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MENTAL HEALTH, SUBSTANCE ABUSE AND RECIDIVISM: PERCEPTIONS OF KEY JUSTICE SYSTEM STAKEHOLDERS IN SOUTHERN CALIFORNIA

Tabari Zahir

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MENTAL HEALTH, SUBSTANCE ABUSE AND RECIDIVISM: PERCEPTIONS
OF KEY JUSTICE SYSTEM STAKEHOLDERS IN SOUTHERN CALIFORNIA

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

by
Tabari Zahir
May 2021

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ABSTRACT

Despite the 2011 landmark decision of the United States Supreme Court ordering the California authorities to address prison overcrowding, the Golden State still faces significant challenges dealing with the size of its correctional population. Recidivism plays a preponderant role in slowing down the momentum toward overcoming relatively high rates of incarceration across the state. The purpose of this study was to explore the perceptions of key human services stakeholders about the intersection of three major challenges in the California criminal justice system: mental health, substance use, and recidivism. Embracing a continuum of care approach, this study ultimately attempted to explore whether there is a novel, meaningful way to tackle the three aforementioned problems and improve the said justice system. Many studies have highlighted the California recidivism problem; however, there is little research on the juncture of mental health, substance use, and recidivism in California through a continuum of care model. Interviews with 10 incarcerated individuals and reentry services providers revealed four major themes: (1) emotional pain from trauma is a catalyst for substance use and repeated criminal acts, (2) lack of mental health and substance use services is directly connected to emphasis on punishment instead of rehabilitation in the criminal justice system, (3) systemic and self-imposed barriers prevent the effective delivery of mental health and substance use services, and (4) there is a need for a continuum of mental health and substance use in the criminal justice system. This study concluded with a

thorough discussion of its findings for theory, research, social work practice, and social work education.

Keywords: mental health, substance use, recidivism, continuum of care, criminal justice system, trauma-informed care

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First and foremost, I must acknowledge my Creator whom without there is no guidance nor understanding. Second, my parents who did beautiful social work without its professional form as I have learned, but benefitted humanity, nevertheless. Third, I want to acknowledge my mentors who saw in me the potential to be a great social worker even when I did not understand its importance. Finally, all of my professors, advisors, classmates, field instructors, internship organizations and clients who allowed me in their lives and spaces affording me the opportunity to get the training I needed to obtain the skills needed to be a significant social worker.

DEDICATION

This research project is dedicated to the founders of the Tayba Foundation whom
without I would have never known the true meaning or value of social work

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Among persistent issues that beset communities and public safety authorities nationwide is recidivism, the tendency of someone convicted of a crime to eventually commit another crime, be convicted, and once again cycle through the criminal justice system (Maltz, 1984). National recidivism rates currently stand at about 44% meaning that almost one in two releasees are going to reoffend (Alper et al., 2018). These statistics are problematic for at least two major reasons. First, the average annual cost to incarcerate someone in the U.S is approximately \$41,000 and taxpayers continually bear this cost (Di Giorgi, 2015). Second, the communities that receive the new releasees are often the victims of new crimes when the formerly incarcerated reoffend. There are currently 2.3 million inmates in American jails and prisons across the nation and 95% of them will eventually return to their communities (Wacquant, 2010).

In most incarceration cases, the communities where the offenders come from usually lag behind in terms of mental health and substance abuse services (Jannetta et al., 2011). Recent research has shown that 65% of incarcerated individuals had experienced some major traumatic event in their lifetime (Stensrud et al., 2019). These events include physical and sexual violence, child

abuse, life-threatening robberies, and loss of family members due to a variety of detrimental life circumstances including incarceration. These underlying traumatic events provide direct inroads to substance abuse which in-turn increases the chances of incarceration. It is also important to consider substance abuse amongst people who are incarcerated. In fact, 75 percent of jail and prison inmates present with traits that meet the criteria for substance dependence and abuse (Carlson et al., 2010).

There is a solution in plain sight. Decisive research over more than four decades has shown that mental health and substance abuse services (MHSAS) can help reduce recidivism (Visher et al., 2017). Even though the majority of incarcerated persons present with mental health and/or substance abuse issues, less than 10% of them have received treatment, despite the overwhelming evidence which indicates that mental health services and drug treatment helps with changing criminal behavior and reduces recidivism (Petersilia & Snyder, 2013).

Due to a landmark legal judgement against the State of California, new laws and initiatives could provide mental health care providers unprecedented opportunities to treat individuals who enter the California criminal justice system (CJS) in order to reduce recidivism. For almost four decades, California had been among the states with highest rates of incarceration (Grattet & Hayes, 2015). California also had also faced the highest recidivism rate in the U.S., at 61-67% between 2000 and 2009, respectively (Lofstrom et al, 2014). Starting in 1984,

legislators began passing laws that quickly filled up the state prisons and between 1984 and 2014, the annual state prison budget ballooned over 500% to more than \$11 billion today. Only four percent of those funds were used for inmate rehabilitation (Grattet & Hayes, 2015). In 2011, the U.S Supreme Court ordered the State of California to reduce the number of inmates they had in their state prisons by 33,000. In response to this order, California authorities had to restructure the entire CJS and at the same time empowered the 58 state counties to create community programs that would be rehabilitative, while simultaneously providing alternatives to incarceration (Hopper et al., 2014).

Purpose of the Study

The purpose of this study was to explore the perceptions of key human services stakeholders about the intersection of three major challenges in the California criminal justice system: mental health, substance use, and recidivism. Exploring the views of formerly incarcerated men and women as well as reentry services providers will shed light on the best way to tackle recidivism in the Golden State. This study attempted to answer a single question: What are the perceptions of key human services stakeholders—social workers, social service administrators, formerly incarcerated clients—about the intersection of three major challenges (mental health, substance use, recidivism) in the California criminal justice system? The ultimate goal is to determine whether there is a need for a continuum of care in the California justice system as a practical way to reduce recidivism.

