasibility of a Critical Time Intervention. *Epidemiology and Psychiatric Services, 21,* 187-193.

Kennedy, K. (2012). Mental health court: A participant's perspective. *Best Practices in Mental Health, 8,* 38-46.

Kesten, K.L., Leavitt-Smith, E., Rau, D.R., Shelton, D., Zhang, W., Wagner, J., & Trestman, R.L. (2012). Recidivism rates among mentally ill inmates: Impact of the Connecticut Offender Reentry Program. *Journal of Correctional Health Care, 18,* 20-28.

Kupers, T.A. (2008). What to do with the survivors? Coping with the long-term effects of isolated confinement. *Criminal Justice and Behavior, 35,* 1005-1016.

Lamb, H.R., & Weinberger, L.E. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry and the Law, 33,* 529-524.

Lamb, H.R., Weinberger, L.E., & Gross, B.H. (2004). Mentally ill persons in the criminal justice system: Some perspectives. *Psychiatric Quarterly, 75,* 107-126.

Lamberti, J.S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services, 58,* 773-781.

Lamberti, J.S., Weisman, R., & Faden, D.I. (2004). Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services, 55,* 1285-1293.

Langan, P.A., & Levin, D.J. (2002). Recidivism of prisoners released in 1994 (Special Report, June 2002, NCJ 193427). Washington, DC: Bureau of Justice Statistics.

Levenson, J.S., & Cotter, L.P. (2005). The impact of sex offender residence restrictions: 1,000 feet from danger or one step from absurd? *International Journal of Offender Therapy and Comparative Criminology, 49,* 168-178.

Lewis, C.F. (2000). Successfully treating aggression in mentally ill prison inmates. *Psychiatric Quarterly, 71,* 331-342.

Lovell, D., Gagliardi, G.J., & Peterson, P.D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services, 53,* 1290-1296.

MacKain, S.J., & Mueser, K.T. (2009). Training in illness self-management for people with mental illness in the criminal justice system. *American Journal of Psychiatric Rehabilitation, 12,* 31-56.

Markowitz, F.E. (2006). Psychiatric hospital capacity, homelessness, and crime and arrest rates. *Criminology, 44,* 45-72.

Markowitz, F.E. (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behavior, 16,* 36-44.

McGrew, J.H., & Bond, G.R. (1995). Critical ingredients of Assertive Community Treatment: Judgment of the experts. *The Journal of Mental Health Administration, 22,* 113-125.

McGrew, J.H., Wright, E.R., Pescosolido, B.A., & McDonel, E.C. (1999). The closing of Central State Hospital: Long-term outcomes for persons with severe mental illness. *The Journal of Behavioral Health Services & Research, 26,* 246-261.

McNiel, D.E., & Binder, R.L. (2007). Effectiveness of a mental health court in reducing criminal recidivism and violence. *The American Journal of Psychiatry, 164,* 1395-1403.

McNiel, D.E., Binder, R.L., & Robinson, J.C. (2005). Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. *Psychiatric Services, 56,* 840-846.

McShane, M.D. (1989). The bus stop revisited: Discipline and psychiatric patients in prison. *The Journal of Psychiatry and the Law, 17,* 413-433.

Mechanic, D., & Rochefort, D.A. (1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology, 16,* 301-327.

Mertens, D. (2010). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (3rd ed.). Thousand Oaks, CA: Sage.

Morgan, D.W., Edwards, A.C., & Faulkner, L.R. (1993). The adaptation to prison by individuals with schizophrenia. *Bulletin of the American Academy of Psychiatry and the Law, 21,* 427-433.

Morgan, R.D., Flora, D.B., Kroner, D.G., Mills, J.F., Varghese, F., & Steffan, J.S. (2012). Treating offenders with mental illness: A research synthesis. Law and Human Behavior, 36, 37-50.

Mueser, K.T., Torrey, W.C., Lynde, D., Singer, P., & Drake, R.E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification, 27,* 387-411.

