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Continuity of Care for Adult Offenders with Severe and Persistent Mental Illnesses: An Action Research Study

LaKeshia C. Gonzalez
Walden University

Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

LaKeshia C. Gonzalez, LCSW

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Debra Wilson, Committee Chairperson, Social Work Faculty
Dr. Debora Rice, Committee Member, Social Work Faculty
Dr. Cynthia Davis, University Reviewer, Social Work Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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by

LaKeshia C. Gonzalez, LCSW

MSW, University of Central Florida, 2014

BS, University of Central Florida, 2011

Project Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

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Abstract

For decades, the representation of adults with severe and persistent mental illnesses (SPMI) in the criminal justice system has steadily grown despite public recognition and increased federal implementation of mental health courts and diversion programs. Though more is known about risk factors associated with psychiatric and criminal recidivism among this population, a gap in the literature remains on collaborative interventions and continuity of care between inpatient mental health and criminal justice facilities. Grounded in resilience theory, the purpose of this qualitative study was to examine challenges social workers faced when attempting to facilitate discharge planning between inpatient mental health facilities and correctional institutions, as well as explored social work practice considerations to ensure continuity of care. A purposeful sample of ten social workers who were familiar with working in Georgia's inpatient hospitals with adult offenders experiencing SPMI were interviewed in two focus groups. Data were collected and analyzed using thematic analysis and constant comparison. Findings revealed that social workers often faced challenges with regard to community resources, basic needs, judicial and political concerns, stigma, criminal charges, and forensic status. Some strategies suggested to mitigate discharge planning concerns included building community rapport, improving collaboration, eliciting multidisciplinary input, ensuring accountability, psychoeducation, strengthening empowerment, and advocacy. The results of this study can be used to influence positive social change by encouraging collaborative efforts to strengthen services and engagement in advocacy regarding social policies and discharge planning processes impacting adult offenders with SPMI.

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Dedication

I want to dedicate this to my family, that handful of close friends who I consider family, and those educators and mentors along the way who have been involved in my personal, professional, and academic journey through encouragement and inspiration. Thank you for being there for me in person or in spirit, for your guidance, for your words of kindness and encouragement, wisdom, and motivation, for your understanding, for your faith, your confidence in my abilities, and for your foresight in knowing that I can achieve anything I set my mind and heart out to do, despite the obstacles that come my way. Without that, I might not have always maintained the immense level of moxie or prowess I needed to see this accomplishment through. Each of you have played a pivotal role, whether big or small. For you, I am grateful.

Most importantly, I dedicate this to my handsome son who graced us with his presence during the thick of this journey. Son, you are and will forever be my motivation and driving force behind all that I do. Thank you for your sacrifice and being my ray of light on this voyage. Mommy loves you with every ounce of my being!

Acknowledgments

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To the research participants, this study could not have been possible without your contributions. You all are the very definition of "change agents," and for that, I thank you!

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Section 1: Foundation of the Study and Literature Review

Introduction

For decades adult offenders experiencing symptoms of and/or diagnosed with severe and persistent mental illnesses (SPMI) have been disproportionately represented among the criminal justice continuum, from encounters with law enforcement, arrests, incarcerations, and convictions to community reentry after being released from correctional facilities (Barrenger & Canada, 2014; Brandt, 2012; Calhoun, 2018; Davis et al., 2008; Gonzalez, 2018; Thompson et al., 2016; Vogel et al., 2014; West et al., 2015). Because of the criminalization of mental illness, deinstitutionalization, psychosocial influences, and criminogenic behaviors associated with mental illness (Brandt, 2012; Calhoun, 2018; Lurigio, 2011), this population must overcome numerous issues related to community reintegration (Barrenger & Canada, 2014; Davis et al., 2008; Gonzalez, 2018; Thompson et al., 2016; Vogel et al., 2014). One of the most prominent barriers is continuity of care between inpatient mental health facilities and criminal justice settings (i.e., correctional facilities) (Martin-Ayers, 2016; Vogel et al., 2014). A lack of resources and continued outpatient treatment can create a barrier to recovery, possible clinical decompensation, and an increased risk of psychiatric recidivism (Martin-Ayers, 2016; Vogel et al., 2014). This vulnerable population thus demonstrates the basic need for services to improve community reintegration and reduce rehospitalization (Davis et al., 2008; Martin-Ayers, 2016; Thompson et al., 2016).

