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Incarceration and Reintegration: How It Impacts Mental Health

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INCARCERATI0N AND REINTEGRATION:

HOW IT IMPACTS MENTAL HEALTH

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

Background: Previous criminal justice policies have been non-effective leading to overpopulated prisons and unsuccessful reintegration. There is a lack of effective supportive and/or rehabilitative services resulting in high rates of recidivism and mental health implications. Objective: This study investigated the perceived impact that incarceration and reintegration with little to no supportive and/or rehabilitative services has on the mental health status of an individual. The emphasis was on participant perception and not on professional reports because of underreporting and lack of attention to mental health in the criminal justice system. Methods: Focus groups in the Inland Empire and Coachella Valley were held to gather preliminary data used to develop the survey for this study. The survey was distributed to 88 male and female ex-offenders over the age of 18 who were no longer on probation or parole. Secondary data from United Way 211 and California State Reentry Initiative was collected to report current trends of supportive and/or rehabilitative services. Results: Incarceration was found to negatively impact perceived mental health status, but reintegration was not. Supportive and/or rehabilitative services continue to be rarely offered and accessed, but when accessed, perceived mental health status is better. Supportive and/or rehabilitative services are more readily available. People who are using these services are improving their quality of life, becoming productive members of society, and preventing recidivism. Conclusions: A paradigm shift is currently

under way to reduce recidivism by improving supportive and/or rehabilitative services during incarceration and reintegration. Many offenders are receiving services as an alternative to incarceration, recidivism rates are being reduced, and ex-offenders are becoming productive members of society. The field of social work is an integral part of reentry services and should continue advocating for policies and services that support reintegration efforts at the micro and macro level.

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April Marie Marier

This project has been a vision of mine for the past ten years. I cannot begin to express the gratitude I have to all those that have contributed. My hope is those who have supported me through this journey, will know my sincere appreciation for your support and direction. This project would not have been as successful without your support. First, and most importantly, I want to thank my research partner Alex Alfredo Reyes for your continued encouragement and support in this collaborative effort. Your passion for micro systems and my passion for macro systems made us a great team! I have learned so much from you. You are a wonderful clinician and will make great contributions to the field of Social Work. Next, I want to thank my advising professor Dr. Cory Dennis. Thank you for your guidance and support, always challenging me to expand my research understanding and skills. I would like to thank California State University Reentry Initiative (CSRI), Carolyn Eggleston United Way 211 Reentry Line, and Gary Madden for their support and secondary data. I would like to thank my cohort and CSUSB, School of Social Work faculty, for the continued support and encouragement during these past 3 years. You have all taught me so much. Finally, I would like to thank the Riverside County Department of Mental Health. I have received great supervision from the many mentors and colleagues (too many to name). They have taught and inspired me to challenge my understanding of mental health and recovery. I am thankful for the programs available within the department made completion of my Master's Degree possible. I look forward to applying

my knowledge to our consumers in order to empower them the same way this department has empowered me.

Alex Alfredo Reyes

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DEDICATION

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I cannot begin to describe the feeling of accomplishment and satisfaction that I have about this project. I have spent many nights and weekends away from my family and friends. It has not been easy, but the rewards are great! I want to thank my family for their continued support and understanding. My husband, Scott Marier, has been my biggest support. He has encouraged me to follow my dreams and complete my degree. His sacrifice was just as significant as mine and he will never understand how his love has inspired me. His understanding and willingness to allow me to remain focused on this thesis, made it possible for me to complete it.

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I have watched many people over the years struggle with addictions and instead of being given treatment they were sent to prison. I have seen them struggle as they attempt reintegration into the community. Unfortunately, many of them returned to old behaviors and/or prison. This project is dedicated to all of you and all those who fell under the old ideologies of the 1980's, 90's and the early 2000's, which believed that incarceration (deterrence) was the answer to addictions. Specifically, those who have inspired this thesis over the years are: my best friend Kathy Reinseth, Eddie Frey, Mike Litzau, Ricky Litzau, Scott Ledbetter, and Billy McGranahan. You all have provided me with inspiration to complete this thesis, to encourage new research, and to inspire new visions for rehabilitation. I have often wondered if things would have been different for some of you, if you had been offered

alternative sentencing programs instead of prison. I hope this project will inspire further research to support the implementation of supportive services.
Alex Alfredo Reyes

I cannot fully describe the hard work and sacrificed time that was put into this thesis project. What I can do, is describe how much I appreciate my family who worked just as hard and sacrificed the same amount of time. I dedicate this thesis project to my wife Maryann, my children Valerie Ann, Veronica Marie, Alexander Albert, and Andrew Alan. I want each one of you to know that not one day in class or one minute studying, passed, without me thinking or wanting to be with you instead. Maryann, you and only you, know how much I love being a father. You and only you knew what I was afraid of happening, by taking this journey. I want you to know that I could not have accomplished this feat, during this time in my life, without knowing that my children were safe with you. For that, I love you very much and will always love you more than words can explain. Valerie Ann, your words echoed in my ears every quarter of this degree about my time away from all of you. I want you to know that I heard you. But, I realized what an opportunity it was to be an example of responsibility and success in today's world, for you, your sister, and brothers to see. So despite wanting to, I did not quit. I saw it through, so you can see it through too. And, now it is your turn to be a better and smarter example than me. Your sister and brothers look up to you. I know you will do it, because of how responsible and successful you are today. I love you my Valerina. Veronica Marie, we share so many qualities, some that are useful and some that are not. But it is who we are and I wouldn't change either one of

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My family means the world to me because I know that I mean the world to you. Our life has not been easy, but it is our life. My gift to you as your son is the family that I have today. I want you to know that I have worked very hard and I hope you are proud of me. And guess what, I am a Master Social Worker! I love you Mom. I love you Pop.

Gabriel and Daniel, brothers are examples whether we want to be or not, whether we think we are or not. I am proud today of the example that I am to both of you. Do what is in your heart, love your family hard, and be an example to your children. I love you Gabriel. I love you Daniel.

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CHAPTER ONE

INTRODUCTION

This chapter discusses the problem of overpopulated prisons and how criminal justice policies have been non-effective, resulting in unsuccessful reintegration of ex-offenders into the community and high recidivism rates. Changing viewpoints and newly implemented legislation on how the criminal justice system addresses recidivism, has many public safety implications to consider, including the mental health of individuals and communities. This chapter discusses how this study proposes to approach these problems and how it may contribute to the social work profession and to society. The terms criminal, violator, offender, convict, felon, and inmate have been used to describe an individual who performs criminal activities and is incarcerated. To avoid confusion this study will use the term offender. The term ex-offender will be used to describe those who have been released from incarceration.

Problem Statement

The United States has more offenders incarcerated in prison than any other nation. In 2011 the United States had just over 2.2 million offenders behind bars. This was approximately 600,000 more than the second leading nation, which is China. Proportionately, the United States is also the leader. In 2011, there were 716 offenders per 100,000 people of the national population, with St. Kitts and Nevis following with 649 offenders per 100,000 people of

their general population (International Centre for Prison Studies, 2013). In 2011, California had approximately 137,000 offenders in the 33 different prison institutions, including in-state and out-of-state fire-camps and private facilities (Department of Corrections and Rehabilitation, 2013). With these staggering numbers, come an alarming number of offenders who will attempt reintegration into the communities from which they were sentenced. For example, during this time, across the United States, just over 735,000 offenders were released from incarceration. In California alone, there were approximately 137,000 offenders released from incarceration (Carson & Sabol, 2011). Many of these ex-offenders will recidivate when they return to their communities.

Recidivism is a controversial issue throughout the United States. Some question whether programs aimed at prevention, deterrence, rehabilitation, or correction actually work (Ross & Fabiano, 1985). Every discipline has a different perspective on what constitutes recidivism. For the purpose of this paper, recidivism will be defined as being rearrested, convicted, and given a new sentence after having been released from incarceration. Over half of ex-offenders will be re-incarcerated within three years of their release date (Langan & Levin, 2002). According to the Council of State Governments Justice Center (2013), there are more repeat offenders incarcerated than first time offenders. The goal of criminal justice and treatment agencies is to

prevent recidivism, and facilitate successful reintegration by helping ex-offenders become productive members of society.

Reintegration is the process of leaving prison or jail and becoming a law-abiding citizen in the community, which requires access to resources aimed at preparing ex-offenders for a safe return to their community (Rosenthal & Wolfe, 2004). Unfortunately, many of them will not successfully reintegrate into the community because of little support and/or lack of participation in supportive/rehabilitative services. This leads to the question of which resources are effective and which resources are not effective in supporting successful reintegration?

Historically, public safety policies have focused primarily on incarcerating offenders who commit crimes. Therefore, over the decades, more prisons were built and more correctional staff were hired (The Council of State Governments Justice Center, 2013). This viewpoint has resulted in an enormous amount of national spending on corrections. For example, from 1988 to 2008, the annual budget for corrections increased from $12 billion to $52 billion; growing at a faster rate than any other state budget (National Association of State Budget Officers, 2013)! With high rates of recidivism across the country, this expensive approach can be viewed as an unsuccessful one. Policy makers must reconsider their approach. Public safety will be better served if policy and budgets are focused on successfully

reintegrating ex-offenders from prison back into the community, rather than simply re-incarcerating them.

Fortunately, reintegration services have been developed and evaluated throughout the world. Over the decades criminal justice administrators realized what little information they had on what works to keep ex-offenders from getting re-incarcerated. Therefore, recent research has been conducted to find out what works at reducing recidivism and improving reintegration. The Council of State Governments Justice Center (2013), highlights the importance of prioritizing resources for ex-offenders who are at moderate to high risk of re-offending, with an emphasis on addressing core criminogenic needs first. As a result, some states who have implemented evidenced-based programs such as intense community supervision, community-based housing, and subsidized employment, have shown a reduction in recidivism (Council of State Governments Justice Center, 2013).

Purpose of the Study

The purpose of this study is to investigate the impact incarceration and reintegration has on mental health from the perspective of the ex-offender. Data collected may be used to identify areas in need of advocacy and influence policy change and program development to reduce dangerous and costly rates of incarceration across the nation, particularly in California. Typically, policy and services are designed and implemented by administrators. Administrators are the ones who make decisions about which

services are best, who to target, and how to implement them. However, this approach is missing a crucial perspective from the individuals involved. Therefore, this study aims to conduct focus groups and surveys with ex-offenders to gather their perspective about the experience of incarceration and reintegration into the community. This perspective may provide unique insight about the effectiveness of current policies and services, and unique insight about policy and services that administrators may have overlooked or omitted. Additionally, this study will analyze secondary data to determine what impact these current policies and services are having on the mental health of individuals and communities.

Mental illness is a significant issue for this population. However, mental illness is not one of the eight core criminogenic needs or risk factors identified by the criminal justice system (Council of State Governments Justice Center, 2013). Mental illness is viewed by the criminal justice system as important, but is secondary to antisocial risk factors. As such, mental illness might go unnoticed or be inadequately addressed. This is a major problem for individuals, family members, and communities at large because without appropriate mental health treatment, mental illness will likely get worse. Mental illness is prevalent in the prison population; therefore, it should be a focus of study (James & Glaze, 2006).