Significance of the Project for Social Work Practice

The findings of this study are anticipated to have implications for the profession of social work. In fact, due to the complete restructuring of the California criminal justice system, and the political will to lower the prison population, all evidence-based solutions that could possibly reduce recidivism suddenly became necessary. California social workers who aid and collaborate with the justice-impacted population now have a two-pronged challenge: 1) to advocate on behalf of this neglected population for their right to proper mental health and substance abuse treatments, and 2) be innovative and assertive while delivering mental health and substance abuse services to this population. Hence, this study will spur a change in the thinking, tactics, and interventions used by social workers in the California justice system. Such change will occur at both the micro level of practice and the macro level of practice.

From a macro aspect, California social workers will have a new opportunity to research and have meaningful dialogue on creating a new system of rehabilitative treatment for incarcerated and formerly incarcerated populations. If enacted, these new policies could represent the actualization of the first value of social work, which in substance means that all human beings deserve access to the resources they need to overcome life's problems and thereby become self-actualized. (Hepworth et al., 2013). As stated above, most individuals in the California CJS did not receive adequate mental health care or substance abuse treatment and thus were effectively deprived of rising to their fullest potential.

From a micro perspective, social workers will have the opportunity to work with clients on a one-on-one basis, relying on evidence available in this study and the broader literature.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will be a review of all the resources used for the study and present a proposal that using a trauma informed continuum of care (CoC) model in the California criminal justice system can help reduce recidivism. The first section will explain the intersection between trauma, substance abuse and recidivism. The second section will explain what the literature lacks about the topic. The third section will provide support that the current study is needed. The fourth section will present the theories which guide the present study. The fifth section will summarize the entire chapter.

The Intersection Between Trauma, Substance Abuse and Recidivism

Janetta, Dodd, & Elderbroom (2011) point out in a study that recidivism does not exist in a void. There are systemic issues which are usually prevalent in the offender's community and in many cases are the underlying causes of arrest; the two which are relevant to this study are mental health issues stemming from untreated trauma, and substance abuse.

Trauma and Recidivism

As for mental health, the story on recidivism begins before jail or prison as trauma in the lives of the incarcerated 40-50% of the time. Untreated trauma in the lives of the incarcerated has been studied at length by Honorato et al. (2016) and has been found to be a determinate for aggression, spontaneous violence, and even murder. At the same, trauma is a contributing factor to substance abuse which in many cases has been used to cover up the pain of the original trauma. The same study gave a clear trajectory from childhood or youth to incarceration in the lives of their subjects as such: 1) childhood or youthful traumatic experience; 2) lack of coping skills or proper support to manage the traumatic experience/long term trauma; 3) substance abuse to escape the pain from the trauma; 4) finally, an act of sudden violence ending in criminal charges. Stensrud et al. (2019) has shown in a recent study the most common types of traumatic events experienced by inmates: 40% of incarcerated males and 55% of incarcerated females have experienced some form of major sexual, physical, or emotional abuse before the age of 18. The numbers were approximately the same for neglect respectively (physical, emotional). Additionally, the numbers for loss of a parent through death, divorce or imprisonment were especially high with incarcerated males reporting at 69% and incarcerated females at roughly the same percentage rates (Stensrud et al., 2019). The critical point with these statistics according to Petersilia and Snyder (2013) is that less than 10% of the incarcerated population in need of mental health services actually receive them.

Mental health issues are a clear factor in recidivism, but the policies to use mental health services systematically for rehabilitation amongst the incarcerated have never fully been implemented or utilized.

Substance Abuse and Recidivism

The numbers are even more alarming when considering substance abuse. Carlson et al. (2010) conducted a study that showed three fourths or 75% of jail and prison inmates meet the criteria for some type of substance dependence or substance abuse. The same study reported that only 24% of inmates who presented with substance abuse problems received treatment. It has also been well documented that substance abuse is a direct predictor of violent crime, robbery, and theft (Pealer, 2017). In general, pre-jail substance abuse by the incarcerated population was reported to be widespread, but the need for programs required for treatment and recovery went largely unmet in jails and state/federal prisons. Without the coping skills to avoid re-using drugs or alcohol, nor the techniques to mentally fortify someone with a disorder, more than 50% of releasees suffering from substance abuse will end up reoffending (Pealer, 2017).

Literature Lacks Explanations for the Dearth of Services for Incarcerated

The case that MHSAS are needed amongst the incarcerated and formerly incarcerated have been clearly laid out by the different studies above (Carlson et

al., 2010). What is also clear is that a portion of the recidivism rates can be directly attributed to untreated trauma and untreated substance abuse (Abracen et al., 2014). A consistent feature across all of the literature is a lack of questioning or explaining why the different criminal justice systems have failed to implement the solutions that the research has indicated would solve some of the high rates of recidivism? This present study sought out to understand those gaps in the literature by asking some stakeholders their perceptions on the issues around trauma, substance abuse and recidivism while at the same time exploring barriers to implementing well researched solutions. The researcher also questioned the incarcerated/formerly incarcerated about barriers—voluntary or involuntary—to consuming programs implemented for the sake of rehabilitation.

The Possibility of Reducing Recidivism in California Using Mental Health and Substance Abuse Services

In California, there is an opportunity for major change in the way mental health and substance abuse recovery services are delivered to those affected by the criminal justice system. In 2011, the U.S. Supreme Court ordered the California authorities to decrease the state prison population by more than 30,000 because the severe overcrowding of the prisons put the health and safety of the prison populations at risk while also constituting a violation of the 8th amendment of the U.S. Constitution which prohibits cruel and unusual punishment (Hopper et al., 2014). In response to this judicial order, California

authorities passed a bill (AB109) commonly known as the ‘realignment bill’ which has completely changed their policing policies, incarceration protocols, community outreach and involvement in order to try and improve the California justice system in an initiative which has been called the most ambitious penal reform project in modern history (Petersilia & Snyder, 2013).

This study investigates the perceptions of key human service stakeholders around the intersection of mental health, substance abuse, and recidivism with a particular focus on the possibility of lowering the recidivism rate by addressing the impact of trauma and substance abuse in this population. A novel approach to these issues has been advanced in this study, namely that a trauma informed continuum of care model is used throughout the CJS to intervene with the justice impacted population in California.

Theories Guiding Conceptualization

The purpose of this study is to investigate the need for a comprehensive method of delivering MHSAS throughout the California justice system in order to reduce recidivism, using two theoretical approaches: (1) continuity of care (CoC) and (2) trauma informed care.