Scholars are working to identify the underlying issues associated with the treatment of individuals diagnosed with SPMI in the criminal justice system as well as

the reduction of recidivism both criminal and psychiatric (Martin-Ayers, 2016). Nevertheless, there remains a gap in the dialogue concerning collaborative interventions and functional strategies to facilitate successful transitions between inpatient psychiatric hospitals and correctional facilities (i.e., jails and prisons). This discussion presents necessary to foster a successful community reintegration and psychosocial recovery, resulting in the reduction of psychiatric recidivism (Martin-Ayers, 2016). It is therefore essential that focus is applied to factors related to continuity of care and the challenges faced by social workers in facilitating such processes.

The upcoming section will be broken down into multiple components, providing a foundational perspective from which to guide the action research study. It will begin with a statement of the problem, followed by an introduction to the purpose of the study, research questions, and critical concepts to be operationally defined. The section will then go on to incorporate a brief discussion of the nature of the research project and highlight the significance of the study. Through this emphasis, the contribution the study outcomes will have on the advancement of social work practice knowledge, its importance for the field of social work, and the implications it will have on positive social change will be evident. It will also address the conceptual and theoretical underpinnings driving the study. Moreover, this section will offer an analysis of how social work ethics and values relate to the clinical context of the social problem, as well as guide the purpose of the action research study and social work practice relative to the area of practice and social issue. The section will conclude with a review of the literature relating to the historical

context and origin of the practice problem, social policies and systemic influences, cultural barriers, and service needs of the client population.

Problem Statement

When conducting research, it is important to first examine the social problem impacting the vulnerable population. Despite public recognition and increased federal implementation of mental health courts and diversion programs, the U.S. criminal justice system continues to receive and detain an immense number of individuals experiencing SPMI (Davis et al., 2008; Martin-Ayers, 2016; Vogel et al., 2014). This overrepresentation has been a trend that has steadily increased since the 1980s (Barrenger & Canada, 2014; Martin-Ayers, 2016; Vogel et al., 2014). Though overall prevalence rates vary across sources, approximately 20% to 21% of the forensic population are comprised of adult offenders meeting the diagnostic threshold of mental health disorders highlighted in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013; Gonzalez, 2018; Vogel et al., 2014). To further put this prevalence into perspective, the general population of individuals diagnosed with SPMI is around or about 4% of the total U.S. population (Barrenger & Canada, 2014; Brandt, 2012; Gonzalez, 2018). The most prevalent mental health concerns experienced by adult offenders in the forensic population are schizophrenia, bipolar disorder, major depressive disorder, and anxiety disorders (Brandt, 2012; Calhoun, 2018). With current prevalence rates of mental health disorders in adult forensic population, the need for consideration of mental health care is apparent.

It is suggested that there are predominantly fewer adults with SPMI undergoing mental health care in community mental health environments than there are incarcerated in correctional facilities (Gonzalez, 2018; Maschi et al., 2009; Torrey et al., 2014; Vogel et al., 2014). The number of incarcerated adults with SPMI is more than roughly 10 times that of adults with similar mental health disorders residing in state psychiatric hospitals (Calhoun, 2018; Torrey et al., 2014). Many local jails and state prisons have become the de facto repository for adults with SPMI, despite being ill-equipped to provide effective and comprehensive mental health services, especially in rural and underserved areas (Brandt, 2012; Lurigio, 2011; Martin-Ayers, 2016; Prins, 2011; Vogel et al., 2014). For example, the same jails utilized to briefly house convicted individuals for a period of less than 1 year, as well as to accommodate individuals who have been arrested and potentially awaiting arraignment, trial, conviction, and sentencing, also hold people diagnosed with mental health disorders as they are pending transfer and admission into mental health facilities (Brandt, 2012). With the limited length of stay and nature of the facility, these correctional environments may lack needed resources and present time-restricted in their ability to tend to mental health issues (Brandt, 2012). It is therefore imperative to give thought to treatment-related concerns within these settings.