Since mental illness receives little consideration from the criminal justice system, this study is interested in the subjective perspective of

ex-offenders about changes in their mental health prior to, during, and after incarceration.

For the purpose of this study, the definition of mental health according to the World Health Organization (2013) will be used:

> Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community. (para. 2)

Any reported change in perceived mental health is considered relevant to this study. This information will be used in order to determine what perceived impact, if any, incarceration and reintegration have on an individual. Other areas of focus will be the process of assessment and identification of mental health problems, process and time of referrals, access to services, quality of services, and effectiveness of services.

Significance of the Project for Social Work

Information gathered from ex-offenders can be used to benefit the field of social work. With the perspective from ex-offenders about their experience of incarceration and reintegration, social work can discover areas in need of advocacy. By collaborating with ex-offenders, social work can be part of a new recovery movement. Typically, the principle of recovery refers to substance abuse, and recently, mental health. Perhaps, the information gathered straight

from ex-offenders may contribute to their empowerment to take their own reintegration into their own hands and recover.

Evaluating policies and services targeting a social problem, creates an opportunity for the development of newer and more effective policies and services. By investigating the impact of recent policy and service changes such as Assembly Bill 109 (AB109), which emphasize reintegration and supportive services versus incarceration, the field of social work will benefit by having information about what works and what needs to be further evaluated and changed. As populations grow, technology changes, and budgets are impacted, change is inevitable. Therefore, it is important for the field of social work to be current with the ever changing face of communities and their problems.

Mental health and criminal justice are both major social problem areas that are addressed by the field of social work; therefore, learning how they co-exist is very important. Previously implemented policies about public safety were developed from a criminal justice perspective, as indicated by not recognizing mental illness as a core criminogenic risk factor. Ignoring this important part of individual and community functioning of ex-offenders, will likely result in unprepared or inappropriate services to meet the mental health needs of this population, which may be a risk factor in recidivism. Additionally, treatment providers may be culturally unprepared to meet the criminogenic attitudes and behaviors of this specific population. Investigating how these

new policy provisions impact the perceived mental health of ex-offenders is significant to the field of social work in order to advocate for effective and appropriate policies and services. The analysis will provide insight into whether mental illness should be included in the core risk factors to recidivism, or not. If considered as important as the other eight core risk factors, the field of social work will have information to advocate for policy changes that will emphasize mental health treatment as much as antisocial measures, therefore, adequately meeting the reintegration needs of ex-offenders.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Many studies have been done to evaluate the effectiveness of reentry programs and services. There appears to be a consensus on a few points: 1) there needs to be a national definition of recidivism and what constitutes the act, 2) social service programs are needed for those reintegrating from incarceration, and 3) there needs to be continued evaluation of current programs to find the most effective services. Mental health services fall under social service programs that are critical to successful community reintegration.

Many studies investigating mental illness in prison populations have also had considerable findings on the prevalence of mental illness and the effectiveness of services. Both the criminal justice and mental health systems play an important role in addressing the challenges of successful reintegration and improving the overall functioning of individuals and communities around the world. This chapter discusses previous studies and their findings about recidivism, differing viewpoints on how to manage criminal offenders, the prevalence of mental health challenges of offenders, and various approaches to meeting the needs of offenders during incarceration, and the needs of ex-offenders after incarceration.

Challenges of Recidivism and Reintegration

In determining effective services, there must first be a national definition or understanding of what constitutes recidivism. Without a common definition, various agencies will take different approaches on how to implement policy. Currently, there is no national definition; as indicated by Austin (2001), “the concept means many things to many people and has various levels of importance to various agencies” (p. 314). The argument usually addresses whether an agency considers recidivism a new crime, a technical violation, or a new conviction. As one could imagine, with such varying opinions about the definition, there is difficulty in measuring success.

Another topic of disagreement is the importance of rehabilitation work. In contrast to deterrence and punishment viewpoints, rehabilitation work is supportive in nature. Rehabilitation is a means of an offender or ex-offender turning their lives around. An example is restorative justice, which is considered a gesture of remorse to victims and communities, a desire to make amends for their wrongs, and an attempt to restore their community to homeostasis. In doing so, criminal thinking and behaviors are reduced (Robinson & Shapland, 2008).

In order to understand how the criminal justice system has arrived to where it is today, looking back at history is important. Over the previous several decades, the focus on managing offenders has been harsher sentencing. A problem with harsher sentencing is that incarceration actually

hurts the offender. According to Gehring (2000), “most readers are aware of the potential for prolonged confinement to debilitate, rather than rehabilitate” (p. 198). He goes on to report that “imprisonment fosters criminality and alienation” (p. 198) and that “confinement interrupts growth” (p. 199). These findings support the idea that stricter sentencing policies and longer incarceration enhances recidivism rates, rather than to reduce them.

Another downfall of harsher sentencing is that there are few programs offered to enhance successful reintegration. Austin (2001) reports that in addition to few programs being available during incarceration, very few offenders actually utilize them. This is a problem for the community because nearly 600,000 offenders are released from incarceration annually (Austin, 2001). This means that they will be released into the community with untreated mental health problems, untreated substance abuse issues, and little to no education or vocational training. With few coping skills and institutionalized attitudes, their ability to secure safe housing and obtain employment is limited. Without support in these areas, ex-offenders will surely fail in their attempt to reintegrate into the community.

Changing Perspective on Managing Offenders

In contrast to harsher sentencing, supportive services aimed at assisting with successful reintegration have also been studied. Seiter and Kadela (2003) conducted a study on reentry services with promising results. For example, vocational training and/or work release programs were shown to

reduce recidivism rates and improve job readiness skills. Offenders, who graduated from drug rehabilitation showed reduced rates of substance use. They were also less likely than other parolees and non-completers to be re-arrested and commit a drug-related offense. Half-way house programs were also successful. They showed a reduction in frequency and severity of future crimes. Pre-release programs were shown to reduce recidivism rates. Although, educational programs increased achievement scores, they did not reduce recidivism rates.

In California, the Realignment Plan, also known as Assembly Bill 109 (AB109), was signed into law on April 4, 2011 by Governor Edmund G. Brown (A. B. 109, 2011). AB109 has revamped how the criminal justice system manages offenders. In response to the federal mandate to reduce prison populations and improve prison safety, AB109 sets provisions preventing offenders who commit low level offenses from returning to state prison (California Department of Corrections and Rehabilitation, 2012). Low level offenses have been defined as non-violent, non-serious, and non-sex crimes. This plan shifts the responsibility from the state to counties for their custody, treatment, and supervision. Consequently, counties have experienced and will continue to experience an influx of low level offenders in the community (California Realignment, 2013). This influx will pose budget, staffing, and program implications, including safety to the offender as well as the community. For example, offenders who are no longer eligible to return to

prison will be sent to jail. Jails will become quickly overcrowded (J. Powell, personal communication, December 2013). As the jails are not able to accommodate the amount of offenders, they will remain under supervision in the community (J. Powell, personal communication, December 2013). Community problems will arise from the common barriers associated with unsuccessful reintegration. Some of these include poor housing options, lack of employment opportunities, and stigma towards ex-offenders (Clark, 2007; Graffam, Shinkfield, & Hardcastle, 2008; Winnick & Bodkin, 2008). These situations lead to re-offending and making communities unsafe.

Mental Health Implications

Mental health problems among offenders are a serious in both prison and jail. According to the 2005 Bureau of Justice Statistics Special Report, over half of all inmates had a mental health problem. This includes jail and both state and federal prisons. Offenders in jail represented the highest rate at 64%, offenders in state prisons represented 56%, and offenders in federal prison represented 45%. Among the mental health problems reported, mania was reported most frequently, followed by major depression, and then psychotic disorders. Over 74% of offenders also reported a substance use disorder. Recent drug use, homelessness, multiple incarcerations, physical or sexual abuse, and injury also correlated with offenders who have mental health problems (James & Glaze, 2006). When accounting for gender differences, female offenders reported higher rates of mental health problems

compared to male offenders (Binswanger, Merrill, Krueger, White, Booth, & Elmore, 2010).

The prevalence of mental illness is one problem. How mental illness is addressed in the criminal justice system is another. Historically, offenders with mental health problems were forgotten. As indicated by Felthous (2009) in his "Introduction to this Issue: Correctional Mental Health Care:"

> In the 1970s, 1960s, and before, those who found themselves behind bars became members of a forgotten population. Except for the rare offender who achieved celebrity-status notoriety, such as "the bird man of Alcatraz" or Charles Manson, most defendants and offenders faded into oblivion with the last bang of the judge's gavel. (p. 655)

He goes on to say that society dismissed them and they were not a major concern to society. Since most offenders are not famous, most of them will not get the appropriate, if any, mental health consideration.

One reason to explain why mental illness is overlooked or inadequately dealt with is that criminal justice professionals and mental health professionals are separate fields with different training. In the collaborative approach to public safety, the Council of State Governments Justice Center highlights similarities and differences. Both entities serve the public, provide client service, practice confidentiality and privacy, and are concerned with evidence based practices (The Council of State Governments Justice Center, 2013). This is not problematic, however, the distinct and conflicting differences may

be. In general, criminal justice perspectives are aimed at maintaining order, management and control of offenders, whereas, mental health professionals are generally focused on least restrictive settings and self-determination. Criminal justice systems are about fairness and equity and have standardized processes with lawyers and judges. Mental health professionals are about individualized and person-centered approaches (The Council of State Governments Justice Center, 2013). These differing perspectives have been problematic because in jail and prison settings, the criminal justice staff is primary, whereas, mental health professionals are secondary. Mental health professionals are considered “guests” in the jail and prison settings (D. Johnson, personal communication, April 18, 2014). All jail and prison functions take priority over mental health functions; often times leaving the offender without any mental health services (B. Webster, personal communication, December 2013).

Although criminal justice staff is primary and mental health professionals are secondary in the correctional setting, collaboration between the two is now taking place more than ever. A shift in mental health care in jail and prison is taking place. For example, in response to the growing incidence of mental health problems in jail and prison, California created the Council on Mentally Ill Offenders in 2001 (California Department of Corrections and Rehabilitation, 2001). Unfortunately, their focus was to investigate and promote cost-effective approaches versus quality of mental health care. On

the other hand, national efforts are currently being conducted by the Council of State Governments Justice Center, with a stronger focus on public safety and strengthening communities. The center serves all states with the goal of promoting effective data-driven practices. Special focus is given to areas where the criminal justice system intersects with other disciplines. In addition to cost-effective approaches, the several projects underway by the center include improving responses to people with mental illness, improving conditions in the neighborhoods where people released from prison return, and evidenced-based practices on the safe and successful return of prisoners to the community (Council of State Governments Justice Center, 2013).

Gaps in Literature, Methodological Limitations, and Conflicting Findings

While many studies have been conducted to investigate recidivism, areas still in need of research include programs such as alternative sentencing that save tax dollars and shift some of the monetary responsibility on to the offender. One of the serious concerns and issues for communities has been the fiscal responsibility it imposes on local and state authorities. Instead of being housed in jail or prison, alternative sentencing programs allow offenders to be monitored in the community with GPS monitoring systems which they must pay for. As indicated by Severson et al. (2011), evaluating programs is an evolutionary process and the timing is ripe to improve our understanding of what interventions work to stop the cycle of crime and keep communities safe.