In the medical health field, there is a model of providing consistent care to a patient over time called ‘continuity of care’ (CoC). Its exact definition is, “the delivery of services by different care providers in a timely and complementary manner in order to achieve connected and cohesive patient care.” (Haggerty et

al., 2008) It is a process in which a team of health providers cooperate with their client to deliver ongoing, high quality, cost-efficient medical care. This concept was first articulated in the 1950's and its theoretical principles were: 1- to meet the total needs of the client, 2- to respond to consumer demand, 3- to enhance the financial viability of healthcare organizations, 4- to provide ongoing quality care (Evashwich, 1989). The CoC model continues to develop, has been thoroughly researched and is associated with higher levels of client satisfaction, improved promotion of health and goals toward well-being, an adherence to doctor prescriptions and reduced hospital use (Gray et al., 2018). Some criticisms of this model are: delayed client diagnoses due to the number of care providers on a case; encouraged complicity amongst providers to certify unconfirmed diagnosis; increased cost due to client seeking second opinions and the cost of increased flexibility of staff arrangement (Freeman & Hughes, 2010).

Lefkovitz (1995) mentioned that by the mid 1990's, the behavioral health field became a fertile ground for the CoC model and began to find favor amongst the behavioral and mental health practitioners. It naturally occurred to this group of professionals to also apply this model in correctional settings. Smith et al., (2010) used this model in several forensic psychiatric environments and found that it did reduce recidivism as well as improve mental health and quality of life. For the purposes of this study, CoC means mental health and substance abuse services (MHSAS) will be made available for every inmate from the time of arrest, up until that offender exits completely from the judicial system, with the

goal to reduce recidivism. There are MHSAS offered in California prisons and in reentry services, but the programs do not include comprehensive jail services nor are they continuous and systematic as was advanced here. The CoC model proposed by this study includes delivering MHSAS at every stage of the jail-to-community sequence: 1) arrest and jail services, 2) sentencing services, 3) resident prison services, and 4) society reentry services.

The second theory guiding this study was trauma informed care (TIC). TIC is an approach to helping individuals and populations who have been exposed to an extraordinary traumatic experience that presents a physical or psychological threat to oneself or others generating reactions of helplessness and fear (Levenson, 2017). This approach is appropriate for this study because according to Stensrud et al. (2019), close to half of the incarcerated population has reported trauma in their childhood or adolescent years.

The TIC approach emerged out of an extensive two-year study (1995-1997) of over 17,000 adults who experienced a wide range of trauma including abuse, neglect, and household dysfunction (Levenson, 2017). TIC theorizes that a persons' psychosocial functioning is adversely affected by the impact and frequency of early age trauma, but with a sensitive approach and proper interventions, the resulting negative symptoms can be reduced and can lead the individual to a full recovery (Levenson, 2017). The principles which underpin TIC are five: 1- 'safety' in the treatment environment and therapeutic relationship, 2- 'trust' is established when ambiguity and vagueness is eliminated, 3- facilitating

'choice' for the client in the service delivery enables self-efficacy, 4- true 'collaboration' between worker and client assists in healing, and 5- client 'empowerment' occurs when the focus is on their resilience and not pathology. Some reported benefits of TIC are improved collaboration between worker and client, less perceived stress by clients in TIC spaces, and less use of restraints and seclusion in psychiatric settings (Hales et al., 2017). Limitations to this approach have been researched by Berliner & Kolko (2016) who mentioned the concept lacks common definitions which impedes its universalization; there is very little direction which helps to operationalize the concept; there are a lack of tools associated with the concept such as assessments, screenings, and referral processes; and there is no systematic method of training practitioners.

Despite the above critiques, TIC is now used in a wide range of spaces including mental health/substance abuse facilities and criminal justice institutions. Mckenna & Holtfreter (2020) found that using this treatment method with the justice-impacted population helps to break the link between victimhood and criminalization, while also promising good results in reducing recidivism.

Summary

This chapter began with a section which reviewed the intersection between recidivism, trauma, and substance abuse. The literature clearly presented a continuum between childhood and adolescent trauma which in many cases can end with substance abuse and incarceration. The second section

shows what was lacking in all the review literature, namely the failure to propose a substantial plan to effectively address trauma and substance abuse in the justice impacted community. The third section bolsters the case for a systematic implementation of mental health and substance abuse services across the California criminal justice system in a way which would help lower recidivism. The fourth section presents the two theories guiding the shaping of the study, that is, a continuum of care model and trauma-informed interventions.

CHAPTER THREE

METHODS

Introduction

The purpose of this study is to examine delivering mental health and substance abuse services throughout the California criminal justice system on a continuum-of-care model in order to reduce recidivism. This chapter contains the details of how the study was conducted, with the following sections described, in a chronological manner, as thus: study design, sampling, data collection and instruments, procedures, protection of human subjects, data analysis, and a summary of the chapter.

Study Design

This study is an exploratory study which will attempt to produce a clearer picture of what is lacking in the California criminal justice system's approach toward treating mental and substance abuse issues in arrestees, inmates and formerly incarcerated to reduce recidivism. This study depended on qualitative data to conceive of a new model on which mental health and substance abuse services can be delivered systematically throughout the California justice system. As for the qualitative data, information was gathered from the experience, perspectives, impressions, and feelings of the formerly incarcerated along with a

mental health professional that provides them therapy. Information was also sought from directors of reentry organizations who provide this population with an array of services.

A strength of an exploratory study is the ability to hear the issue from the experience of the interviewee. In this study, it is important to know directly from the formerly incarcerated what they encountered in relation to trauma, mental health and substance abuse services, and what they can imagine would change if a trauma informed continuum-of-care system had been in place. It was also important to hear the perspectives of several stakeholders of the CJS of the existing issues around recidivism and possible solutions.

As for limitations in exploratory studies, they do not capture statistical data in a direct and precise manner. Due to the nature of this study, very little statistical data was captured such as costs of the proposal nor budgets or amounts that could be saved if implemented.