National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2002). *The Nathaniel Project: An alternative to incarceration program for people with serious mental illness who have committed felony offenses.* Program Brief Series. Delmar, NY: Author.

New York State Commission on Quality Care and Advocacy for Persons with Developmental Disabilities. (2010). *Review of residential crisis treatment programs (RCTPs).* Schenectady, NY: Author.

New York State Department of Corrections and Community Supervision [NYS DOCCS] Bureau of Mental Health. (2011). Mental Health Program Descriptions – 7/5/11. Retrieved from http://www.op.nysed.gov/surveys/mhpsw/doccs-att6.pdf.

New York State Office of Mental Health [NYS OMH]. (n.d.-a). Central New York Psychiatric Center. Retrieved from https://www.omh.ny.gov/omhweb/facilities/cnpc/.

New York State Office of Mental Health [NYS OMH]. (n.d.-b). Personalized Recovery Oriented Services (PROS). Retrieved from https://www.omh.ny.gov/omhweb/pros/.

New York State Office of Mental Health & New York State Department of Correctional Services [NYS OMH & NYS DOCCS]. (2009). *Residential mental health unit program description.* New York: Author.

O'Connor, F.W., Lovell, D., & Brown, L. (2002). Implementing residential treatment for prison inmates with mental illness. *Archives of Psychiatric Nursing, 16,* 232-238.

Olley, M.C., Nicholls, T.L., & Brink, J. (2009). Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behavioral Sciences and the Law, 27,* 811-831.

Osher, F., Steadman, H.J., & Barr. H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC model. *Crime & Delinquency, 49,* 79-96.

Ottens, A.J., & Klein, J.F. (2005). Common factors: Where the soul of counseling and psychotherapy resides. *Journal of Humanistic Counseling, Education and Development, 44,* 32-45.

Pescosolido, B.A., Medina, T.R., Martin, J.K., & Long, J.S. (2013). The "backbone" of stigma: Identifying the global core of public prejudice associated with mental illness. *American Journal of Public Health, 103,* 853-860.

Pescosolido, B.A, Monahan, J., Link, B.G., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health, 89,* 1339-1345.

Pope, L.G., Smith, T.E., Wisdom, J.P., Easter, A., & Pollack, M. (2013). Transitioning between systems of care: Missed opportunities for engaging adults with serious mental illness and criminal justice involvement. *Behavioral Sciences and the Law, 31,* 444-456.

Prins, S.J. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system? *Community Mental Health Journal, 47,* 716-722.

Prins, S.J. (2014). Prevalence of mental illness in U.S. state prisons: A systematic review. *Psychiatric Services, 65,* 862-872.

Rector, N.A., Seeman, M.V., & Segal, Z.V. (2003). Cognitive therapy for schizophrenia: A preliminary randomized controlled trial. *Schizophrenia Research, 63,* 1-11.

Redlich, A.D., Steadman, H.J., Monahan, J., Petrila, J., & Griffin, P.A. (2005). The second generation of mental health courts. *Psychology, Public Policy, and Law, 11,* 527-538.

Rotter, M., & Carr, W.A. (2011). Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches. *Community Mental Health Journal, 47,* 723-726.

Rotter, M., McQuistion, H.L., Broner, N., & Steinbacher, M. (2005). Best practices: The impact of the "incarceration culture" on reentry for adults with mental illness: A training and group treatment model. *Psychiatric Services, 56,* 263-267.

Schultz, D., & Schultz, S.E. (1998). *Theories of personality* (6th ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Skeem, J.L., Emke-Francis, P., & Eno Louden, J. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior, 33,* 158-184.

Skeem, J.L., Encandela, J., & Eno Louden, J. (2003). Perspectives on probation and mandated mental health treatment in specialized and traditional probation departments. *Behavioral Sciences and the Law, 21,* 429-458.

Skeem, J.L., Winter, E., Kennealy, P.J., Eno Louden, J., & Tatar, J.R. (2014). Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38,* 213-224.