As California continues the implantation of AB109, the fiscal responsibility placed on local communities has to be taken into consideration. California will be faced with figuring out how counties can minimize overwhelming budget costs. Fiscal requirements on local jurisdictions have overwhelming responsibilities attached to AB109. Riverside County will now be required to hold an additional 5,740 offenders each year (Executive Committee of the Community Corrections Partnership, 2012). San Bernardino County Probation Department expects approximately 6,700 Post Release Community Supervision Offenders (PRCS) (San Bernardino County Reentry Collaborative, 2012). With staggering numbers of offenders remaining under county supervision and in the community, it will be important to collect data about the fiscal impact.

Restorative justice is another area that requires further research. Restorative justice emphasizes repairing harm rather than punishment. Punishment only focuses on the offender, where restorative justice focuses on all who are involved. This includes the offender, the victim, and the community. This is accomplished through various activities such as victim/offender mediation, video conferencing, victim assistance, ex-offender assistance, restitution, and community service (Prison Fellowship International Centre for Justice and Reconciliation, 2013). This approach allows victims and offenders to heal by encountering each other. It allows offenders to make

direct amends to those who were affected by their behavior. By including all stakeholders, it results in successful community re-integration.

Theories Guiding Conceptualization

In order to provide a clear understanding of obstacles that individuals face, communities must look at the services available to support their success. Robinson and Shapland (2008) stated, “There is certainly scope for improving offenders’ access to ‘traditional’ rehabilitative resources, whether in custodial or non-custodial contexts. There is also scope to improve opportunities for reparative activities in the interests of ‘strengths-based rehabilitation’” (p. 353). So as society considers successful programming, there must be consideration of accessible services.

Many criminal justice agencies within the reentry system rely on conflict perspectives to guide their research. Conflict perspectives claim that the laws and social norms are designed by the rich and powerful for their own benefit (Brown, Esbensen, & Geis, 2007). This theory explains previous focus on deterrence which removes an offender from society with little thought about their release efforts. Discussion previously covered in this study provided information that policies and programs have originally been created by administrators, with no consideration or discussion with those for whom the policies are created. Including recipients of the services designed by policy makers may be more efficient and cost-effective.

Another theory with important considerations is social bond theory. Social bond theory considers how an individual connects to their community. As explained by Hirschi in (Brown, Esbensen, & Geis, 2007), social bond theory explains crime as “weakened or broken social bonds that reduce a person’s stakes in conformity” (p. 348). This theory suggests that the weaker the bonds are to the society in which they operate, the higher the risk of deviance. Hirschi describes four elements involved in positive social bonds: attachment (to parent(s)), commitment (to social norms), involvement (in positive activities), and belief (in conventional order). When an individual is lacking in these areas, there appears to be a higher risk of weakened social bonds. When there is no investment in their community, they have less regard for that community.

Conflict perspective is one-sided as it is developed by the rich and powerful for their own benefit. Social bond theory is also one-sided as it emphasis how the individual connects to their community, without thought of the community fostering the connection. On the other hand, systems perspective looks at both sides. Systems theory focuses on the interactions between small and larger systems, such as a person and their environment (Suppes & Wells 2009). Hutchinson (2008) explains, “Systems perspective sees human behavior as the outcome of reciprocal interactions of persons operating within linked social systems” (p. 43). This perspective suggests the way an individual interacts with their families, friends, neighbors, and

community can have an effect on their ability to operate in society. If there is a lack of resources and supportive services available to individuals, it can create difficulty in social functioning.

This study will use an ecosystems approach, which grew from basic systems theory and ecological theory. In addition to systems interacting with each other, ecosystems theory takes into consideration the simultaneous and reciprocal interactions between the individual and their environment and how they adapt to each other (Suppes & Wells 2009). To understand obstacles and services which create difficulties and perpetuate recidivism for the returning offender, it is critical to use a comprehensive theory, one that considers the environment that influences and interacts with them, what types of stressors are involved, and the manner in which the environment reciprocally interacts with them.

Summary

Previous research has shown that over the decades a strong emphasis on harsh deterrence sentences has been non-effective in managing offenders. Focusing budgets and staff on incarcerating offenders is non-effective in reducing recidivism, costly, and ignores the overall health of individuals and the community. Research has led to a changing perspective that supportive services are needed in order to help ex-offenders successfully reintegrate into the community. With this paradigm shift comes many implications regarding public and individual safety. Therefore, this study will use an ecosystem

approach to investigate the interactions, stressors, and adaptations between offenders and incarceration and between ex-offenders and reintegration, by exploring their perceptions about their mental health status as they experience incarceration and reintegration into the community.

CHAPTER THREE

METHODS

Introduction

This chapter discusses the study design, including the purpose of the study and the research methods used. Specific information regarding the selection criteria and justification of the sample are explained. Data collection methods, instruments, and procedures that were used to collect the data are described. Ethical considerations for the protection and privacy of human subjects and data analysis are discussed.

Study Design

The purpose of this study was to investigate the impact that incarceration and reintegration have on the mental health of a person. Multiple research methods were used in this study, including focus groups, surveys, and secondary data analysis.

The first research method used was the focus group method. Two small focus groups were conducted in order to gather firsthand data from ex-offenders. Focus groups were used to avoid common patterns of making assumptions without direct input from ex-offenders. Two separate focus groups were used to check response reliability.

The second research method used was the survey method. The survey was developed specifically for this study by using data collected during the

focus groups. Data from the focus groups was determined to be representative of the experience and viewpoint of individuals who had experienced incarceration and reintegration; therefore, establishing content validity of the survey. The survey was then distributed to a larger sample of the targeted population.

The final research method was the collection of secondary data from Inland Empire United Way 211 San Bernardino and the California State University Reentry Initiative (CSRI). The purpose of collecting and analyzing this secondary data was to identify and evaluate the impact of current policies and services.

Using these methods, we tested the hypothesis that incarceration and poorly supported reintegration has a negative impact on the perceived mental health status of an individual. Additionally, we assessed for a current paradigm shift in supporting reintegration.

Sampling

Participants for this study were obtained by utilizing the snowball sampling approach. This approach was used because it is effective in reaching hard to reach interconnected populations (Schutt, 2008). All research participants for this study were adults 18 years or older. All research participants had previous experience of incarceration and reintegration. Individuals currently on parole or probation would have required Department of Justice approval. The approval process is lengthy and difficult to obtain (G.

West, personal communication, February 21, 2013). Therefore, given our time constraints and limited resources, this study only focused on participants that were no longer on probation or parole.

Two separate geographical areas were selected for this study. One was the Coachella Valley which consists of many small rural cities located in Eastern Riverside County, California. Rural is defined by the United States Census Bureau (2010) as encompassing “all population, housing, and territory not included within an urban area” (Para. 2). The other geographical area was the Inland Empire which consists of many urban cities located in Western Riverside County and San Bernardino County, California. Urban is defined as, “The territory identified according to criteria must encompass at least 2500 people, at least 1500 at which reside outside institutional group quarters” (United States Census Bureau, 2010, Para. 2). Researchers selected two distinct geographical areas in order to capture potential differences that may exist when reintegrating into a rural area compared to an urban area.

The first focus group covering the Coachella Valley area took place in Indio, California. A total of five adults participated (one female and four males). The second focus group covering the Inland Empire area took place in Riverside, California. A total of five adults participated (one female and four male adults).

A total of 88 surveys were completed. Forty two surveys were collected from the Coachella Valley area (eight female participants and 33 male

participants). Forty six surveys were collected from the Inland Empire area (16 female participants and 30 male participants). Although, a sample of 88 surveys is not large enough to generalize the total population of individuals who experience incarceration, it seemed to be large enough to give some generalizable results about reintegration to the Coachella Valley and Inland Empire areas.

Secondary data was obtained from the Inland Empire United Way 211 San Bernardino which is an easy-to-access toll free phone number, online database and directory for providing information and referrals for vital health and social services in the local community of San Bernardino, California. The 211 Reentry phone line was designed in August 2013 to meet the increasing demand for reentry resources information and assist in successful reintegration. The 211 Reentry phone line is staffed by a reentry specialist who provides information and referral services to anyone that calls (family member or participant). Secondary data was also obtained from the California State University Reentry Initiative, a Day Reporting Center contracted and funded by the California Department of Corrections and Rehabilitation since February 2011 to help parolees reintegrate into their communities by providing supportive services.

Data Collection and Instruments

Focus Group

During the focus groups, general demographic information about research participants was collected. Open ended questions were used to obtain qualitative data. The questions were developed by researchers, specifically for this study (see Appendix A for Focus Group Questionnaire). Prior to implementation, the questions were reviewed by colleagues of the researchers, including Licensed Clinical Social Workers and Addiction Professionals, who have experience facilitating focus groups. The feedback ensured that researchers were using questions that were not suggestive, but encouraged discussion and expression of opinions and viewpoints of the participants. Responses were then analyzed and used by researchers to develop the survey.

Survey

In the survey, general demographic information about research participants was collected. Data regarding incarceration, reintegration, perceived impact on mental health status, types of services offered, quality of services, and barriers to accessing services was collected (see Appendix B for Survey Questionnaire).

Perceived Mental Health

The dependent variable was the impact on perceived mental health status. Researchers defined mental health according to the World Health Organization (2013):

> Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community. (para. 2)

Therefore, any subjective change in mental health status is considered relevant to this study.

Incarceration and Reintegration

The subjective experience of incarceration and reintegration were the two main independent variables of this study. Other independent variables analyzed were age, gender, race/ethnicity, education level, employment status, transportation status, number of times incarcerated, total number of months incarcerated, and geographic location.

Participants were asked to rate their perception of their mental health, prior to, during, and after incarceration. All questions are subjective and were measured on a scale from one to five. Questions regarding perceived mental health status ranged from “very poor” to “very positive”. Participants were asked to rate their perception of incarceration impacting their mental health

status; options ranged from “incarceration made my mental health significantly worse” to “incarceration made my mental health significantly better”. Participants were asked to rate their perception of reintegration impacting their mental health status; options ranged from “reintegration made my mental health significantly worse” to “reintegration made my mental health significantly better”.

Rehabilitative Services

Participants were asked to rate the supportive and rehabilitative services they received; options ranged from “very poor” to “very positive”. Participants were asked to rate their satisfaction with the time it took to receive services; options ranged from “very dissatisfied” to “very satisfied”. Participants were asked to describe the wait time it took to receive supportive and rehabilitative services; options ranged from “very long wait time” to “very short wait time”.

To measure mental health status, participants were asked to describe what type of emotions they experienced during incarceration and reintegration by selecting from a list of both positive and negative emotions. Participants were asked to select supportive and rehabilitation services they were offered during incarceration. Both questions allowed participants to select all options that applied.

Qualitative data was also obtained from the surveys. Open-ended questions were used to ask participants for additional information about the

impact of incarceration and reintegration on mental well-being that may be deemed pertinent by the participant but may have been overlooked by researchers (see Appendix A for Focus Group Questionnaire).