Sampling

This study was conducted using a convenience non-probability sample of interviewees who were chosen due to their similarity of backgrounds and experiences. The first and largest sample were six formerly incarcerated individuals who spoke from experience about trauma, mental health and substance abuse before, during and after release from prison. The group ranged in adult age between 29-59, their ethnicities were Black, White, and Latino,

various social-economic classes, and male and female genders. The next sample was a mental health professional (MHP) who consistently interacts with this population and provides them mental health services. This MHP provided insight into which mental health and substance abuse issues were most common with this population along with their levels of severity, why they were common, and if earlier interventions (in-prison) would have yielded better results. The last group of people who were part of the sample pool are directors of programs who provide a variety of reentry services to the justice impacted population. This group gave information about mental health access of their consumers, regularity of sessions, experiential hypotheses regarding mental health and recidivism, etc.

Data Collection and Instruments

The data for this study was collected using individual personal interviews. The demographic data collected represented age, genders, time spent incarcerated, number of subjects who were offered and/or received MHSAS before incarceration, during incarceration, and those who received stated services during their reentry process. Also, any relevant factors that speak to the occurrence between incarceration and mental health/substance abuse. The interview topics related to the occurrences of trauma prior to prison. Therefore, the researcher focused on (a) connections between trauma and substance abuse, (b) connections between trauma and criminal behavior, (c) connections between substance abuse and criminal behavior, (d) in-custody contacts

between subjects and mental health/substance use services, (e) availability of in-custody mental health/substance abuse services, (f) cultural, institutional, lifestyle barriers to named services, and (g) reentry and mental health services (see appendix A).

Procedures

Beginning in November 2020, the researcher began to interview formerly incarcerated individuals who had already agreed to participate in a 'mental health study'. The interviews were recorded via the video-platform Zoom where the researcher explained in detail the purpose, methods, goals, and process of the current study to the participants. The researcher emailed every individual who agreed to the study a consent form which explained confidentiality and requested the interviewee to sign and return the document. Participants were also emailed a debriefing statement. The series of questions (appendix A) was asked from the participants and they were able to respond by vocalizing their answers or signaling their answers by way of a head signal. Many of the questions were open-ended to provoke thought, stimulate memory and encourage discussion. The sessions were approximately 30 mins to one hour.

The second group of interviewees were professionals who service the formerly incarcerated, are intimately aware of their needs, and can speak to the phenomenon of trauma, substance abuse and recidivism as it relates to their clients and consumers. This group included a mental health therapist and three

reentry organization directors. These interviews were conducted one-on-one and they were all advised of confidentiality and consent. These sessions were also held via Zoom and consisted of open-ended questions to evoke thought and discussion. All sessions ended with debriefing statements.

Protection of Human Subjects

California State University San Bernardino Institutional Review Board gave the research approval to conduct this study. Due to the ongoing emergency of Covid-19, all communication with interviewees were conducted virtually. All the participants of this study were given confidentiality and anonymity statements and it was explained to them what the contents meant. On Zoom calls, many times the people present can be identified by their phone and or Zoom ID, so the researcher asked that all participants remove or change their name before logging on to the Zoom call. The formerly incarcerated participants were advised to not use specific identifying information such as neighborhoods, precincts, nicknames and prison locations of their incarceration when describing their upbringing, places of arrest, and prisons of residence. Therapists and program directors were asked to refrain from identifying their places of work and clients names. The recorded Zoom calls are being kept on a USB drive and then locked in a private desk drawer. Two years after the recordings were transcribed, the USB will be destroyed. At the conclusion of every meeting, all participants were given a debriefing statement.

Data Analysis

Each recorded session was assigned a reference number and every participant was assigned a number to distinguish between the different speakers. With the aid of transcription software (Otter.ai), all of the interviews were transcribed into writing and then listened to/read several times in order to identify participants' patterns in thought, behavior, responses, sentiments, intentions, willingness and perceived political will. Using thematic analysis techniques, the researcher then coded the data based on participants' responses. The researcher particularly noted connections and similarities across the interviewees' statements and entered them into a Microsoft Excel document to record comparison purposes. The next step consisted of grouping similar codes into larger concepts called themes.

Summary

This chapter has explained the methods used in the exploratory study, including using one-on-one interviews of formerly incarcerated individuals along with different service providers who provide a variety of reentry services for this population. How confidentiality and anonymity was explained. The method of data collection was discussed along with instruments to be used and how that data was analyzed.

CHAPTER FOUR

RESULTS

Demographics

Interviews were conducted with seven formerly incarcerated individuals, one mental health professional specializing in delivering MHSAS to the justice impacted population, and three directors of Southern California based community-based organizations that provide a range of services to the justice impacted population (one of which was formerly incarcerated). Table 1 below presents the sociodemographic characteristic of the 10 individuals who took part in this research.

Table 1

Sample Demographic Characteristics (N=10)

Race/Ethnicity	N (10)	% (100)
White	2	20
Black	5	50
Latinx/Hispanic	3	30
Gender	N (10)	% (100)
Male	8	80
Female	2	20
Justice Impacted	N (10)	% (100)
Formerly Incarcerated	8	80
Non-Impacted	2	20
Age	N (10)	% (100)
Under 40	3	30
Over 40	7	70
Years Incarcerated	N (10)	% (100)
Never Incarcerated	2	20
0-9	2	20
10-19	3	30
20-29	3	30
Experienced Pre-prison Trauma and/or Substance Abuse	N (10)	% (100)
Pre-prison Trauma	8	80
Substance Abuse	7	70

As exhibited in Table 1, of the entire sample, half were Black (50%), one-third were Hispanic (30%) and the smallest from the sample were White (20%). The majority of the interviewees were male (80%), while the remainder were female (20%). Most of the participants were formerly incarcerated (70%), while only a few were not justice-impacted (30%). Participants ages ranged from 29 to 55. Time spent incarcerated ranged between 2 and 29 years. All the seven formerly incarcerated interviewees (100%) experienced pre-prison trauma and only one (14%) had been diagnosed with a mental health disorder before being sentenced to prison. Four of the seven formerly incarcerated participants (57%) had been arrested more than once and attributes their re-arrests to untreated trauma and or drug abuse.