Smith, H., Sawyer, D.A., & Way, B.B. (2004). Correctional mental health in New York: Then and now. *Psychiatric Quarterly, 75,* 21-39.

Soderstrom, I.R. (2007). Mental illness in offender populations: Prevalence, duty, and implications. *Journal of Offender Rehabilitation, 45,* 1-17.

Stahler, G.J., Mennis, J., Belenko, S., Welsh, W.N., Hiller, M.L., & Zajac, G. (2013). Predicting recidivism for released state prison offenders: Examining the influence of individual and neighborhood characteristics and spatial contagion on the likelihood of reincarceration. *Criminal Justice and Behavior, 40,* 690-711.

Steadman, H.J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences and the Law, 23,* 163-170.

Stephens, D.J. (2011). Substance abuse and co-occurring disorders among criminal offenders. In T.J. Fagan & R.K. Ax (Eds.), *Correctional mental health: From theory to best practice* (pp. 235-256). Thousand Oak, CA: Sage.

Suto, I., & Arnaut, G.L.Y. (2010). Suicide in prison: A qualitative study. *The Prison Journal, 90,* 288-312.

Tartaro, C., & Lester, D. (2005). An application of Durkheim's theory of suicide to prison suicide rates in the United States. *Death Studies, 29,* 413-422.

Torrey, E.F. (1995). Editorial: Jails and prisons – America's new mental hospitals. *American Journal of Public Health, 85,* 1611-1613.

Tripodi, S.J., & Bender, K. (2007). Inmate suicide: Prevalence, assessment, and protocols. *Brief Treatment and Crisis Intervention, 7,* 40-54.

Vogel, W.M., Noether, C.D., & Steadman, H.J. (2007). Preparing communities for reentry of offenders with mental illness: The ACTION approach. *Mental Health Issues in the Criminal Justice System, 45,* 167-188.

Way, B.B., Miraglia, R., Sawyer, D.A., Beer, R., & Eddy, J. (2005). Factors related to suicide in New York state prisons. *International Journal of Law and Psychiatry, 28,* 207-221.

Way, B.B., Sawyer, D.A., Barboza, S., & Nash, R. (2007). Inmate suicide and time spent in special disciplinary housing in New York State prison. *Psychiatric Services, 58,* 558-560.

Way, B.B., Sawyer, D.A., Lilly, S.N., Moffitt, C., & Stapholz, B.J. (2008). Characteristics of inmates who received a diagnosis of serious mental illness upon entry to New York State prison. *Psychiatric Services, 59,* 1335-1337.

Wlock, M., Lilly, S.N., & Moffitt, C.E. (2011). *Intermediate care program 2010 annual report.* Marcy, NY: Central New York Psychiatric Center, New York State Office of Mental Health.

Wolff, N., Frueh, B.C., Huening, J., Shi, J., Epperson, M.W., Morgan, R., & Fisher, W. (2013). Practice informs the next generation of behavioral health and criminal justice involvement. *International Journal of Law and Psychiatry, 36,* 1-10.

Appendix A

Prerelease Recruitment Email

Dear Office of Mental Health prerelease coordinators,

My name is Lauren Meath and I am a doctoral candidate in the Clinical Psychology Psy.D. program at Antioch University New England. I also recently completed a year-long predoctoral psychology internship at Hutchings Psychiatric Center.

I would like to invite you to participate in my dissertation project, which is a study of clinician perspectives on community reentry for inmates with mental illness, including both prison and community providers.

Your participation would involve one confidential, semi-structured interview over the phone or in person, which should last for approximately 1 to 1 ½ hours. If you agree to participate, I will ask you about strengths of the reentry program, as well as challenges that you face in your work finding community services for inmates with mental illness. It may also involve a brief follow-up conversation after data analysis to check that I have correctly understood your point of view.

Please review the attached informed consent form to learn more about participation. This project has been approved by Antioch University New England's Institutional Review Board. If interested, please reply by email so that we can discuss your potential participation and I can address any questions or concerns you might have. If you are not interested, I would be grateful to hear that, too, so that I do not trouble you with a second invitation.