One drawback to provision of care is correctional facilities that offer mental health treatment to incarcerated individuals depend on the ability to administer psychotropic medication as the most common form of psychotherapeutic approaches (Brandt, 2012; Gonzalez, 2018; Vogel et al., 2014). As correctional staff are generally untrained to help clinically manage adult offenders with SPMI and may exclusively

assess, monitor, and perform crisis management practices, medication management is routinely amid the only psychiatric care obtained by this population in criminal justice settings, whereas the alternative is to be transferred to inpatient mental health facilities for stabilization (Brandt, 2012; Gonzalez, 2018; Vogel et al., 2014). Nonetheless, the deficits in warm handoffs and facilitation of community outpatient follow-up and aftercare present an issue that is often projected to stifle continued treatment and recovery (Gonzalez, 2018; Vogel et al., 2014). Consequentially, recidivism, either criminal or psychiatric, are marked and often indisputable issues that impact this population of adult offenders (Fazel & Wolf, 2015; Gonzalez, 2018; Maschi et al., 2009; Sfetcu et al., 2017; Thompson et al., 2016; Vogel et al., 2014).

In addition to the critical need to alleviate the risk of criminal and psychiatric recidivism, it is important for this vulnerable population to achieve a successful community reintegration (Barrenger & Canada, 2014; Davis et al., 2008; Gonzalez, 2018; Thompson et al., 2016). Yet the service gap between inpatient hospitals and correctional facilities is among the most marked social change concerns confronted by adult offenders experiencing SPMI. The lack of continuity of care is especially prominent for those who have encountered and been admitted to forensic units in mental health hospitals (Gonzalez, 2018; Vogel et al., 2014). It is suggested that the risk of criminal and psychiatric recidivism, obstacles to recovery, and resultant clinical decompensation are all symptomatic of an absence of integrated services and interagency collaboration (Fenge et al., 2014; Gonzalez, 2018; Vogel et al., 2014). Although researchers have set out to pinpoint risk factors and predictors associated with recidivism and have begun to

address said factors, a gap in literature still exists when discussing effective and collaborative interventions between criminal justice facilities, psychiatric hospitals, and community providers (Gonzalez, 2018). Additionally, there is also limited discussion regarding the processes and strategies that these entities might implement to improve and fortify psychosocial recovery, stimulate heightened resiliency, and mitigate psychiatric and criminal recidivism rates among adult offenders with SPMI (Gonzalez, 2018). The above understanding both offered direction for this study and aided in identifying favorable research strategies when framing the facilitation of continuity of care through discharge planning with adult offenders experiencing SPMI.

Purpose Statement and Research Questions

I aimed to explore the challenges faced by social workers as it relates to facilitating discharge planning and continuity of care between inpatient psychiatric hospitals and correctional facilities for adult offenders with SPMI, as well as identify effective ways to minimize rehospitalization. The study addressed the following practice-focused research questions:

- Research Question 1: What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with SPMI from inpatient psychiatric hospitals to criminal justice facilities?
- Research Question 2: From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?

Concepts and Operational Definitions

Key concepts central to this action research project include adult offenders, severe and persistent mental illness, inpatient psychiatric hospitalization, community reintegration, continuity of care, and recidivism/rehospitalization. These concepts are operationally defined as the following.

Adult offenders: Individuals 18 years of age and older who have been arrested and incarcerated or confined for criminal behavior. As a group, adult offenders make up the forensic population.

Severe and persistent mental illness (SPMI): Operationally defined utilizing the DSM-5 criteria for a collection of mental health diagnoses included in the categories of schizophrenia spectrum and other psychotic disorders, bipolar, depressive disorders, obsessive-compulsive, and related disorders excluding substance-related disorders, neurodevelopmental disorders, social concerns and anxiety disorders, or medical-related disorders, and by an extended period of marked impairment or limitation in functioning either intermittently or continuously (APA, 2013).

Inpatient psychiatric hospitalization: An admission into a 24-hour mental health facility/hospital in which a patient resides for at least one night to receive needed mental health care. Throughout this literature, the terms “psychiatric” and “mental health” are used interchangeably when referencing inpatient hospitals/facilities.

Community reintegration: The process of integrating an individual from inpatient psychiatric hospitalization or incarceration back into the community in which they are a member.

Continuity of care: The progression and maintenance of constant mental health care and services between treatment environments such as inpatient psychiatric hospitals, criminal justice facilities, and community (mental health) providers.

Recidivism/Rehospitalization: For this research study, recidivism is divided into the identification of two distinct constructs, psychiatric and criminal. Psychiatric recidivism will be operationally defined as one or more readmissions into mental health treatment settings as a result of clinical decompensation or a relapse (Gonzalez, 2018; Sfetcu et al., 2017). The concept of psychiatric recidivism will be used synonymously and interchangeably with the terms rehospitalization or recurring hospitalization, for this research study. Conversely, criminal recidivism will be defined as the continuous or intermittent recurrence of criminal acts resulting in rearrests, reindictment, resentencing, or reincarceration (Fazel & Wolf, 2015; Gonzalez, 2018).