Study Themes

This study attempted to answer a single question: What are the perceptions of key human services stakeholders—social workers, social service administrators, formerly incarcerated clients—about the intersection of three major challenges (mental health, substance use, recidivism) in the California criminal justice system? Four major themes emerged from the qualitative data collected for this study: (1) emotional pain from trauma was a catalyst for substance abuse and repeated criminal acts, (2) the lack of MHSAS is directly connected to the emphasis of punishment in the criminal justice system instead of rehabilitation, (3) systemic and self-imposed barriers prevent the effective

delivery of MHSAS, (4) If MHSAS were available on a continuum, the currently and formerly incarcerated would be able to utilize and benefit from it (need for a continuum of care). Table 2 below summarizes the four themes identified in this research.

Table 2

Major Study Themes

<i>Themes</i>	<i>Description</i>
Theme 1	Emotional pain from trauma is a catalyst for substance use and repeated criminal acts
Theme 2	Lack of MHSAS* is directly connected to emphasis on punishment instead of rehabilitation in the criminal justice system
Theme 3	Systemic and self-imposed barriers prevent the effective delivery of MHSAS
Theme 4	There is a need for a continuum of MHSAS in the criminal justice system

* Mental health and substance abuse services

As seen in Table 2, the themes are consistent with the research question pursued in this study. In other words, these themes reflect the connection between mental health, substance use, and recidivism in the Golden State criminal justice system. An in-depth look at each of the themes above is provided below.

1. *Emotional pain from trauma is a catalyst for substance abuse and repeated criminal acts.*

Every formerly incarcerated interviewee (100%) admitted to some type of severe pre-prison trauma. Some interviewees were even explicit in declaring that their trauma drove them to see everything through a filter of anger which caused them to hurt themselves and others. Most of the same sample (85%) could easily connect their drug use and criminal acts to the pre-prison trauma. These statistics are consistent with the above cited literature that most of the incarcerated population has mental health and substance abuse issues which will manifest in recidivism if not treated (Carlson et al., 2010).

“When I shot the first person, I got it in my head that everybody's coming after me now. So, I kept doing drugs. I started going into like my own psychosis and starting to believe that I had people- when in reality- later when I heard it in court, they were more scared of me than I was scared of them.” [Male Participant #2]

“Because a lot of those situations or negative traumas, they put us in situations where we don't really care. Then it becomes like-- at the time you really don't know-- when you look back and you get old, it is self-preservation; you start doing things in order to survive, to make you feel like you're surviving. Part of it is- you know- maybe part of it for me was like hey getting high again, high leaving the pain- you know? Running with the homies you know? Perpetuating violent acts on other people, you

know? Just getting aggression off because it was perpetuated on me as a kid-so here it is! I'm going to take that and perpetuate it on somebody else." [Male participant #6]

2. *The lack of MHSAS is directly connected to the emphasis of punishment in the CJS instead of rehabilitation.*

This theme is giving voice to the phenomenon named 'new punitiveness' by mass incarceration scholars (Feeley, Simon, 1992). Starting in the 1970's, there was an academic and legal shift away from the idea that prisoners could be rehabilitated, and in its place, the new norm became to treat those convicted of a crime as social rejects who had to be kept separated from the rest of society. Most rehabilitative programming was removed from the prisons due to the punitive notions. Today, lawmakers and scholars are utilizing extensive research to reverse this erroneous idea and to identify more humane and effective ways of helping this population.

"Even though there are a few psychologists in the prison system, their attitudes and behavior are not conducive to therapy because they act as CO's. And so, you can see the conflict of interest, a CO's primary duty in prison is safety and security, they drill that into you, safety and security, safety and security. Whereas a medical professional, your main priority is the benefit of that individual." [Male participant #10]

3. *Systemic and self-imposed barriers prevent the delivery of MHSAS.*

Study participants reported two different types of barriers to receiving MHSAS: the first was institutional policy concerning how the current mental health professionals (MHP) who work in the CJS are used by the different administrative bodies (judges, wardens, parole boards) to gather information which negatively impact the inmate. It may be that their private conversations are used to give them higher security levels, or they are deemed un-eligible for parole in response to their self-proffered mental conditions. Due to the widespread knowledge of how this works, most inmates stay clear of the MHP's who work in the system because their experiences with them are quite negative. The second barrier to MHSAS discussed by the formerly incarcerated were the self-imposed barriers due to fear of gang retaliation or personal stigma:

“The only time I would see a psych would be when I was preparing to go to board. And they are required to have you see a psych like six months before we go to board. And, and it was more like, they were trying to determine how they can keep me in there longer or keep us in there longer. You know, I mean, just looking at my past on file, I was extremely violent. You know, they said I had antisocial personality. They would say I was a psychopath or sociopath because I can do the violence and not feel any way. They never asked how I got to that point or what happened.”

[Male participant #1]

“No, to be honest with you, they would utilize anything I said, to go towards my case. So instead of them helping me if I said I was angry, or

these are the feelings I may have had, or this and that, they contributed that to be as far as like, would I continue to offend and, you know, this is what he's capable of; it wasn't anything on how we can get him therapy, how we can help, it was more so- I suggest he's placed on house arrest or this and that, so it was never like, giving me a therapist or what route we can take to help him. It was more so how can we create another case?

[Male Participant #4]

“What you see is like, depending on what gang you ran, like when you go to prison, they pretty much tell you if you're a Hispanic, you're a northerner, or you're a southerner, some guys go in the brothers [Blacks] go in your BGF, 415, your Blood, your Crip. And like the whites, they go in whatever they do, right? And then you go in, they tell you, you can't go get medication. We don't talk to psych's. Like, if you do, you could be removed. And the worst thing to do is to lose your protection in prison.”