Thank you in advance for your time and consideration. I hope to hear from you.

Sincerely,
Lauren Meath

Appendix B

Prerelease Informed Consent

Project Title: Outpatient and Prison Provider Perspectives on Community Reentry for Mentally Ill Offenders

Principal Investigator: Lauren Meath, M.A., M.S.
Doctoral Candidate
Department of Clinical Psychology
Antioch New England Graduate School
40 Avon Street, Keene, NH 03134

IRB Chair: Donald Woodhouse
40 Avon Street, Keene, NH 03134

Thank you for considering participation in this research project seeking to improve understanding about community reentry for inmates with mental illness. The purpose of this study is to obtain qualitative information from prerelease coordinators and outpatient clinicians about their experiences with community reentry for inmates with mental illness.

If you agree to participate, I will ask you about your experience working with these individuals, either to release them into the community or working with them in the community toward reintegration. Participation in this study will include at least one telephone or in-person interview, to be arranged at your convenience. Follow-up telephone calls may occur if additional information is needed, and to ensure that the themes adequately capture your opinions. Interview questions will be geared toward understanding any agency strengths and challenges you perceive, and also more generally about your experiences with this population.

Your participation in this research is voluntary. You can withdraw from the study without penalty at any point up until the time of data analysis. You are not required to answer any interview questions that you do not wish to answer.

There is a small risk that someone might be able to tell who you are from reading the published report. To protect your privacy, your name or any other identifiable information will not be used. However, there is still a small risk that people who know you may be able to figure out who you are from reading the published report.

There will not be any compensation for your participation in this research project. You will receive my gratitude, and also know that you have had an opportunity to give your voice to the process of understanding community reentry for a stigmatized population.

We will respect and protect your confidentiality. Your name and specific work location will not be used. Instead, the information you provide will be given a code number in order to ensure confidentiality. Your interview will be audio recorded to ensure that the interviewer can accurately review and understand your responses. The audio recordings will be transcribed and

stored on the principal investigator's password protected personal computer in a password protected document. The only place your name will appear is on this consent form, and only the code number will appear on other documents, including the transcript. The recordings will be stored in a locked cabinet in the principal investigator's home and will be destroyed after transcription. Your interview will be reviewed for themes, which will be coordinated with themes arising from other interviews. Quotes from your interview might be included in the final report, but they would not be connected with your identity. The principal investigator and a second rater from Antioch University New England will have access to the transcript of your interview for purposes of data analysis. The investigator's dissertation committee members may have access to the de-identified transcripts. One of the dissertation committee members is an employee of Central New York Psychiatric Center, but she will not have access to any participant identifying information, including work location.

If you have any questions or concerns about this study, you can contact Lauren Meath, M.A., M.S. at lmeath@antioch.edu or my dissertation chair, Kathi Borden, Ph.D. at kborden@antioch.edu. If you have questions or concerns about your rights as a participant, you can contact Donald Woodhouse, Chair of the Institutional Review Board at Antioch University New England, at dwoodhouse@antioch.edu or 603-283-2101.

I have read the information provided and agree to participate in the interview of my experiences as a prerelease coordinator.

Please Print Name: _____

_____ _____

Signature Date

Appendix C

Prerelease Follow-up Email

Dear Office of Mental Health prerelease coordinators,

My name is Lauren Meath and I am a doctoral candidate in the Clinical Psychology Psy.D. program at Antioch University New England. I sent you an email two weeks ago describing my dissertation project and seeking participants who are currently employed as prerelease coordinators for the Office of Mental Health. I am writing now to follow-up as I have not received a response from you and would very much appreciate having you participate in my study. I have attached the informed consent form again for your review. Please reply by email if interested in participating or if you have any questions or concerns. Please also feel free to notify me if you are not interested in participating. Thank you for your consideration.