Nature of the Doctoral Project

I utilized an action research design with a qualitative component when conducting this research study. An exploratory and systemic approach to inquiry and participatory engagement, action research is brought about through the awareness and identification of service gaps and social change issues faced by populations and communities of vested interest (Gonzalez, 2017; Stringer, 2007). Action research cultivates inclusivity, solution-focused thinking, participant and community empowerment, and positive movement toward reaching valuable solutions to distinct social problems, through its participatory process and collaborative exploration (Gonzalez, 2017; Stringer, 2007). Much of the fundamental principles of action research are derived from the framework of qualitative

research (Gonzalez, 2017; McNiff, 2016; Stringer, 2007). The objective of action research is to seek clarity on a social issue through the viewpoints of the community. This collaborative approach enables stakeholders or participants to arrive at a more complex and sounder understanding of the particular problem, thereby piloting the resolution of social issues and eliciting social change efforts amongst communities motivated and committed to resolving those challenges (Gonzalez, 2017; McNiff, 2016; Stringer, 2007). With respect to these functions, the action research and qualitative approaches applied in this study were implemented to assist in exciting critical dialogue and establishing a foundation from which to mobilize change.

Through the exploratory nature of action research, I sought to identify the overarching and interrelated social work practice issues and factors associated with or impeding upon the continued provision of care for adult offenders with SPMI between inpatient mental health and correctional facilities. As a result of identifying these challenges, social workers and community practitioners will then be able to make informed decisions and implement action steps toward addressing and improving social work practice, interagency collaboration, continuity of care, and community reintegration for adult offenders impacted by this social issue. In doing so, this may reduce psychiatric and criminal recidivism among adult offenders with SPMI.

The principal data sources that informed this research study were two focus groups conducted with social workers. The participant sample was comprised of social work practitioners who are working or have worked directly with adult offenders coping with SPMI and have played a critical role in their discharge planning from inpatient

mental health facilities to correctional institutions. Structured interviews in a focus group setting allowed for the gathering of data and gaining of increased insight into social work practice issues impacting the social workers and the client population, as well as their perception of those issues (Stringer, 2007). Both the questions and their resulting answers aided in laying the foundation and setting the stage for the research process. Furthermore, it offered the ability to establish a framework from which to proceed. A small sample size of 10 social workers across both focus groups, five social workers per group, was used to strengthen communication amongst participants (Stringer, 2007). This sample size allowed for a smaller and more comfortable forum in which the participants shared and collaborated openly. Moreover, it fostered the opportunity to obtain a representative sample and depiction of the inherent problems impacting the continuity of care and reintegration of adult offenders with SPMI, from the perspective of social workers (Stringer, 2007).

When conducting action research, an important part of the investigation process includes the interpretation and analysis of information obtained from research participants (Stringer, 2007). A thorough examination is essential in identifying common themes in participant responses and discussion. Data were collected via audio recording on Zoom, a secure video and teleconferencing platform. Research data were subsequently analyzed through manual coding utilizing NVivo, a data organization and analyzing program. As a result, I was able to identify contextual themes, trends, content, and patterns. By categorizing key concepts, it helped clarify the essence of the problem impacting the stakeholders, as well as offered the identification of associated and

underlying issues (Stringer, 2007). Employing an action research methodology, I sought to develop knowledge and insight into the challenges social workers encounter when coordinating discharge planning with adult offenders with SPMI receiving inpatient mental health care and transitioning back to correctional facilities. Moreover, through collaboration, I aimed to identify practices, procedures, services, and strategies to aid in ensuring continuity of care.

Significance of the Study

An action research design was not only applied as a mechanism for examining the social problem, expanding knowledge and understanding, increasing insight, and mobilizing social change but also to highlight the significance of the study. To ensure successful mental health recovery and prevention of criminal and psychiatric recidivism, continuity of care is paramount for individuals experiencing SPMI, proceeding a period of incarceration or forensic hospitalization (Dieleman, 2014; Maschi et al., 2009). The study findings will aid in identifying mechanisms in which to help an agency minimize rehospitalizations. Moreover, from a social work perspective, the study findings will contribute to the overall knowledge base of the field by offering insight into the challenges social workers face when facilitating community reintegration and continuity of care for adult offenders with SPMI between inpatient psychiatric hospitals and correctional facilities. Furthermore, the knowledge obtained may then aid in the mobilization of social change. In doing so, the study will assist in bridging the gap between state-run mental health facilities and correctional institutions, thus improving

reentry processes while preventing a lapse in continuity of care and consequential decompensation (Thompson et al., 2016; Vogel et al., 2014).