[Male participant #2]

4. If MHSAS were available on a continuum, they would be utilized by the currently and formerly incarcerated.

Every single participant responded in the affirmative—two with conditions- - when asked if the justice-impacted population would use and benefit from MHSAS if made available on a continuum. One participant explained that even if they failed to use the MHSAS in the beginning of their sentence, eventually they would get around to it because self-reflection and desire for improvement is a

natural occurrence in prison. This was an important statement because it emphasizes the need for these services on a continuum. The two participants who responded 'yes' conditionally proposed that 1- for the prison politics to change, more confidentiality is needed from the mental health professionals in the CJS, and 2- the mental health stigma must be addressed:

“Absolutely. I think that if the continuum of care would have been in place when I first went in, even though I was reluctant to accept help, I think that if it would have been in place it would have continually given me the option to do this. Based on my experience, once I got out, you know, all I would have to do is look back and say, they told me this was going to happen. And it did. You know, even if it did happen, I would still at least have that little bit of information that says, somebody told you don't do this.” [Male participant #3]

“You know, so that's a great proposal to make, you know, for mental health care to start when you first go in and continue while you're in-- and even when you're out-- because like I said, a person can go in mentally sane and come out with mental disorders. You know, people get hooked on drugs in there, and they lose their mind.” [Female participant #5]

“Definitely! because I would have been able to express the emotions and just the thoughts I was having. And somebody who, you know, is professional, and just even being able to provide me clinical help, would have been able to understand and be able to tie some of these behaviors

and some of these actions and even the issues that I've had with authority, and just even lack of a father figure out the house, there have been a lot of things that I'd have been able to, they could have unraveled for me. I just know that there was areas of my life, that my emotions were only going through one filter, and it was violence, it was anger, but in all reality, I was sad, I was hurt, you know, I was all of these things. But I didn't even know how to express it." [Male participant #4]

CHAPTER FIVE

DISCUSSION

The objective of this study was to examine a novel way to reduce recidivism in the CJS by treating some underlying causes of criminal offense and re-offense. The underlying causes focused on in this study were trauma and substance abuse. The connection between trauma, substance abuse and recidivism has been studied extensively so it was important for this study to tie together those studies with an original proposition to make MHSAS available on a CoC model for the entire CJS population in order to treat some underlying causes of recidivism. This study is significant because California is under a Supreme Court mandate to drastically reduce their prison population which will prove to be impossible without also reducing the recidivism rate.

The first theme drawn out from this study was ‘emotional pain from trauma was a catalyst for substance abuse and repeated criminal acts.’ All of the formerly incarcerated participants of this study were victims of trauma; these findings mirror prior research, which found that trauma was experienced by the vast majority (65%) of the justice-impacted population (Stensrud et al., 2019). The present study also found that in most participant incarceration cases, trauma was a direct catalyst to substance abuse. This also confirms earlier studies which reported three out of four inmates presented with traits that met the criteria for substance dependence and abuse (Carlson et al., 2010). So, in this study and in earlier research, trauma and substance abuse were frequent issues amongst the

currently and formerly incarcerated. From the various discussions around trauma, substance abuse and repeated criminal offenses, the first theme which emerged for the researcher made clear that the trauma in participants caused such emotional pain that it was a natural impulse to seek relief via substances which in most cases led to criminal acts and sometimes repeatedly.

The second theme highlighted the perspectives of the professionals who are providing the currently and formerly incarcerated different services such as housing, job training and placement, MHSAS, and case management. Using a trauma informed approach—intentionally or otherwise—these service providers could see that their focus had to be on the rehabilitation of their consumers and not on punishment as is reflected in the policies and actions of the CJS. This group of stakeholders also realized that this population responds well to the values inherent in rehabilitation such as believing in their potential, seeing past their worst act, giving them the skills needed to thrive and not just survive, and even advocating on their behalf with the state legislature in Sacramento. They believe that the CJS is wasting an enormous amount of time and valuable resources—including human resources—by focusing on punishment instead of rehabilitation. They also believe that if the CJS were to shift their focus to rehabilitating their populations, they would naturally understand and implement MHSAS due to its massive need. Thus, the second theme, ‘The lack of MHSAS is directly connected to the emphasis of punishment in the CJS instead of rehabilitation.’

Another finding of this study that parallels earlier work is that MHSAS are rare amongst the justice-impacted: Petersilia & Snyder (2013) reported that less than 10% of the justice-impacted received MHSAS and this study discovered a very similar low figure (13%) which received MHSAS while in custody. The reasons given by participants for the low rates of MHSAS in the CJS revolve around two types of barriers: structural and personal. The structural barriers have to do with certain policies that emphasize MHP's in the CJS act similar to guards who are forced to report to different authorities (judges, wardens, parole boards, prosecutors) the secrets inmates disclose in private sessions. This creates an atmosphere of distrust between the MHP's and their possible clients and results in the inmates rejection of any possible cooperation to receive effective interventions. The second barrier which is personal and self-imposed by inmates has to do with the prevalence of mental health stigma in poorer vulnerable communities which are overrepresented in the CJS. Frequently, the purpose of therapy is misunderstood, mental disorders are neglected, and as a result, many suffer in silence. Nevertheless, both barriers come together to give life to the third theme of the study which is 'systemic and self-imposed barriers prevent the delivery of MHSAS.'

Finally, the last theme extracted from the interviews was 'If MHSAS were available on a continuum, they would be utilized by the currently and formerly incarcerated' and there was no difference of opinion concerning this idea amongst the interviewees. When the formerly incarcerated were asked the

question concerning a CoC model across the CJS, they unanimously responded in the affirmative even though their reasonings were different. A few interviewees mentioned that after some time in prison, reluctance and resistance to self-improvement wears off and then you would have an established resource to receive help. Others mentioned that processing their pain with a professional could possibly have made the difference between their freedom and incarceration. The reentry service providers were also supportive of the CoC model in the CJC but several had certain conditions: 1) that those receiving MHSAS are not forced to segregate from general population which is the current policy and contributes to stigmatization; and 2) that MHSAS are not forced on the population; 3- that the MHP's delivering the services are not prison staff which forces them into a position of divulging the private files of the inmates to adversarial administrative bodies.

Implications of Findings for Theories, Research, Social Work and Stakeholders

Implications of Findings for Theories

The two theories used as a basis for this study were 1- a continuum of care model and 2- trauma informed approach to care. These theories proved to be essential to this research in several ways: the CoC model which was proposed in this study was understood by all the stakeholders as a critical missing element in their experience of the CJS. In other words, every single study participant understood from different points of view that a CoC model in the

CJS could possibly reduce recidivism by personal example or client cases.

Another argument in favor of using this model in the CJS is that it was also used in prior forensic studies and the findings were positive in reducing recidivism. This study adds support to the comprehensive efficacy of the CoC model, and extends its use from the medical field into the forensic field.

As for the trauma-informed care, this study is in line with prior research which has confirmed that trauma is a factor in many criminal offenses and any solution to reduce offenders re-offending needs to include an assessment and treatment process which addresses the underlying traumatic causes. In this case, a trauma-informed assessment and intervention also effectively applies itself into the forensic field in tandem with the CoC model.