Secondary data was obtained from the Inland Empire United Way 211 San Bernardino. The purpose of the data collection was to examine the requests for services by current ex-offenders attempting reintegration. The data was collected during phone calls from the period of March 2013 through December 2013. This data included general demographic information, purpose of call, and referrals made.

Secondary data was also obtained from the California State University Reentry Initiative to examine the services being provided by the program which are improving the quality of life and has impacted a reduction in recidivism to the participants. The data collected included monthly reports from March 2013 through September 2013. This data included general demographic information, comparative indicators, program updates, performance indicators, collaborative efforts, course offerings, and other statistics.

Procedures

A snowball sampling approach was used to recruit participants for the focus groups. We first sought out potential participants through personal knowledge of people who had previously been incarcerated. Informed consent was provided to explain the study to the potential participant. Once the

participant agreed, information about the focus group date, time, and location was provided. The initial participant was then asked for a name and phone number of a potential participant who might be interested in participating in the study. This process continued until enough participants were obtained for the focus groups.

Between both focus groups, researchers alternated between facilitator and co-facilitator. Informed consent was once again provided in a group format. Each participant was asked if they understood the purpose of the study and was given the opportunity to ask questions about the informed consent. Participants were reminded of the opportunity to deny or agree to participation. Demographic information was collected from each participant. Qualitative data was collected using open-ended questions (see Appendix A for Focus Group Questionnaire). Data was recorded and analyzed by both researchers. Debriefing statements were provided to participants. Researchers were available to participants to answer any questions they had about the focus group.

The snowball sampling approach was also used to recruit participants for the survey. We pursued and engaged an initial participant in their designated area and requested names and phone numbers for other possible participants. Informed consent was provided to explain the study to the potential participant. Once agreed to participate, the survey was administered. Participants were given as much time as they needed to complete the survey.

Researchers were available to answer questions that participants had about the survey. Upon completion of the survey, the debriefing statement was given to the participant. Once again, researchers were available for any questions about the debriefing statement. The initial participant was then asked for a name and phone number of a potential participant who might be interested in completing the survey. This process continued until we were able to obtain further participants.

Regarding the collection of secondary data, we communicated through collaborative meetings, phone calls, and e-mail communications with both the Inland Empire United Way 211 San Bernardino and the California State University Reentry Initiative. A data extraction form was provided (see Appendix C for Data Extraction Form) to both sites. Information collected during phone calls from the period of March 2013 through December 2013 was obtained from Inland Empire United Way 211 and monthly reports were obtained from California State Reentry Initiative.

Protection of Human Subjects

An informed consent was provided to all participants (see Appendix D for Informed Consent). Research participants were informed of confidentiality limitations such as other participants hearing their openly discussed responses. We encouraged participants to maintain confidentiality about information learned during the focus groups, but could not ensure that other participants will keep confidence. Collected data were locked in a container

and stored by researchers. A debriefing statement was given to each participant at the end of each research contact, summarizing the purpose of the study, and reminding the participant about privacy and confidentiality of their personal information (see Appendix E for Debriefing Statement).

Data Analysis

Focus groups were utilized to collect qualitative data necessary to create the questions for surveys. The questions asked of the participants were conducted in an open discussion to determine specific areas of concern to be covered in the data collection. The data was analyzed by researchers to find themes and areas of interest for further investigation.

Univariate analysis was conducted using quantitative data to describe the population studied. Frequency distribution reports were generated to report gender, race/ethnicity, transportation status, number of months incarcerated, and geographical area. Frequency distribution reports were generated to report age, education level, employment status, living situation, and number of incarcerations.

Univariate analysis was also conducted using quantitative data to describe personal perceptions about incarceration and reintegration being related to mental health problems. Frequency distribution reports were used to show responses regarding the personal perception that incarceration and reintegration negatively impacts mental health status. Frequency distribution

reports were also used to show responses regarding the types of emotions participants experienced during incarceration and reintegration.

In order to understand the relationships between the studies primary variables, correlations were analyzed in order to determine statistical significance between the variables of perceived mental health status prior to incarceration, during incarceration, and during reintegration into the community; and the variables perceived impact of incarceration and perceived impact of reintegration into the community on mental health status. A Pearson Chi-Square test was conducted to determine statistical significance between reported feelings during the condition of incarceration and the condition of reintegration. Additionally, an independent t-test was conducted to determine statistical significance between services offered during the condition of incarceration and perceived mental health status.

Summary

This study hypothesized that the experience of incarceration and reintegration has a negative perceived impact on the mental health status of the individual. This chapter described how the study was designed. A description of the sample characteristics and procedures was provided. Data collection procedures and the process of developing the survey were described. Procedures for protecting human subjects were explained. How researchers analyzed data analysis was explained.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the results of this study. Participant demographics, focus group results, and specific questions and responses from the surveys are also presented. Additionally, findings from aggregate data are compared.

Demographic Characteristics of Focus Group Participants

Demographic characteristics of focus group participants are displayed in Table 1. Two separate focus groups were conducted, one in the Coachella Valley and one in the Inland Empire. Most participants were male (80%) and between the ages of 45-54 (60%). The largest ethnic group was Caucasian (60%). Most participants had some college (60%) and were employed (60%). No participants were homeless and most of them had transportation (80%).

Table 1. Demographic Characteristics of Focus Group Participants

Variable (N = 10)	*Frequency (n)*	*Percentage (%)*
Gender		
Male	8	80
Female	2	20
Region		
Inland Empire	5	50
Coachella Valley	5	50
Age		
18-24	0	0
25-34	0	0
35-44	2	20
45-54	6	60
55-64	1	10
65 and older	1	10
Ethnicity		
African American	1	10
Caucasian	6	60
Hispanic	2	20
Biracial	1	10
Other	0	0
Highest Level of Education		
No High School Diploma	0	0
High School Diploma	1	10
Some College	6	60
Associate's Degree	0	0
Bachelor's Degree	2	20
Master's Degree	1	10
Employment Status		
Unemployed/Not Seeking Employment	2	20
Unemployed/Seeking Employment	1	10
Part-time Employment	0	0
Full-time Employment	6	60
Student	1	10
Disabled	0	0

Variable (N = 10)	*Frequency (n)*	*Percentage (%)*
Living Situation		
Living independently in a house	2	20
Living independently in an apartment	4	40
Living with family	3	30
Living with friends	1	10
Homeless/Living in a shelter	0	0
Homeless/Living transient	0	0
Transportation		
Transportation	8	80
No Transportation	2	20

Presentation of the Focus Group Findings

Most participants spent several years in custody with multiple incarcerations. Major themes captured in the focus groups included both negative and positive experiences. Some of the common negative feelings included fear, loneliness, paranoia, and powerlessness. Guilt and shame from being separated from their families was common. Positive feelings included relief, comfort, and familiarity, although, most of them reported hiding their true feelings from other inmates as a way to survive. Some of the challenges experienced included forced racial segregation and an inability to conform to prison life. Sleep deprivation and violence was also reported. Many of them spent time in solitary confinement.

In regards to supportive and/or rehabilitative services, all participants reported receiving a risk evaluation to determine appropriate placement upon intake. Mental health counseling, church, and 12-step programs were the most

common services offered, while some reported no services offered at all. It was common to not seek mental health services in fear that it would negatively impact their release, and when mental health services were sought, long wait times were common. Other types of services reported were fire camp opportunities, educational, and substance use disorder treatment. Most participants reported not being offered services until their fourth or fifth custody term.

When trying to reintegrate into the community, many reported feelings of fear, being unprepared, confusion, and feeling lost. On the other hand, some reported they could not wait to go back to their old neighborhoods, resume their criminal behaviors and drug use. Some of the challenges participants faced during reintegration were not being able to find employment, lack of housing, overcoming insecurities, adapting to new rules, learning to live without structure, and social and family acceptance. For some, they had no one to turn to but the people they were with when they committed their crimes, which led to increased anxiety, skepticism, depression, hopelessness, nervousness, and a surreal reality. When released, some participants were offered PAC meetings, $200 gate money, and had some form of family support upon release. Those who had support, found hope, self-esteem, and were eager to live and learn to stay in “the here and now”.

Participants were provided an opportunity to report anything further that was missed during the focus groups. The most common opinion was that

incarceration without addiction treatment does not help a person struggling with addictions. Untreated addiction will likely lead to an individual returning to the same addictive behavior and recidivate. Another common opinion was that more access to 12-step programs would be beneficial. More exit programs such as housing options, counseling, addiction treatment, and job preparation, are needed to help a person prepare to live productively in the community. Additionally, a thorough evaluation during custody and more mental health services need to be offered. However, some participants expressed that incarceration saved their life and that some people are not going to change until they are ready to.

Demographic Characteristics of Survey Participants

Demographic characteristics of survey participants are displayed in Table 2. The survey sample consisted of 88 participants. Just over half were from the Inland Empire area (52.3%) and just under half were from the Coachella Valley are (47.7%). The majority of participants were male (72.7%). The largest ethnic group was Caucasian (38.6%) followed by Hispanic (35.2%). Most of the participants were between the ages of 35-54 (69.3%). Nearly three quarters had at least a high school education (73.9%) and almost 20% had a college degree; (6.8%) had an Associate's degree, (6.8%) had a Bachelor's degree, and (5.7%) had a Master's degree. More than half of the participants were full-time employed (52.3%). Almost 64% were living independently; with (39.8%) in a house and (23.9%) in an apartment. Almost

80% had access to transportation. Most of the participants had been incarcerated five or more times (76.1%).

Table 2. Demographic Characteristics of Survey Participants

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Gender		
Male	64	72.7
Female	24	27.3
Region		
Inland Empire	46	52.3
Coachella Valley	42	47.7
Age		
18-24	2	2.3
25-34	12	13.6
35-44	30	34.1
45-54	31	35.2
55-64	12	13.6
65 and older	1	1.1
Ethnicity		
African American	9	10.2
Caucasian	34	38.6
Hispanic	31	35.2
Biracial	5	5.7
Other	9	10.2
Highest Level of Education		
No High School Diploma	23	26.1
High School Diploma	29	33.0
Some College	19	21.6
Associate's Degree	6	6.8
Bachelor's Degree	6	6.8
Master's Degree	5	5.7

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Employment Status		
Unemployed/Not Seeking Employment	4	4.5
Unemployed/Seeking Employment	14	15.9
Part-time Employment	9	10.2
Full-time Employment	46	52.3
Student	4	4.5
Disabled	11	12.5
Living Situation		
Living independently in a house	35	39.8
Living independently in an apartment	21	23.9
Living with family	21	23.9
Living with friends	4	4.5
Homeless/Living in a shelter	3	3.4
Homeless/Living transient	4	4.5
Transportation		
Transportation		
No Transportation	70	79.5
	18	20.5
Number of Times Incarcerated		
1	4	4.5
2	6	6.8
3	6	6.8
4	5	5.7
5 or more	67	76.1
Total Months Incarcerated (n = 87)		
Range	1-312	
Mean	97.83	
Median	81	
Mode	120	

Presentation of Survey Frequencies

Participants were asked to report their perceived mental health status prior to incarceration, during incarceration, and during reintegration (See Table 3). Perceived mental health status was expected to be worse during

incarceration and during reintegrating into the community. For the condition prior to incarceration, slightly more participants perceived their mental health status to be poor (43.2%), compared to positive (38.6%), and neutral (18.2%). For the condition during incarceration, more participants perceived their mental health status to be neutral (42%), compared to poor (39.8%), and positive (17.1%). For the condition during reintegration more participants perceived their mental health status to be poor (43.2%), compared to positive (37.5%), and neutral (19.3%).