Theoretical and Conceptual Framework

When addressing the challenges encountered by social workers while transferring responsibility of care between inpatient psychiatric hospitals and correctional facilities to enable community reintegration, I employed the theoretical perspective of resilience theory. Resilience theory supports the consideration of protective factors and their impact on enhancing resilience. This theoretical underpinning rendered a structure from which to develop and direct the action research study (Creswell, 2013; Gonzalez, 2018). Likewise, it aided in the emergence, expansion, and management of research questions. Furthermore, it offered a foundation for data collection processes and procedures (Creswell, 2013; Gonzalez, 2018).

Resilience Theory

The underlining premise of resilience theory asserts that vulnerability, risk, and protective factors shape resiliency (Bolton et al., 2017; Gonzalez, 2018; Maring et al., 2012). With the improved capacity to gain an accurate understanding of what supports positive functioning among individuals, within the context of adversity and social disadvantage, the acquired awareness can be incorporated into more developed and functional practice approaches (Bolton et al., 2017). Accordingly, the concept of thriving in lieu of purely surviving influences the resilience theory (Bolton et al., 2017; Gonzalez, 2018). Moreover, resilience theory offers a conceptual framework for understanding and

studying the forensic population coping with SPMI utilizing a strengths-based approach (Bolton et al., 2017; Gonzalez, 2018; Zimmerman, 2013).

Resilience theory also provides a foundation to examine developmental, psychosocial, and environmental factors influencing recidivism as well as inform intervention strategies and social work practice provision (Bolton et al., 2017; Gonzalez, 2018; Zimmerman, 2013). Though some populations may be vulnerable to particular risks because of their social identities, resilience theory provides structure and a premise that helps shape the provision of interventions and services (Bolton et al., 2017; Bottrell, 2009; Gonzalez, 2018). These practice provisions, as a result, will then strengthen resilience factors while absorbing the impact of adversity and disadvantage (Bolton et al., 2017; Bottrell, 2009; Gonzalez, 2018). Amid the theoretical underpinnings related to the theory, there is the potential for the absence of available environmental resources to unfavorably impact resilience (Green et al., 2003; Gonzalez, 2018). The implementation of resilience theory will furnish an integrated and comprehensive foundation and structure from which to promote discussion of challenges and barriers to social work practice (Gonzalez, 2018). Furthermore, it may generate dialogue regarding practical strategies to address such problem issues as continuity of care and recidivism amidst adult offenders with SPMI (Bolton et al., 2017; Gonzalez, 2018). When examining such factors, it is essential to consider associated values and ethics.

Values and Ethics

The acknowledgement of ethical practice is among the fundamental components of social work. Facilitating social change while promoting and cultivating social justice

for the greater good of individuals, groups, and populations is the chief intent of social work practice (National Association of Social Workers [NASW], 2021). In doing so, particular focus is dedicated to the empowerment and psychosocial needs of the socially oppressed, vulnerable, and marginalized (NASW, 2021). When enacting such social change efforts, it is vital for social workers to consider and adhere to the core values and ethics of the profession (NASW, 2021). Action research embodies the social work profession and its foundation of core values and ethics, as it is not only guided and propelled by the recognition, exploration, and discussion of social issues and service gaps in client communities but stimulates solution-focused thinking and progression towards bringing about social change (Stringer, 2007).

The research practice problem that was studied was the challenges faced by social workers when facilitating continuity of care for adult offenders with SPMI when transitioning between inpatient psychiatric hospitals and correctional facilities. Of the values identified in the NASW (2021) code of ethics, those that are relevant to the discussed research study are “service” and “social justice,” respectively underlined by the ethical principle that “social workers’ primary goal is to help people in need and address social problems.” Service is a foundational concept as it relates to the importance of identifying service gaps and related practice challenges. In addition to the study highlighting the significance of carrying out the primary goal of social work, to help clients in need, it also underscores a social injustice relative to social work practice and client continuity of care.