Implications of Findings for Research

This study investigated preliminary perspectives and viewpoints of the need for implementing MHSAS across the CJS in California. As this was an initial inquiry, there remain other avenues of research open to future exploration of this project and include but not limited to: costs associated with implementing this project, how laws could facilitate its implementation, policies which need to be developed within the CJS to ensure its proper development and success, and finally explore how prison/jail guards and MHP's can work together for the rehabilitation of inmates instead of their deprivation.

Although convergent with previous research in the areas of trauma, substance abuse and recidivism, this study sharply diverges from all other

studies, at least on one major point: the investigating of key stakeholders' perspectives around three major challenges faced in the California CJS and ways through which to overcome them. In so doing, this study contributes to the literature.

By focusing on California where the prison population still 5% over capacity (California Department of Corrections, 2021), the findings in this study have significance. Following a 2011 State Supreme Court decision that mandates to address prison overcrowding, many studies have elucidated the California recidivism problem—meaning offender arrest-release-arrest—which drives up the prison population. However, to the researcher's knowledge, the existing literature contains no studies that explore the link between mental health, substance use, and recidivism in California through a CoC model. Hence, the significance of the study for research.

Implications for Social Work Practice

The essence of Social Work is to assist the most vulnerable populations. In that spirit, this study re-visits the conditions of a well-documented vulnerable population which for many different reasons have been neglected in the MHSAS realm. As this and other studies have found, the justice-impacted are not receiving what they and their service providers have identified as primary to their success and rehabilitation. Hence, a position implied in this study is that social work practitioners have an opportunity to learn and implement trauma-informed MHSAS and work toward lowering the recidivism rate, which is prohibiting the

actualization of potential in this vulnerable population. Another point is to learn and implement a comprehensive, systematic method (like CoC) of delivering MHSAS to the justice-impacted community.

Implications for Social Work Education

Taking this study's model of trauma-informed CoC from a theoretical level to developed policies to actual implementation would require research and educational initiatives to realize the project as conceived. Social Work education would be indispensable to bring the project to fruition. At the macro level, there would be a need for curricula, syllabi, and literature to educate and train the next generation of social workers to address the problems researched in this study and the greater issue of mass incarceration. There is also the need to develop a method of addressing MHSAS stigma amongst the justice-impacted. At the micro level, social workers would be the front line in assessment and treatment and their experiences would further enrich the learning in this field.

Implications for Criminal Justice Stakeholders

This study sets out clear markers for the different stakeholder to follow up on while continuing to serve and advocate for the justice-impacted population. MHP's could use this data to take initiative and use trauma-informed care with the currently and formerly incarcerated. Directors of programs which service this population could further the project by collecting more data on the necessity for trauma-informed care and gather testimony from the justice-impacted for the necessity of the CoC model. Civil rights advocates—especially those working

against mass incarceration—could use this data to advocate for the implementation of more robust MHSAS on legal grounds.

After all, the phenomenon of recidivism in America is high, with a 43% national average rate. With a 62% rate, the State of California has the highest state recidivism rate in the country (Lofstrom et al., 2014). These percentages take enormous financial and social costs in a country with 2.3 million people currently incarcerated and 9 million people released every year (Janetta et al., 2011). Recidivism harms communities because of recurring crimes, and places enormous financial burdens on local governments who must constantly re-arrest the formerly incarcerated. There are other non-quantifiable costs like harm to victims, families, neighborhood fear and community strain due to support needed from the incarcerated repeat offender or their families who are forced to request different types of assistance from local social services. But Janetta et al. (2011) pointed out in a study that recidivism does not exist in a void. There are systemic issues that are usually prevalent in the offender's community and in many cases are the underlying causes of arrest, mainly mental health issues stemming from untreated trauma, and substance abuse. The findings in this study can be used toward addressing the intersectional matrix of mental health, substance use, and recidivism.

Limitations and Recommendations for Future Research

This study contains several limitations, including small sample size, location, and research methodology. In fact, the study sample consisted of only 10 participants. While relatively decent, this sample size limits the scope of applicability of the findings in this study. As for location, all 10 study participants resided in Southern California. Hence, the findings in this study only reflect the Golden State. In terms of methodology, the qualitative design under which this study was conducted is vulnerable to biases, mainly confirmation bias and desirability bias. There is no evidence, though, that biases occurred over the course of this study. Knowing that biases can negatively affect the validity of the findings, the researcher made every effort to limit them during the interviews.

Future research should target larger samples and participants that are more diverse. Most of the participants in this study sample were people who spent many years in prison. Future research should seek out the experiences of recidivists who only had short stays in jail, work camps, and were released on probation after being charged with an offense. Subsequent studies should also include more women for a more balanced approach toward understanding the relationship between the three concepts/variables discussed in research. Furthermore, the recruitment of prison employees, lawmakers, and policy analysts would increase the breadth and scope of future research studies.

Conclusion

The objective of this study was to investigate the possibility of reducing recidivism using a trauma informed Continuum of Care model of mental health and substance abuse services throughout the California Justice System. The basis of the study was that recidivism has several primary underlying causes which include trauma and substance abuse and if they are treated systematically, the recidivism rate in California will drop saving the taxpayers money and actualizing potential of the currently and formerly incarcerated. The study included several CJS stakeholders such as the formerly incarcerated and those who provide them reentry and mental health services. The results suggest that the justice impacted population would undeniably benefit from the proposed model and thereby reduce recidivism.

Despite its noted methodological limitations, this study is significant by tapping into the experiences of a group of CJS stakeholders and explores a possible new solution to the pernicious problem of recidivism. This study will be useful within the existing literature on recidivism and the CJS while also providing an original way forward for future researchers who tackle the problem of trauma, substance abuse and recidivism in California.

APPENDIX A
INTERVIEW QUESTIONS

Interview Questions for the Formerly Incarcerated

Did you experience a traumatic event pre prison?

The point of this and similar questions is to compare our results with earlier studies as to the frequency of traumatic events amongst the formerly incarcerated. Traumatic events will be defined as life-threatening or causing physical/sexual harm.

If yes to above, did you ever receive therapy/counseling for that event?