Sincerely,
Lauren Meath

Appendix D

Outpatient Recruitment Email

Dear Hutchings Psychiatric Center outpatient clinicians,

My name is Lauren Meath and I am a doctoral candidate in the Clinical Psychology Psy.D. program at Antioch University New England. I also recently completed a year-long predoctoral psychology internship at Hutchings Psychiatric Center.

I would like to invite you to participate in my dissertation project, which is a study of clinician perspectives on community reentry for inmates with mental illness, including both prison and community providers. I will be asking you about your experiences working with clients with mental illness who have also served time in state prison. The criteria for participating are that you have worked with clients who have been referred from state prison and are coming to outpatient care directly following time in prison OR directly following an inpatient admission as a transfer from state prison. For inclusion, you should have begun working with the client within three months of their release. These could either be current clients or individuals you have worked with in the past.

Your participation would involve one confidential, semi-structured interview over the phone or in-person that should last for approximately 1 to 1 ½ hours. It may also involve a brief follow-up conversation after data analysis to check that I have correctly understood your point of view.

Please review the attached informed consent form to learn more about participation. This project has been approved by Antioch University New England's Institutional Review Board. If interested, please reply by email and we can discuss your potential participation and I can address any questions or concerns you might have. If you are not interested, I would be grateful to hear that, too, so that I do not trouble you with a second invitation.

Thank you in advance for your time and consideration. I hope to hear from you.

Sincerely,
Lauren Meath

Appendix E

Outpatient Informed Consent

Project Title: Outpatient and Prison Provider Perspectives on Community Reentry for Mentally Ill Offenders

Principal Investigator: Lauren Meath, M.A., M.S.
Doctoral Candidate
Department of Clinical Psychology
Antioch New England Graduate School
40 Avon Street, Keene, NH 03134

IRB Chair: Donald Woodhouse
40 Avon Street, Keene, NH 03134

Thank you for considering participation in this research project seeking to improve understanding about community reentry for inmates with mental illness. The purpose of this study is to obtain qualitative information from prerelease coordinators and outpatient clinicians about their experiences with community reentry for inmates with mental illness.

If you agree to participate, I will ask you about your experience working with these individuals, either to release them into the community or working with them in the community toward reintegration. Participation in this study will include at least one telephone or in-person interview, to be arranged at your convenience. Follow-up telephone calls may occur if additional information is needed, and to ensure that the themes adequately capture your opinions. Interview questions will be geared toward understanding any agency strengths and challenges you perceive, and also more generally about your experiences with this population.

Your participation in this research is voluntary. You can withdraw from the study without penalty at any point up until the time of data analysis. You are not required to answer any interview questions that you do not wish to answer.

We do not foresee any risks to participants in this research, beyond those of your everyday work life.

There will not be any compensation for your participation in this research project. You will receive my gratitude, and also know that you have had an opportunity to give your voice to the process of understanding community reentry for a stigmatized population.

We will respect and protect your confidentiality. Your name and specific work location will not be used. Instead, the information you provide will be given a code number in order to ensure confidentiality. Your interview will be audio recorded to ensure that the interviewer can accurately review and understand your responses. The audio recordings will be transcribed and stored on the principal investigator's password protected personal computer in a password protected document. The only place your name will appear is on this consent form, and only the code number will appear on other documents, including the transcript. The recordings will be

stored in a locked cabinet in the principal investigator's home and will be destroyed after transcription. Your interview will be reviewed for themes, which will be coordinated with themes arising from other interviews. Quotes from your interview might be included in the final report, but they would not be connected with your identity. The principal investigator and a second rater from Antioch University New England will have access to the transcript of your interview for purposes of data analysis. The investigator's dissertation committee members may have access to the de-identified transcripts. One of the dissertation committee members is an employee of Central New York Psychiatric Center, but she will not have access to any participant identifying information, including work location.

If you have any questions or concerns about this study, you can contact Lauren Meath, M.A., M.S. at lmeath@antioch.edu or my dissertation chair, Kathi Borden, Ph.D. at kborden@antioch.edu. If you have questions or concerns about your rights as a participant, you can contact Donald Woodhouse, Chair of the Institutional Review Board at Antioch University New England, at dwoodhouse@antioch.edu or 603-283-2101.