The synthesis of social work practice and action research fosters the identification and exploration of interrelated and overarching factors or issues related to social problems impacting communities and populations, through the lens and guidance of social work values and code of ethics (Thiollent, 2011). Moreover, action research in social work or human services aligns with the NASW (2021) code of ethics, as research opens the doors to bring awareness to social issues impacting individuals, groups, populations, and communities on a micro, mezzo, and/or macro level. The NASW code of ethics suggests that social workers become catalysts for research that contributes to the knowledge base of the profession and can be utilized in practice to establish the use of effective, evidence-based interventions and services (NASW, 2021).

Review of the Professional and Academic Literature

Historical Context and Social Policy

For the research issue to be fundamentally understood, it is essential to explore its origin and sociopolitical underpinnings. Literature suggests that social paradigms and shifts in policies, with respect to criminal justice and social welfare, have been instrumental in the overrepresentation and disparate rate of recidivism among incarcerated adults diagnosed with SPMI and/or co-occurring substance use disorders (Barrenger & Canada, 2014; Martin-Ayers, 2016; Torrey et al., 2014). Research has cited such contributors as deinstitutionalization, strict drug enforcement laws, legal restrictions, police tactics, criminalization, and services gaps as influential in the disproportionate historical representation of adult offenders with mental health disorders involved in the criminal justice system (Brandt, 2012; Calhoun, 2018; Lurigio, 2011).

Transinstitutionalization, or the functional interdependence between the state psychiatric hospital and the criminal justice system, is a concept often associated with the topics of mental health and criminal justice (Barrenger & Canada, 2014). The current arrest rate of individuals coping with SPMI is better attributed to other matters such as increased rates of incarceration for drug offenses, an absence of funding to community resources, and a shortage of affordable and sustainable housing (Barrenger & Canada, 2014; Martin-Ayers, 2016). With adequate and appropriate wrap-around social and mental health services and supports in place, with consideration to the nature of their offenses, adult offenders coping with SPMI and/or co-occurring substance use disorders can be afforded the opportunity to succeed in community settings rather than impede upon their growth and recovery through reinstitutionalization (Martin-Ayers, 2016; Prins, 2011).

Criminal Justice and Social Policies

From a perspective of criminal justice and social policies, approaches like the War on Drugs, three-strike laws, police tactics, and stagnant social welfare policies have all been influential in the inflation of arrests, extended incarceration, and overrepresentation of individuals experiencing SPMI along the criminal justice continuum (Barrenger & Canada, 2014; Brandt, 2012; Martin-Ayers, 2016). Moreover, housing policies and social welfare policies such as social security disability income (SSDI), Medicare, and Medicaid were historically introduced to support the shift of treatment from state psychiatric hospitals to community-based facilities (Barrenger & Canada, 2014; Martin-Ayers, 2016). Despite the induction of such social policies, their

associated function and purpose have since diminished due to the decrease in funding, narrowing of benefit eligibility, and subsequent elimination of some social welfare programs (Barrenger & Canada, 2014; Martin-Ayers, 2016). Furthermore, in some states benefits such as supplemental security income (SSI) and Medicaid go into suspense after more than 30 days in a state institution such as a psychiatric hospital or correctional facility. The Social Security Administration (SSA) subsequently terminates benefits if admitted or detained for a prolonged period, typically beyond 12 months. Consequentially, this has the potential of having a significantly negative impact on the reintegration process and the ability to gain access to a variety of supports, resources, and services (Barrenger & Canada, 2014; Martin-Ayers, 2016).

Over recent years, initiatives have been taken by local, state, and federal policymakers to inaugurate and mobilize reentry and court-based diversion programs such as mental health court and grant funding programs under the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) and Second Chance Act of 2007 (Bureau of Justice Assistance, 2016; Lurigio, 2011; Martin-Ayers, 2016; Prins, 2011; Seltzer, 2005). These measures were established to address the social change issues of adult offenders with SPMI involved in the criminal justice continuum and astounding recidivism rates (Lurigio, 2011; Martin-Ayers, 2016; Prins, 2011; Seltzer, 2005). Though with reasonable intent, mental health court is suggested not to excite strong political forethought in addressing the source of the issue, resulting in the appraisal that it is structurally and fortuitously flawed (Martin-Ayers, 2016; Seltzer, 2005). Instead, mental health court demonstrates an attitude of acceptance regarding the differential involvement

and exposure of adults with SPMI to the criminal justice system (Seltzer, 2005). Moreover, the literature maintains that it merely applies a bandage to real and existing policy issues (Martin-Ayers, 2016; Seltzer, 2005). Additionally, there are demonstrated procedural shortcomings in that there must be an arrest for individuals to participate in such diversion programs (Seltzer, 2005). Furthermore, if an individual is non-compliant with mandated treatment, it is probable that they may be rearrested (Martin-Ayers, 2016; Seltzer, 2005). Despite policy enactments and the development of grant funding and diversion programs, in response to legislative and scholastic attention, social issues remain prominent in the lives of this fraction of the forensic population (Martin-Ayers, 2016; Prins, 2011; Prins, 2014).