This question is designed to measure the amount of interaction formerly incarcerated persons have with mental health specialists pre-prison.

Were you ever diagnosed with a mental health disorder before having any police contact?

Can you connect your trauma event (if yes to first question) to any type of substance abuse?

This question is designed to trace the trajectory between trauma and substance abuse in formerly incarcerated persons.

Ex. emotional pain which led to antisocial behavior including substance abuse?

Ex. emotional pain which led to association with people who were had substance abuse problems?

Ex. people who may have offered you quick fixes (substances) to your pain?

Ex. trauma and pain which broke down social supports? interference with schooling because of trauma and/or substance abuse?

Can you connect your trauma and/or substance abuse to a criminal arrest?

This question is about the relationship between untreated trauma and police contact. In other words, a person may have anger issues which led to violence; or substance abuse which led to theft and or breaking and entering; substance abuse which has led to domestic violence and or assault, etc.

After your initial arrest, did you see any mental health or substance abuse profession in the institution? If so, when?

During booking? After the bail hearing? When requested, etc. This question is about the availability of mental health and substance abuse services as soon as a person encounters the criminal justice system. We are trying to reduce recidivism, which actually begins at this point: as soon as a person comes in contact with the criminal justice system.

If you had a chance to speak to a mental health or substance abuse professional at this point of arrest would you have done so? Why or why not?

This question is concerning the stigma of mental health and substance abuse problems and if given the chance would a formerly incarcerated person have sought out the services-- if they were available.

After your initial incarceration, did you ever see a mental health or substance abuse professional? If so, how were you referred to them?

This question is about community access to services and if the criminal justice system is actively trying to help those in their custody/ or prior custody to receive necessary services.

After completing your time in prison, did you have access to mental health and substance abuse services? If so, did you use them? Why or why not?

This question is seeking out the attitudes, stigma, and willingness of the formerly incarcerated to use the above-mentioned services if given a chance.

If rearrested, --even several times-- was there a connection between any past trauma, diagnosis, substance abuse and the subsequent arrests?

This question is attempting to understand and document the connections between pre prison trauma, mental health diagnosis, substance abuse and recidivism.

If there were a continuum of care model in place, would you have benefited from it? How? Why or why not?

Questions for Mental Health and Substance Abuse Specialists

Overall, how do you view the mental health of the formerly incarcerated? Are they in need of mental health?

Are they informed as to what mental health and substance abuse services are? Do they have a resistance to it?

Do they speak about pre-prison trauma? In-prison, post prison trauma? Connections of their trauma to substance abuse?

Did the formerly incarcerated speak about in-prison mental health and substance abuse services? Whether they use them or not?

Do you see a need for more mental health and substance abuse services in the community-based organizations?

Do you think the formerly incarcerated could benefit from a continuum-of-care model?

Questions for the Reentry Service Directors

Do you have mental health and or substance abuse services as a part of your programming? Why or why not?

Do you think these types of services are needed?

Do you think those services that are an adequate number of those services available? Why or why not?

Do your clients think that these services are needed? Have they requested them?

Do you think your clients understand the importance of these services? What more do you think can be done to highlight the importance of these services?

In your opinion? Would a continuum of care model benefit your clients/consumers?

APPENDIX B
IRB APPROVAL LETTER

December 18, 2020

CSUSB INSTITUTIONAL REVIEW BOARD

Administrative/Exempt Review Determination

Status: Determined Exempt

IRB-FY2021-119

Rigaud Joseph, Tabari Zahir
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Rigaud Joseph & Tabari Zahir:

Your application to use human subjects, titled “Mental Health, Substance Use, and Recidivism: Perceptions of Key Justice System Stakeholders in Southern California” has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at <https://www.csusb.edu/academic-research>.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-119 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
CSUSB Institutional Review Board

APPENDIX C
INFORMED CONSENT FORM

INFORMED CONSENT

The study in which you are asked to participate is designed to examine the need for systematic mental health and substance abuse services across the California criminal justice system to reduce recidivism. The study is being conducted by Tabari Zahir, a graduate student, under the supervision of Dr. Rigaud Joseph, assistant professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of your study is to explore the perceptions of key justice system stakeholders in California on the juncture of recidivism and mental health/substance use. The ultimate goal is to reduce recidivism linked to a lack of continuum of care in the justice system.

DESCRIPTION: Participants will be asked about experienced trauma, substance abuse and how the two intersected with their criminal charges. They will also be asked about the availability of mental health and substance abuse services pre-prison, in-prison, and post-prison.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported in group form only.

DURATION: It will take approximately 1.5 hours to complete the interview.

RISKS: Due to the questions around past traumatic experiences, there is a chance that participants may experience some discomfort and/or adverse feelings to the questions. You are not required to answer and may skip the question or end your participation. Should you feel any such discomfort or adverse feelings associated with participating this study, the researchers encourage you to access your usual source of care for help, or call 211 for information on helpful mental health resources in your community.

BENEFITS: There will not be any direct benefits to the participants. However, findings from the study will contribute to our knowledge in this area of research.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Rigaud Joseph at (909) 537-5507.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu>) at California State University, San Bernardino after July 2021

I agree to have this video and audio recorded _____ Yes _____ No

I understand that I must be 18 years of age or older to participate in your study, have read and understood the consent document, and agree to participate in your study.

Place an X here

Date

APPENDIX D
DEBRIEFING STATEMENT

Study of Reducing Recidivism Using Mental Health Services

Debriefing Statement

This study that you have just completed was designed to assess the need for mental health and substance abuse services amongst the formerly incarcerated in order to reduce recidivism. It is hoped that this study will provide the groundwork for further studies and research which will eventually establish a robust mental health process within the criminal justice system.

Due to the nature of this study, which enquires into your past traumatic experiences, you may have adverse thoughts and feelings which may require a therapist. If you feel that you need to talk to a therapist, please contact Dr. Armando Barragan at: 909.537.3501 or abarragan@csusb.edu

Thank you for your participation in this study, and for not discussing the contents of this interview with other members as they may be asked to participate in the same study at a later date.

If you have any questions about this study, or wish to withdraw your data from the study, please contact Dr. Armando Barragan at: 909.537.3501 or abarragan@csusb.edu

Thank you for your participation!

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