I have read the information provided and agree to participate in the interview of my experiences as an outpatient clinician.

Please Print Name: _____

_____ _____

Signature Date

Appendix F

Outpatient Follow-up Email

Dear Hutchings Psychiatric Center outpatient clinicians,

My name is Lauren Meath and I am a doctoral candidate in the Clinical Psychology Psy.D. program at Antioch University New England. You were sent an email two weeks ago on my behalf describing my dissertation project and seeking participants who currently work in an outpatient clinic at Hutchings Psychiatric Center and who have worked with individuals soon after release from prison. I am writing now to provide another chance to respond if you are still interested in participating. I would greatly appreciate the opportunity to include you in my study. I have attached the informed consent form again for your review. Please reply by email if interested in participating or if you have any questions or concerns. Please also feel free to notify me if you are not interested in participating. Thank you for your consideration.

Sincerely,
Lauren Meath

Appendix G

Prerelease Interview Questions

1. Ask relevant demographic questions: age, gender, race, title/degree, how many years employed within NYS prisons, any previous jail or prison work (if yes, elaborate), how many years as prerelease coordinator, setting (rural vs. urban— to which setting does he/she primarily discharge)
2. How many inmates do you typically have on your caseload at one time?
3. Tell me about the current protocol for preparing to discharge an inmate with SMI.
4. At what point in an inmate-patient's sentence does the discharge planning process begin? What are your thoughts about the length of time that is allotted to the discharge planning process (e.g. do you think the length of time is adequate)?
5. What types of outpatient settings and services do you most need? Regarding those settings and services, what is it specifically that you need? Are there some individuals who have atypical circumstances and need any other types of planning? If so, describe their needs.
6. Tell me what it is like trying to find outpatient services that meet the needs of someone with SMI who is involved with the criminal justice system. What challenges do you have trying to place released inmates in optimal settings?
7. What resources do you currently have to place people in the community? What about staff resources? What resources do you wish you had (cost and other limits aside)?
8. Have you found there to be any challenges when collaborating with DOCCS regarding discharge?
9. What collaboration do you do with community agencies prior to discharge?
10. Do you notice any gaps in community agencies' abilities to work with individuals with mental illness and previous criminal justice involvement (i.e. can most agencies adequately attend to criminal justice and mental health needs)?
11. Do you perceive there to be effective collaboration among community agencies involved with an individual's care (e.g. probation, mental health, case management, etc.)?
12. What types of mental health programs are these inmates typically released to (e.g. ACT, community mental health centers, etc.)?
13. Do you find differences in placing people in mental health services in rural vs. urban settings? If yes, what differences? Any potential challenges with either setting?
14. Besides mental health and substance abuse needs, what other needs do you commonly try to help inmates meet (e.g. religious, housing, social support, employment, recreational, etc.)? Ask follow-up questions for any needs mentioned: In what way do you help with that area, and have you found any difficulties in helping with that need?
15. How often do you see family involvement in an inmate's release? Please elaborate on how you see family involvement impacting release.
16. What facilitates an inmate leaving with a good discharge plan?
17. Which inmates are the hardest to place? Which are easiest?
18. Have you found any challenges in collaborating with an inmate to coordinate his release, e.g. regarding motivation to continue with mental health services? If yes, do you have any thoughts on how providers might help them become more engaged in services?
19. What are the housing options like for inmates being released? Please elaborate on housing difficulties (e.g. homelessness).

20. Tell me about the release challenges associated with an inmate having dual diagnoses. For instance, any increased housing difficulties with this population? What about specialized substance abuse needs? Is it difficult to find outpatient services to suit their mental health, substance abuse, and criminal history needs?
21. Can you tell me about a particularly challenging case?
22. Can you tell me about a particularly rewarding case or one where the system worked especially well for the inmate?
23. (If applicable and person works with SMI and less chronic mental illness) Have you noticed any placement differences for inmates with SMI versus those with less chronic mental health problems?
24. Have personal reactions about certain types of crimes affected you during your work with this population? If yes, please elaborate.
25. In an ideal world, how would you envision the discharge process? What would it look like during discharge, and what would it look like for the released inmates?
26. Please tell me anything else about the reentry process for inmates with mental illness that you think is important for me to know.