When only accounting for poor ratings across the three conditions, perceived mental health status was more frequently considered poor prior to incarceration (43.2%) compared to during incarceration (39.8%); and then more considered it poor again when leaving incarceration and reintegrating into the community (43.2%).

When only accounting for positive ratings across the three conditions, perceived mental health status was more than twice as positive prior to incarceration (38.6%) compared to during incarceration (17.1%); and then improved twice as much when leaving incarceration and reintegrating into the community (37.5%).

Table 3. Perceptions of Mental Health Status

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Prior to Incarceration		
Very Poor	21	23.9
Somewhat Poor	17	19.3
Neutral	16	18.2
Somewhat Positive	22	25
Very Positive	12	13.6
During Incarceration		
Very Poor	17	19.3
Somewhat Poor	18	20.5
Neutral	37	42
Somewhat Positive	10	11.4
Very Positive	5	5.7
During Reintegration		
Very Poor	17	19.3
Somewhat Poor	21	23.9
Neutral	17	19.3
Somewhat Positive	19	21.6
Very Positive	14	15.9

Participants were then asked about their perception of how incarceration and reintegration into the community impacted their mental health status (See Table 4). Incarceration and reintegration into the community were expected to have a perceived negative impact on their mental health status. Almost half of the participants perceived that incarceration made their mental health status worse (47.8%), while the same amount (47.8%) perceived reintegration into the community made their mental health status better.

Table 4. Perceptions of Mental Health Impact

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Incarceration made my mental health		
Significantly Worse	18	20.5
Somewhat Worse	24	27.3
Had No Impact	20	22.7
Somewhat Better	19	21.6
Significantly Better	6	6.8
Reintegration made my mental health		
Significantly Worse	18	20.5
Somewhat Worse	15	17
Had No Impact	13	14.8
Somewhat Better	24	27.3
Significantly Better	18	20.5

Participants were asked about the feelings they experienced during incarceration and reintegration (See Table 5). Negative feelings were expected over positive feelings during both conditions of incarceration and reintegration. Overall, negative feelings were experienced more (N = 809) than positive feelings (N = 436). Negative feelings were experienced more (N = 432) during incarceration compared to during reintegration (N = 377). During incarceration, more than half of the participants felt *demoralized* (55.7%), *anxious* (55.7%), *distrustful* (53.4%), and *depressed* (52.3%). Just under half of the participants felt *sad* (48.9%) and *nervous* (48.9%). During reintegration, more than half of the participants felt *anxious* (53.4%) and *fearful* (51.1%). Positive feelings were experienced more (N = 263) during reintegration compared to during incarceration (N = 173). The highest reported

positive feeling during reintegration was *good* (42%) and the highest reported positive feeling during incarceration was *connected* (29.5%).

Table 5. Feelings during Incarceration and Reintegration

Variable (N = 88)	*During Incarceration n(%)*	*During Reintegration n(%)*
Negative Feelings		
Sad	43(48.9)	19(21.6)
Depressed	46(52.3)	27(30.7)
Anxious	49(55.7)	47(53.4)
Shock	21(24.1)	23(26.1)
Distrustful	47(53.4)	39(44.3)
Abandoned	25(28.4)	24(27.3)
Hopeless	39(44.3)	34(38.6)
Demoralized	49(55.7)	25(28.4)
Fearful	30(34.1)	45(51.1)
Nervousness	43(48.9)	40(45.5)
Isolated	40(45.5)	28(31.8)
Terror	0(0)	26(29.5)
Total	432	377
Positive Feelings		
Confidence	21(23.9)	27(30.7)
Powerful	16(18.2)	18(20.5)
Welcomed	23(26.1)	23(26.1)
Happy	12(13.6)	35(39.8)
Cheerful	13(14.8)	25(28.4)
Comfort	17(19.3)	23(26.1)
Secure	15(17)	21(23.9)
Trust	7(8)	13(14.8)
Connected	26(29.5)	19(21.6)
Great	4(4.5)	22(25)
Good	19(21.6)	37(42)
Total	173	263

Participants were asked to report which supportive and/or rehabilitative services they were offered during incarceration (See Table 6). Limited offering of supportive and/or rehabilitative services was expected. Of the supportive and/or rehabilitative services offered, the most offered was church (71.6%). Mental health assessment (42%) and physical health assessments (42%) were the next most offered supportive and/or rehabilitative services, followed by substance abuse treatment (36.4%).

Table 6. Services Offered during Incarceration

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Mental Health Assessment	37	42
Counseling	22	25
Work Training	26	29.5
Group Therapy	17	19.3
Anger Management	25	28.4
Fire Camp	16	18.2
Medication	30	34.1
Individual therapy	5	5.7
Substance Abuse Counseling	32	36.4
Life Skills	21	23.9
Physical Health Screening	37	42
Physical Health Medication	23	26.1
General Ed Degree (GED)	36	40.9
Degree Education	4	4.5
12 Step Program	34	38.6
Church	63	71.6
Arts	9	10.2
Psychiatric Health	21	23.9
Other	10	11.4
No Services	6	6.8

Participants who did receive supportive and/or rehabilitative services were asked to rate the services they received, their satisfaction with the time it took to receive the services and to describe the length of wait time it took to receive those services (See Table 7). Of the participants who did receive supportive and/or rehabilitative services, most reported the services as positive (42.1%). More than half described the wait time as too long (56.8%), and just under half (48.9%) were dissatisfied with the services they received.

Table 7. Perceptions of Services

Variable (N = 88)	*Frequency (n)*	*Percentage (%)*
Ratings of Services		
Very Poor	21	23.9
Somewhat Poor	7	8
Neutral	21	23.9
Somewhat Positive	21	23.9
Very Positive	16	18.2
Time to Receive Services		
Very Dissatisfied	30	34.1
Somewhat Dissatisfied	13	14.8
Neutral	17	19.3
Somewhat Satisfied	18	20.5
Very Satisfied	7	8
Length of Wait Time		
Very Long Wait Time	28	31.8
Somewhat Long Wait Time	22	25
Neutral Wait Time	22	25
Somewhat Short Wait Time	8	9.1
Very Short Wait Time	5	5.7

Secondary Data Collected through United Way 211

This study includes secondary data that was collected by United Way 211 between March and December of 2013 (See Table 8). This data was obtained to understand the various social services and information being requested to assist with successful reintegration into the community. Callers included reentry persons, family members, friends, agencies, and caregivers. One thousand-one-hundred-ninety-one phone calls were received during this time period. The majority of these calls were made from San Bernardino County (95.7%). San Bernardino, Victorville, Ontario, Apple Valley, and Fontana were the top five cities where calls came from. Callers ranged from 13 years old to 65 years and older. Callers were from a wide range of ethnic backgrounds, but most were white (19.1%). Most callers reported no income (18.2%) and the main source of transportation was public transportation (28.6%). Out of the callers who disclosed supervision status, most were on county probation (10.5%).

The most common referrals requested by the callers were for shelter resources (emergency, cold weather, transitional, and motel vouchers). Other resources that referrals were made for include: emergency food, medical care (Arrow Care), family development, career/employment building, specialty treatment (substance abuse, domestic violence and sexual abuse), transportation assistance, and legal service.

Table 8. Demographic Characteristics of 211 Callers

Variable (N = 1191)	*Frequency (n)*	*Percentage (%)*
County (n = 1191)		
San Bernardino	1140	95.7
Riverside	17	1.4
Los Angeles	14	1.2
Other	20	1.7
City (n = 565)		
San Bernardino	244	20.5
Victorville	118	9.9
Ontario	86	7.2
Apple Valley	66	5.1
Fontana	51	4.3
Age (n = 490)		
13-17	3	.3
18-20	3	.3
21-28	73	6.1
29-34	93	7.8
35-40	66	5.5
41-49	115	9.7
50-60	102	8.6
61-64	18	1.5
65 and older	17	1.4
Caller (n = 856)		
Reentry Person	720	60.5
Family Member	85	7.1
Friend	26	2.2
Agency	24	2.0
Caregiver	1	.1
Ethnicity (n = 543)		
African American	188	15.8
Caucasian	228	19.1
Hispanic	165	13.8
Biracial	10	.9
Native American	3	.3
Asian	1	.1
Pacific Islander	4	.3
Other	14	1.2

Variable (N = 1191)	*Frequency (n)*	*Percentage (%)*
Gender (n = 637)		
Male	347	29.1
Female	290	24.3
Language (n = 1191)		
English	1180	99.1
Spanish	11	.9
Transportation (n = 648)		
Own Vehicle	192	16.1
Public Transportation	342	28.6
Bicycle	4	.3
No Transportation	110	9.3
Source of Income (n = 428)		
No Income	217	18.2
Temporary Assistance for Needy Families (TANF)	70	5.9
Social Security Insurance (SSI)	56	4.7
Employment	37	3.1
Social Security Disability Insurance (SSDI)	15	1.3
Unemployment Benefits (EDD)	15	1.3
Other	18	1.5
Supervision Status (n = 297)		
County Probation	125	10.5
State Parole	122	10.2
Prop 63 (unsupervised)	16	1.3
AB 109 (supervised)	9	.8
AB 109 (unsupervised)	9	.8
Discharged/Completed	6	.5
Federal Probation	5	.4
290 Registrant	4	.3
GPS Supervised	1	.1

Secondary Data Collected from California State Reentry Initiative

This study also includes secondary data collected from California State Reentry Initiative (CSRI), between the months of March and September of 2013. This data was obtained to understand the various social services and information that are being provided to improve the quality of life and impact recidivism of their participants. Participants of CSRI are referred to as students. Since the program opened in San Bernardino, 805 students have been served. Each student is under state parole supervision when beginning the program. Participation is voluntary and courses are free. Courses include the following: community reintegration, batterer's intervention, substance abuse education, anger management, pre-employment, career development, GED preparation, cognitive behavioral strategies, IRS Tax Clinic, critical thinking, proud parenting, basic computer skills, basic writing skills, health education, CSRI Alumni Club, and Toastmasters Club.

Since the opening of the program to September of 2013, parole has made 1920 referrals to CSRI. Two-hundred-forty of those students have obtained employment. Over the 6 months covered in this study, the rate of recidivism has steadily decreased from 16.3% to 14.7%, which is significantly lower than the statewide average of 65%. The daily cost to provide services at CSRI was $34.93 per person, compared to $129.05 that it cost to incarcerate an individual for one day. CSRI received in-kind donations of $1,066,821 to

date from community partners interested in making a difference in the lives of this population.

The average student age was 38 years old. The average age of first drug use was 12 years old. The average number of prior arrests was 12.8. The average number of children per student was 2.3. There were 25 Gangs represented at CSRI with no incidents of violence since opening the program.

Relationship between Incarceration, Reintegration and Mental Health Status

Our hypothesis was that the experience of incarceration and reintegration into the community with little to no supportive and/or rehabilitative services would have a negative impact on the mental health status of the individual. Perceived mental health status was expected to be reported as worse during incarceration than prior to incarceration. Perceived mental health status was also expected to be reported as worse during reintegration into the community than during incarceration. Pearson Correlation tests were conducted to measure any significant correlations between the following variables: perceived mental health status prior to incarceration, perceived mental health status during incarceration, and perceived mental health status during reintegration into the community (See Table 9). A weak to moderate positive correlation was found between perceived mental health status during incarceration and during reintegration, $r = .29$, $p = .007$.

Table 9. Correlations Perceived Mental Health Status

(N = 88)		*Prior to Incarceration*	*During Incarceration*	*During Reintegration*
Prior to Incarceration	r	1	.127	.008
During Incarceration	r	.127	1	.287**
During Reintegration	r	.008	.287**	1

** Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation tests were conducted to measure any significant correlations between the following variables: the impact of incarceration on mental health status and the impact of reintegration on mental health status. Incarceration and reintegration into the community were expected to negatively impact their mental health status, according to their perception. A moderate positive correlation was found, $r = .33$, $p = .002$.

Differences between Feelings during Incarceration and during Reintegration

A Chi-Square test was conducted to determine any differences between reported feelings during the following conditions: incarceration and reintegration. As shown in Table 10, all (100%) of the negative feelings were found to be significantly different. Depressed, anxious, shock, demoralized, and fearful were all found to have a modest relationship. Sad, abandoned, hopeless, nervousness, and isolated were found to have a moderate relationship. And, distrustful was found to have a strong relationship.

Regarding positive feelings, as seen in Table 10, approximately two-thirds were found to be significantly different. Powerful, trust, connected, and great were found to have a modest relationship. Confident, secure, and good were found to have a moderate relationship. None of the positive feelings were found to have a strong relationship.

Table 10. Chi-Square Test – Feelings during Incarceration and Reintegration

Variable	*X2(df)*
Negative Feelings	
Sad	12.12(1)**
Depressed	5.11(1)**
Anxious	6.29(1)**
Shock	6.59(1)**
Distrustful	23.09(1)**
Abandoned	14.53(1)**
Hopeless	9.33(1)**
Demoralized	3.77(1)**
Fearful	6.48(1)**
Nervousness	10.19(1)**
Isolated	11.17(1)**
Positive Feelings	
Confidence	16.79(1)**
Powerful	6.52(1)**
Welcomed	1.21(1)
Happy	.61(1)
Cheerful	2.36(1)
Comfort	2.47(1)
Secure	8.64(1)**
Trust	4.76(1)**
Connected	6.20(1)**
Great	5.59(1)**
Good	13.54(1)**

** Chi-Square is significant at the 0.05 level (2-tailed).

Effect of Supportive and/or Rehabilitative Services

An independent t-test was conducted to determine if accessing supportive and/or rehabilitative services had a significant effect on the perceived mental health status during the following conditions: during incarceration and during reintegration. Accessing services was expected to have a positive effect on perceived mental health status in both conditions. As shown in Table 11, accessing counseling, group therapy, anger management, and education/GED, had a significant effect on perceived mental health status during incarceration. While accessing substance abuse counseling had a significant effect on perceived mental health status during reintegration. The only service that had a significant effect during both incarceration and reintegration was the 12-step program. Also shown in Table 11 are the mean scores which show that perceived mental health status was reported to be better when accessing services.

Table 11. Independent T-Test - Services

Variable		*During Incarceration*	*During Reintegration*	*Services Accessed (M)*	*Services Not Accessed (M)*
Counseling	*t*	-2.021	.551	3.05	2.50
	df	85	86		
	p	.046**	.583		
Group	*t*	-2.288	-1.946	3.19	2.51
Therapy	*df*	85	86		
	p	.025**	.055		
Anger	*t*	-2.188	-.560	3.04	2.48
Management	*df*	85	86		
	p	.031**	.577		
Substance	*t*	-1.943	-2.146	3.53	2.86
Abuse	*df*	85	86		
Counseling	*p*	.055	.035**		
Education	*t*	-3.403	-.196	3.08	2.31
/GED	*df*	85	86		
	p	.001**	.845		
12-Step	*t*	-2.140	-2.085	2.94	2.43
Program	*df*	85	86		
	p	.035**	.040**		

** Independent T-test is significant at the 0.05 level (2-tailed).

Summary

This chapter presented the results of this study. Our hypothesis was that the experience of incarceration and reintegration into the community with little to no supportive and/or rehabilitative services would have a negative impact on the mental health status of the individual. Perceived mental health status was expected to be reported worse during incarceration and during reintegration into the community. Incarceration and reintegration was expected to have a negative impact on perceived mental health status. Additionally, negative feelings were expected to be reported more frequently than positive

feelings. Higher reports of negative feelings during incarceration and reintegration are considered to reflect poor perceived mental health status.

Perceived mental health status was reported slightly better during incarceration and slightly worse during reintegration. However, when controlling for only positive responses of perceived mental health status, it was found to dramatically worsen during incarceration. A weak to moderate positive correlation was found between perceived mental health status during incarceration and during reintegration. It was reported that incarceration did negatively impact perceived mental health status with a moderate positive correlation, but not reintegration.

Overall, more negative feelings were reported than positive feelings. Negative feelings were reported more during incarceration than reintegration. Positive feelings were reported less during incarceration, and more during reintegration. All negative feelings were found to be significantly different during incarceration and reintegration. Approximately two-thirds of the positive feelings were found to be significantly different during incarceration and during reintegration. The relationship indicates that participants felt worse during incarceration and felt better during reintegration.

Part of our hypothesis is that little to no supportive and/or rehabilitative services are offered during incarceration and reintegration, therefore, resulting in incarceration and reintegration having a negative impact on the mental health status of the individual. Church was the most common service to be

offered, followed by mental health assessment, physical health assessment, and substance abuse treatment. Overall, services were rated as positive, but there was too long of a wait time to receive them. When comparing the perceived mental health status between those who did access services and those who did not, accessing services was found to improve perceived mental health status.

The secondary data we collected from United Way 211 reflects the changing paradigm of providing more supportive and/or rehabilitative services to ex-offenders who are reintegrating into communities. The most common referral requested by ex-offenders is shelter resources. Other referral requests include emergency food, medical care, family development, career/employment building, specialty treatment, transportation, and legal assistance. Secondary data was also collected from CSRI to show an example of a program that is actively providing those services which are requested by ex-offenders. CSRI is providing free services in order to prevent access barriers to this already vulnerable population. CSRI has received over 1920 referrals, and among those have been served by CSRI, employment rates have improved and recidivism rates have decreased.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the implications of the results and whether the results support the hypothesis that incarceration and reintegration into the community have a negative impact on the perceived mental health status of an individual. Unanticipated results and possible explanations are also provided. Limitations of this study are described. Additionally, recommendations for future social work practice, policy, and research are provided.

Discussion

The first thing that we would like to point out, are the demographic findings from both of the focus groups and surveys. It is worthy to note, that most of the participants who participated in this study can be characterized as productive members of society today. An overwhelming number of participants from the focus groups and surveys have at least some college education, with some having a college degree up to a Master's level. Most of them are employed either part-time or full-time and have access to transportation. Most of them have adequate housing with only a small percentage that is homeless. This is a shift from the characteristics before incarceration and can be viewed as protective factors to prevent future incarceration, since greater protective factors improve the quality of life and reduce a person's risk of recidivism. The

over-representation of males in this study is reflective of the prison and jail populations (Carson & Sabol, 2012; Minton, 2012). Similarly, Caucasians were the most common ethnic group in this study, which is also representative of the jail populations (Minton, 2012), but not of the prison populations which houses more people of color than whites (Carson & Sabol, 2012). Having more Caucasians participate in this study may be an indication that more people of color are still incarcerated. People of color are imprisoned at higher rates compared to Caucasians (Sabol & Carson, 2012).

Our hypothesis was that the experience of incarceration and reintegration into the community would have a negative impact on the perceived mental health status of an individual. We expected perceived mental health status to be poorer during the process of incarceration and reintegration compared to prior to incarceration. Only a weak correlation was found. When looking across the three conditions, it appears that perceived mental health status was slightly worse prior to incarceration, leveled off during incarceration, and then slightly worsened when leaving incarceration. This may be reflective of some of the responses we obtained during the focus groups. Many participants indicated that their lives prior to incarceration were filled with stress, chaos, and uncertainty, and that when they were incarcerated, they felt as if they could relax. As indicated by a focus group participant, “I get a place to sleep and I get three meals a day” (Indio Participant #1, Focus group, July 2013).

When controlling for only poor responses of perceived mental health status across the three conditions, once again it appears that there was a slight improvement during incarceration. When controlling for only neutral responses in perceived mental health status, it appears that there was a dramatic improvement during incarceration. On the other hand, when controlling for only positive responses in perceived mental health status, positive responses were reported twice as less during incarceration. We believe that the conflicting findings are an indication of people not being able to easily talk about the possibility of having a mental health problem. Generally, it may be difficult for any person to admit that they may have a mental health problem, but for this population, not admitting to the possibility of having a mental health problem may be viewed as a protective factor. Recalling the focus groups, it was said that it was common to not seek mental health services “in fear of negatively impacting the chances of release and survival”, (Riverside Participant #1, Focus group, August 2013). Additionally, it is generally easier to discuss positive feelings in an open and honest manner. Therefore, we give more weight to the positive reports of perceived mental health status. And since positive reports are cut in half during incarceration, we believe this supports part of our hypothesis that incarceration does have a negative impact on the mental health status of an individual. These findings do not support the other half of our hypothesis that reintegration also has a negative impact on perceived mental health status. Reports of positive mental

health status increased during reintegration. This may be a reflection of being happy to be leaving prison or jail. Despite the reports of life being stressful, chaotic, and uncertain, most offenders are “happy to leave prison or jail” (Indio Participant #2, Focus group, July 2013).

When accounting for the perceived impact that incarceration and reintegration have on the mental health status of an individual, part of our hypothesis is supported. Although, only a moderate positive correlation was found, approximately 48% of the participants perceived that incarceration made their mental health status worse. Considering the protective nature of not disclosing the possibility of a mental health problem, we asked participants to report their perception about incarceration and reintegration having an impact on their mental health status. Taking the focus off individual deficit and putting the focus on incarceration and reintegration, we believed made it easier to report honest and accurate perceptions. The same amount of participants perceived that reintegration into the community made their mental health status better than it was before and during incarceration. This did not support part of our hypothesis that reintegration also has a negative impact on the mental health status of an individual. This is exciting to us. Part of the purpose of this study evolved from our assumption that reintegrating into the community is not an easy process and that little support is available. These findings reflect the changing paradigm that policy and programs are available and accessible, which can help reduce and prevent mental health problems,

and lead to successful reintegration. For example, the California Department of Corrections and Rehabilitation, Division of Rehabilitative Programs (DRP) has taken an innovative approach by using technology to improve successful reintegration. Director Millicent Tidwell (2014) reports in his electronic mailing list that computer kiosks are being used:

> The Automated Rehabilitation Catalog and Information Discovery (ARCAID) Machines can assist parolees in finding and locating a wide range of available community resources including substance abuse treatment, sober living environments, health services, employment assistance, child care, and necessary government services like DMH, Social Security and veteran-related administrative offices. (para. 2)

Additionally, this information implies that the model of service offered by CSRI is an ideal program model for those reintegrating into the community. The reduction in recidivism is evidence that rehabilitative services support successful reintegration for this population.