Appendix H

Outpatient Interview Questions

1. Ask relevant demographic questions: age, gender, race, title/degree, how many years employed at Hutchings Psychiatric Center, any previous work with individuals with SMI, any previous work with individuals with a history in the correctional system.
2. How many individuals do you currently have on your caseload who have been recently released from prison? How many individuals do you estimate you have ever worked with who had recently been released from prison? What proportion of these clients were considered SMI?
4. Do you have any communication or follow-up with CNYPC or DOCCS after an individual is released and in your care?
5. What are the primary issues that your clients face as a result of being both mentally ill and being released from prison? How are these needs handled with the client? Where are there gaps in how your agency handles these needs?
6. Besides mental health, what other needs do you commonly find these clients need help with (e.g. substance abuse, religious, housing, social support, employment, recreational, etc.)? Ask follow-up questions for any needs mentioned: In what way do you help with that area, and have you found any difficulties in helping with that need?
7. Have any of these clients been homeless? What are typical housing situations for these clients?
8. How often do you see family involvement with these clients?
9. Do you perceive there to be adequate collaboration among community agencies for these clients (e.g. probation/parole, case management, etc.)?
10. Have you found that these clients have challenges navigating the various community agencies that they are involved with?
11. Have you found any challenges engaging these clients in services? Have you found any strategies to be helpful in engaging these clients?
12. Can you tell me about a particularly challenging case?
13. Can you tell me about a particularly rewarding case or one where the system worked particularly well for the client?
14. What has been the biggest help to you in your work with these clients?
15. Have any of these clients returned to jail/prison while you were working with them? If yes, do you know how long it was after initial release that they got rearrested?
16. If applicable: What differences have you noticed in working with clients with SMI versus those with less chronic mental health problems?
17. Have personal reactions about certain types of crimes affected you during your work with this population? If yes, please elaborate.
18. In an ideal world, how would you envision community mental health services looking for these clients?
19. Please tell me anything else about the reentry process for these clients that you think is important for me to know.

Appendix I

Thematic Analysis

Themes	Subthemes
Inmate Psychosocial Risk Factors	Attitudes and Beliefs that Interfere with Reentry
	Personal Impairments
	Substance Use History
	Lack of Family Support
Issues of Access to Community Resources	Lack of Resources in the Community
	Diagnostic Limitations
	History of Violence and SMI
	Housing Issues
	Geographic Limitations
Problems in Discharge Planning Process	Inadequate Diagnostic Assessment
	Clinician Burden
	Lack of Psychological Preparedness
	Barriers to Coordinating Resources
Factors that Facilitate Discharge Planning Process	Clinician Characteristics that Positively Relate to Treatment
	Reintegration to a Community of Prior Connection
	Collaboration
	Creating Individualized Treatment Plans (Being Person-Centered)

Appendix J

Relevant Acronyms

ACT	Assertive Community Treatment
AOT	Assisted Outpatient Treatment
CBT	Cognitive-Behavioral Therapy
CNYPC	Central New York Psychiatric Center
CORP	Community Orientation and Reentry Program
CTI	Critical Time Intervention
DOCCS	Department of Corrections and Community Supervision
FACT	Forensic Assertive Community Treatment
ICP	Intermediate Care Program
MICA	Mentally Ill Chemical Abuser
OMH	Office of Mental Health
PSTP	Parole Supported Treatment Program
PROS	Personalized Recovery Oriented Services
RCTP	Residential Crisis Treatment Program
RMHU	Residential Mental Health Unit
SHU	Special Housing Unit
SMI	Serious Mental Illness
SSI	Supplemental Security Income
STEP	Safe Transition and Empowerment Project