When accounting for feelings experienced during incarceration and reintegration, findings support the first part of our hypothesis, but not the second. Incarceration does have a negative impact on the perceived mental health during incarceration, but reintegration does not. Overall, negative feelings were reported almost twice as much as positive feelings. Negative feelings were experienced more during incarceration compared to reintegration. The two strongest feelings reported were *anxious* and

demoralized, followed by *distrustful* and *depression*. A total of 8 negative feelings were reported by over 40% of the participants, where, only one positive feeling was reported by just fewer than 40% of the participants. Positive feelings were reported least during incarceration. Because negative feelings are reported higher during incarceration and lower during reintegration, we interpret this as incarceration having a negative impact on mental health status. When an offender is incarcerated, their mental health status gets worse, and when they leave prison or jail, their mental health status gets better. Because positive feelings are reported less during incarceration and more during reintegration, we interpret this as incarceration having a negative impact on mental health status.

Aside from our hypothesis, we wanted to understand which supportive and/or rehabilitative services are being offered to offenders and what kind of impact they have on mental health status. Surprisingly, the most offered service was church, but was not found to be significantly related to their perceived mental health status. However, in our qualitative questions, many participants listed that finding a relationship with their Higher Power helped them during incarceration. Unfortunately, we are not clear if this happened in church or a 12-step program. We believe this is because religion may be kept private by people. Mental and physical health assessments followed and neither was significantly related to perceived mental health status. Once again, we refer back to the focus group information we collected. Many offenders feel

the need to hide the true nature of their conditions in order to “survive the prison and jail environment” (Riverside Participant #2, Focus group, August 2013). To admit to mental or physical health problems, may be viewed as weakness or vulnerability. Substance abuse treatment was the next most offered service, and was found to be significantly related to the perceived mental health status. Those who received substance abuse treatment reported the highest improvement in perceived mental health status compared to any of the other services. This is also exciting to us, because most of the offenders in prison and jail have a substance abuse problem. Adequately addressing substance abuse issues during incarceration appears to have a positive impact on mental health status. In addition to substance abuse treatment, counseling, group therapy, anger management, 12-step program, and education/GED, all had a significant relationship with perceived mental health status. All participants who accessed these services reported an improvement in their mental health status. This is promising as it also reflects the changing paradigm that supportive and/or rehabilitative services are crucial in the overall successful reintegration of ex-offenders trying to change their lives in a positive direction.

Findings of secondary data also support this trend. Previous decades, ex-offenders had nowhere to turn. Services were not readily available. They were expected to “go home until the next time”, (Indio Participant #3, Focus group, July 2013). The good news is that programs such as the United Way

211 are answering the call, literally. In only a six month period that we researched, United Way 211 received almost 1200 phone calls from ex-offenders and/or support persons asking for help. Ex-offenders now have a place to turn. And, based on the referrals that were provided, they have direction to follow and resources to access. This should lend to the overall changing trend of unsuccessful reintegration and prevent recidivism.

Programs like the California State Reentry Initiative (CSRI) are also answering the call. The CSRI is helping ex-offenders every day to improve their quality of life and prevent recidivism. CSRI recognizes that these ex-offenders fresh out of incarceration have limited financial resources and are providing free services. Services provided at the CSRI are the same type of services that this study showed to have a positive impact on mental health status. Therefore, the field of social work should continue investing in and developing programs that match the mental health needs of ex-offenders attempting reintegration into their community.

Limitations

This study had several limitations that may have impacted the outcome. The focus groups were small in size with only five participants per focus group in each geographical area. The groups also lacked ethnic and gender diversity. Two women participated in the focus groups and the ethnicity of the group members did not represent the diversity of the Inland Empire and

Coachella Valley communities, therefore the surveys were based on limited feedback and information.

The survey created for this research was created from the information collected during the focus groups and was not tested for validity and reliability before implementation. Some of the participants were interviewed and guided through the survey while others completed the survey on their own. If face-to-face interviews would have been conducted with all the participants, the data may have been more comparable because clear instructions or explanations could have been provided to each participant regarding the meaning of each question. It is not clear if all the participants had the same understanding of the questions.

The snowball sampling approach is not fully representative of the total populations of interest due to a large number of participants are in a 12-step program. The majority of the original participants in the study are people in recovery. After those participants completed the survey and were asked for a contact that was formally incarcerated and off of probation and/or parole supervision, they referred us to others in the 12-step recovery community who may have a different perspective about effective services and the perceived impact those services had on their mental health. It is important to note, all participants are not connected to the 12-step program or in recovery.

We also did not ask participants about their convictions and/or reasons for incarceration. The data collected may have implications for their mental

health status before incarceration, which may have shed some light on which services may have been needed for that participant. The survey did not ask about services offered during reintegration which could have provided more insight into reintegration needs (i.e. life skills, housing, vocational rehabilitation, etc.). We only asked participants about the services they were offered and not actually accessed; therefore the rating is unclear of which services were utilized. It is difficult to determine if the services were helpful or not.

Recommendations for Social Work Practice, Policy and Research

We recommend that social workers become more involved in providing rehabilitative services to offenders. This research study supports the need for rehabilitative services during and after incarceration. There needs to be more of a focus on the mental health of an offender upon incarceration to connect them with needed services. Many offenders need assistance and incentives to accessing services and not fear retribution or punishment in obtaining those services.

As social work practice evolves to meet the needs of those previously incarcerated, there needs to be more programs available and implemented for a population unable to effectively advocate for themselves. Social work practice should begin to include peer support services that include the use of recovering ex-offenders to support and mentor those attempting reintegration.

Restorative justice practices (i.e. victim offender dialogues, meaningful community service, and victim awareness/impact classes) could provide the needed skills to improve social bonds to the community and build self-esteem of the ex-offender to succeed in the future.

Policy changes need to be implemented to shift their focus to alternative sentencing programs that will provide rehabilitative services to include individual therapy, group counseling, education, substance abuse treatment, self-help programs, vocational rehabilitation and anger management treatment which will provide the services needed to overcome previous destructive behaviors and criminal thinking patterns. There needs to be effective collaboration between the criminal justice system and behavioral health providers to provide supportive services and clear direction for participants as they are released from custody. A mandate to participate in services from the criminal justice system, in lieu of custody, and an interactive collaboration with community supervision agencies (i.e. probation, parole, law enforcement) with behavioral health providers, would provide the communication needed for advanced case management.

Including mental illness as a core criminogenic need and/or risk factor will provide the initial identification to connect the offender with needed services. As California continues with the implementation of AB 109, it is critical for behavioral health agencies to continue working with detention centers to provide services during incarceration and reintegration. Connecting

offenders to programs before they are released from prison will provide a continuation of services and avoid some getting lost in accessing those services.

More research related to the mental health status before, during and after incarceration should include the ex-offenders' perspective is needed to further study the use and effectiveness of rehabilitative services. Ex-offenders need the opportunity to advocate for services that will improve their reintegration efforts and improve their mental health status. To expand accessible evidence-based services in other areas, there needs to be continual research on services provided to this population. Further studies could be helpful to measure the level of effectiveness services have before, during and after incarceration.

Future studies could include a larger number of participants to provide gender and ethnic diversity. Research that includes a more inclusive representation of this population would help in determining needed services. A geographical study to include other areas within California would provide a better understanding of service accessibility in specific areas. This impact may change the needs or motivation of ex-offenders to access services in some areas. New studies could research the impact of being released to the neighborhoods they committed their crime in and how that may affect their ability to recover. Studies like these may provide the information needed to enhance services, evaluate motivation and improve outreach efforts.

Conclusions

This study was developed to investigate how incarceration and reintegration impact the mental health status of an individual. We chose to avoid professional reports of mental health prevalence because of the nature of having different theoretical approaches between criminal justice and mental health professionals. In addition, information gathered from focus groups indicate an underreporting of mental health status while incarcerated. Therefore, we chose to obtain personal reports from ex-offenders about their own perceptions of how incarceration and reintegration impacts their mental health status. Findings outlined in this chapter, support that incarceration does have a negative impact on the mental health status of an individual. Personal reports about perceived mental health status show a slight impact to their mental well-being. However, when asking about the feelings they experienced during incarceration and reintegration, evidence shows a stronger case that mental health status is negatively impacted by incarceration than originally reported. On the other hand, findings did not support that reintegration has a negative impact on mental health status. Supportive and/or rehabilitative programs are in existence more than ever, and are showing promising results. Additionally, people are staying out of jail and prison and are becoming productive members of society.

APPENDIX A

FOCUS GROUP QUESTIONNAIRE

FOCUS GROUP QUESTIONNAIRE

DEMOGRAPHICS

How old are you?
What is your gender?
What is your Race/ethnicity?
What is your current education level?
What is your current employment status?
What is your current living situation?
What is your current transportation status?
When were you incarcerated? Please list each term.

OPEN ENDED QUESTIONS

1) What was it like when you went to jail or prison?
2) What kind of challenges did you experience when you went to jail or prison?
3) What kind of support was offered to you while you were in jail or prison?
4) How do you define mental health problems?
5) How would you describe your mental health before you went to jail or prison?
6) How did your mental health change while you were in jail or prison?
7) Which mental health services were you referred to?
8) What kind of mental health services did you receive?
9) What kind of barriers did you experience when accessing mental health services?
10) What was it like when you returned to the community?
11) What kind of challenges did you experience when you returned to the community?
12) What kind of support was offered to you when you returned to the community?
13) How do you define reintegration into the community from jail or prison?
14) How would you describe your mental health before you returned to the community?
15) How did your mental health change while you were reintegrating into the community?
16) Which mental health or other services were you referred to?
17) What kind of mental health or other services did you receive?
18) What kind of barriers did you experience when accessing mental health or other services?

Is there anything else that you would like to say, good, bad, or indifferent about incarceration and/or reintegration?

Created by April Marie Marier and Alejandro Alfredo Reyes

APPENDIX B

SURVEY QUESTIONNAIRE

SURVEY QUESTIONNAIRE

DEMOGRAPHICS

1. Please indicate your age range.
   ___18-24 ___25-34 ___35-44 ___45-54 ___55-64 ___65 or older

2. Please indicate your gender:
   ___ Female ___ Male

3. Please indicate your race/ethnicity: (Check all that apply)
   ___African American ___Asian
   ___Caucasian ___Pacific Islander
   ___Hispanic ___Middle Eastern
   ___Native American ___Other

4. Indicate your highest grade completed of education:
   ___No high school diploma ___High school diploma/GED
   ___Some college ___Associates Degree
   ___Bachelor's Degree ___Master's Degree
   ___Doctoral Degree

5. Indicate your employment status:
   ___unemployed/not seeking employment ___unemployed/seeking employment
   ___part-time employed ___full-time employed
   ___student ___disabled (unemployed)

6. Indicate your living situation:
   ___Living independently in a house ___living independently in an apartment
   ___living with family ___living with friends
   ___homeless living in shelter ___homeless living transient

7. Indicate your transportation status:
   ___Transportation ___no transportation

8. Indicate how many times you were incarcerated:
   ___1 ___2 ___3 ___4 ___5 or more

9. Please indicate the number of years and months you were incarcerated: ____

INCARCERATION – IMPACT ON MENTAL HEALTH

Please check the answer that BEST describes your experience.

10. Please complete the following statement: My mental health before incarceration…..
    ___was very poor
    ___was somewhat poor
    ___was neutral
    ___was somewhat positive
    ___was very positive

11. Please complete the following statement: My mental health during incarceration…..
    ___was very poor
    ___was somewhat poor
    ___was neutral
    ___was somewhat positive
    ___was very positive

12. Please complete the following statement: My mental health upon reintegrating into the community…..
    ___was very poor
    ___was somewhat poor
    ___was neutral
    ___was somewhat positive
    ___was very positive

13. Please complete the following statement: Incarceration…..
    ___made my mental health significantly worse
    ___made my mental health somewhat worse
    ___had no impact on my mental health
    ___made my mental health somewhat better
    ___made my mental health significantly better

14. Please complete the following statement: Reintegration into the community…..
    ___made my mental health significantly worse
    ___made my mental health somewhat worse
    ___had no impact on my mental health
    ___made my mental health somewhat better
    ___made my mental health significantly better

15. During incarceration, I felt _____ most of the time: (check all that apply)

___Sad	___happy	___hopeless	___great
___depressed	___cheerful	___demoralized	___good
___anxious	___comfort anxious	___secure	___fearful
___confidence	___shock	___trust	___nervousness
___powerful	___distrustful	___connected	___isolated
___welcomed	___abandoned		

16. During reintegration, I felt _____ most of the time: (check all that apply)

___Sad	___happy	___hopeless	___great
___depressed	___cheerful	___Demoralized	___Good
___anxious	___comfort	___terror	___secure
___Fearful	___confidence	___shock	___trust
___nervousness	___powerful	___Distrustful	___connected
___isolated	___welcomed	___abandoned	

SUPPORTIVE/REHABILITATIVE SERVICES

17. Which supportive/rehabilitation services were offered to you while you were incarcerated? (check all that apply)

___mental health assessment	___medication	___education/GED
___counseling	___individual therapy	___education/Degree
___work training	___substance abuse	___12-steps
___group therapy	___life skills	___church
___anger management	___physical health screening	___arts
___fire camp	___physical health medication	
___psychiatric health	___none	

___Other_____

18. If you did receive supportive/rehabilitative services how would you rate them?
___Very poor
___somewhat poor
___neutral
___somewhat positive
___very positive

19. When you were referred for supportive/rehabilitative services, how would you rate the time that it took for you to actually receive those services?
___Very dissatisfied
___Somewhat dissatisfied
___Neutral
___Somewhat satisfied
___Very satisfied

20. How would you describe the wait time for receiving supportive/rehabilitative services?
    ___Very long wait time
    ___Somewhat long wait time
    ___Neutral
    ___Somewhat short wait time
    ___Very short wait time

21. Is there anything else that you would like to say about incarceration?

    _____

    _____

22. Is there anything else that you would like to say about reintegration?

    _____

    _____

23. What helped you the most while you were incarcerated?

    _____

    _____

24. What hindered you the most while you were incarcerated?

    _____

    _____

25. What helped you the most while you reintegrated into the community?

    _____

    _____

26. What hindered you the most while you reintegrated into the community?

    _____

    _____

APPENDIX C

DATA EXTRACTION FORM

CDCR California Department of Corrections & Rehabilitation

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

DAY REPORTING CENTER

March 15, 2013

Ms. April Marier and Mr. Alex Reyes
CSUSB MSW Students
Department of Social Work
San Bernardino, CA 92407

Dear Ms./Mr. Marier and Reyes:

This letter is to detail the agreement for your thesis research. The CSUSB Day Reporting Center (now known as the Cal State University Reentry Initiative, CSRI) supports your research at the site. It is our understanding that you are requesting to work with the former students who have been discharged from parole. Interviewing this population will not require approval from the California Department of Corrections and Rehabilitation (CDCR). In addition, all appropriate secondary information not required by CDCR research approvals will be shared.

It is also our understanding that participation in your study by CSRI staff and former students will be entirely voluntary. Please coordinate your visits and appointments through me. We will soon be opening two additional sites so this is a very busy time for us.

Best of luck with your research; we look forward to your findings. We hope to use them to improve services with parolee programming efforts. This is important work.

Sincerely,

Carolyn Eggleston, Ph.D.
CSRI Administrator
Professor, Special Education
CSUSB College of Education

909.327.2981 • fax: 909.327.2101
1465 SOUTH D STREET, SUITE 100, SAN BERNARDINO, CA 92408-3217

Inland Empire United Way
Program Office: 9272 Helms St Avenue, Rancho Cucamonga, CA 91730
(909) 980-2557 - Fax 980-2957 - www.iewu.org

March 19, 2013

April Marier

April,

United Way 211 is happy to provide you with aggregate data of the requests, referrals, demographics and other information about the reentry population calling 211. At least 2% (1400) of the 70,000 annual calls to 211 are from someone previously incarcerated.

Sincerely,

Gary Madden
Director, 211 San Bernardino

APPENDIX D

INFORMED CONSENT

INFORMED CONSENT – Focus Group

The study in which you are being asked to participate, is designed to investigate the impact that incarceration and reintegration has on mental health. This study is being conducted by April Marier and Alex Reyes under the supervision of Dr. Cory Dennis, Assistant Professor of Social Work, at California State University, San Bernardino. This study has been approved by the School of Social Work Sub-Committee of the Institutional Review Board, at California State University, San Bernardino.

PURPOSE OF THE STUDY: The purpose of this study is to investigate the impact that incarceration and reintegration has on the mental health of a person.

DESCRIPTION OF THE STUDY: You are being asked to particpate in a focus group containing no more than 10 individuals that have previously been incacerated to discuss your perspective of the impact incarceration and/or reintegration had on your mental well-being.

PARTICIPATION: Your participation in this study is completely voluntary. If you decide not to participate, there will not be any negative consequences. Please be aware that if you do decide to participate, you may choose not to answer any specific questions, or you may choose to stop participating in the study at any time.

MAINTAINING YOUR CONFIDENTIALITY: Participation in this study is completely anonymous and will not include your name. All identifiable information such as age, gender, treatment accessed, length of incarceration and type of conviction, will be coded using numbers. All information will be kept entirely confidential by researchers. Limitations of confidentiality include other participants hearing self disclosed information. All participants will be encouraged to maintain confidentiality.

TIME REQUIRED FROM YOU: Approximately 60-90 minutes.

POTENTIAL RISKS OF THE STUDY: You may come across topics in this study that might provoke unpleasant or upsetting feelings. If you feel uncomfortable, you have the right to decline to answer specific questions or to stop the study at any time.

BENEFITS: This study has the potential to advocate, promote change, and bring awareness to the impact of incarceration and reintegration services that may cause mental health issues and social barriers. Your participation may increase awareness of how incarceration and reintegration policies and services may affect recidivism. Your participation may provide information to promote services that improve reintegration.

CONTACT: If you have questions about the research and your rights, please contact Dr. Cory Dennis at cdennis@csusb.edu or 909-537-3501.

RESULTS: If you would like to obtain the results from this study, you may find it at the John M. Pfau Library at California State University, San Bernardino after September 2014 or with the California State University, San Bernardino Reentry Initiative.

CONFIRMATION STATEMENT:

1. I understand to participate in this study I must be above the age of 18 and have formerly been incarcerated. I am not on parole or probation at this time.
2. I have read the information above in its entirety and agree to participate in your study.

□ I agree □ I disagree

INFORMED CONSENT - Survey

The study in which you are being asked to participate, is designed to investigate the impact that incarceration and reintegration has on mental health. This study is being conducted by April Marier and Alex Reyes under the supervision of Dr. Cory Dennis, Assistant Professor of Social Work, at California State University, San Bernardino. This study has been approved by the School of Social Work Sub-Committee of the Institutional Review Board, at California State University, San Bernardino.

PURPOSE OF THE STUDY: The purpose of this study is to investigate the impact that incarceration and reintegration has on the mental health of a person.

DESCRIPTION OF THE STUDY: You are being asked to complete a survey asking questions regarding the impact incarceration and/or reintegration had on your mental well-being.

PARTICIPATION: Your participation in this study is completely voluntary. If you decide not to participate, there will not be any negative consequences. Please be aware that if you do decide to participate, you may choose not to answer any specific questions, or you may choose to stop participating in the study at any time.

MAINTAINING YOUR CONFIDENTIALITY: Participation in this study is completely anonymous and will not include your name. All identifiable information such as age, gender, treatment accessed, length of incarceration and type of conviction, will be coded using numbers. All information will be kept entirely confidential by researchers. Limitations of confidentiality include other participants hearing self disclosed information. All participants will be encouraged to maintain confidentiality.

TIME REQUIRED FROM YOU: Approximately 10-20 minutes.

POTENTIAL RISKS OF THE STUDY: You may come across questions in this study that might provoke unpleasant or upsetting feelings. If you feel uncomfortable, you have the right to decline to answer specific questions or to stop the study at any time.

BENEFITS: This study has the potential to advocate, promote change, and bring awareness to the impact of incarceration and reintegration services that may cause mental health issues and social barriers. Your participation may increase awareness of how incarceration and reintegration policies and services may affect recidivism. Your participation may provide information to promote services that improve reintegration.

CONTACT: If you have questions about the research and your rights, please contact Dr. Cory Dennis at cdennis@csusb.edu or 909-537-3501.

RESULTS: If you would like to obtain the results from this study, you may find it at the John M. Pfau Library at California State University, San Bernardino after September 2014 or with the California State University, San Bernardino Reentry Initiative.

CONFIRMATION STATEMENT:

1. I understand to participate in this study I must be above the age of 18 and have formerly been incarcerated. I am not on parole or probation at this time.
2. I have read the information above in its entirety and agree to participate in your study.

□ I agree □ I disagree

APPENDIX E

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for participating in this study!

This study was conducted by April Marier and Alex Reyes under the supervision of Dr. Cory Dennis, Assistant Professor of Social Work, at California State University, San Bernardino. The purpose of this study was to investigate the impact that incarceration and reintegration has on mental health. The information from this study will be used to identify barriers and obstacles to an individual trying to reintegrate back into the community and to advocate for changes in policy and service that promote successful reintegration into the community.

The results of this study will be available after September 2014 and can be found at the John M. Pfau Library at California State University, San Bernardino and/or the California State University, San Bernardino Reentry Initiative.

If you have any questions or would like to know more about this study, please contact, Dr. Cory Dennis, School of Social Work, California State University San Bernardino, at 909-537-3501.

Thank you again for participating in this study!

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: April Marier & Alex Reyes

2. Data Entry and Analysis:

   Team Effort: April Marier & Alex Reyes

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: April Marier & Alex Reyes

   b. Methods

      Team Effort: April Marier & Alex Reyes

   c. Results

      Team Effort: April Marier & Alex Reyes

   d. Discussion

      Team Effort: April Marier & Alex Reyes