Deinstitutionalization

Often one of the most cited factors for overrepresentation, deinstitutionalization is the process by which states began to close their mental health facilities triggering patients to be discharged from those psychiatric hospitals and into community-based mental health centers (Barrenger & Canada, 2014; Brandt, 2012; Calhoun, 2018; Lurigio, 2011; Prins, 2011; Torrey et al., 2014). The dissolving of these facilities was said to have been prompted by media coverage alleging patient abuse, the introduction of reportedly effective psychotropic medication to remedy severe mental illnesses, and the allocation of federal funding for community-based mental health facilities (Brandt, 2011; Calhoun, 2018). Ideally, the concept of deinstitutionalization was that the newly funded community-based mental health facilities would offer critical services for people with mental illness who resided in the community, in the least restrictive manner, with

consideration to a limited presentation of imminent harm to themselves or others (Calhoun, 2018). Though the government seemingly allocated funding for such causes, community-based mental health centers were either not established and implemented properly within communities or they presented fragmented and inadequate in services (Brandt, 2011; Calhoun, 2018; Lurigio, 2011). Consequentially, it only partially achieved the concept of deinstitutionalization by reducing the use of state psychiatric hospitals (Brandt, 2011; Calhoun, 2018; Lurigio, 2011).

Moreover, the literature maintains that the facilities the communities established did not offer sufficient and specialized treatment for individuals with severe mental illnesses and did not render adequate services for individuals with limited financial stability (Brandt, 2011). Research has indicated that the insufficiency of mental health care and supplementary supports needed to carry out independent living triggered a considerable number of people coping with mental illness becoming homeless and/or incarcerated (Calhoun, 2011). However, some sources conclude that though the aftermath of deinstitutionalization may have outwardly appeared as a catalyst to the transfer of mental health care from state psychiatric hospitals to correctional facilities, studies have found that between 1980 and 2000 the movement was only at the helm of 4% to 7% of the rise in prison population (Calhoun, 2018).

Nevertheless, scholars have posited that deinstitutionalization policies implemented in the 1960s and 1970s, in concurrence with scant subsidies for community-based mental health care and a consequential lack of services, offers an explanation regarding the criminalization of adults coping with mental health conditions (Barrenger

& Canada, 2014; Calhoun, 2018; Prins, 2011; Torrey et al., 2014). Moreover, due to inaccessibility of beds in state-governed psychiatric hospitals as well as community care deficits and inadequacies, criminal justice facilities have transitioned into de facto mental health treatment environments (Barrenger & Canada, 2014; Lurigio, 2011; Martin-Ayers, 2016). This more current care-related issue also dates back to studies conducted in the 1980s where it was found that individuals with severe mental illnesses were being arrested and detained in correctional facilities when mental health care, though a more appropriate and suitable option, was inaccessible due to limited community-based mental health alternatives (Calhoun, 2018; Lurigio, 2011). It is important to note that the criminal justice system, often considered a catchment place for socially identified criminal behavior, was historically founded as a means of punitive measures (Vogel et al., 2014). Moreover, the criminal justice system was not mainly or initially intended for rehabilitation (Brandt, 2012). In turn, the system was not adequately prepared for the provision of wide-ranging mental health treatment needed by many of its inmates (Martin-Ayers, 2016; Vogel et al., 2014).

Criminalization

Criminalization is a concept cited by scholars for decades (Calhoun, 2018; Lurigio, 2011). Researchers like Calhoun (2018) and Lurigio (2011) posited that to be criminalized is for an individual with untreated symptoms of mental illness, with no intent to engage in criminal activities and behaviors, to be arrested and processed through the criminal justice system for ordinance violations (i.e., public disorderly conduct and nuisance offenses) or minor crimes, instead of being introduced to the mental health care

system. Early studies and literature suggested that people coping with SPMI were more likely to be arrested after an encounter with law enforcement than those who did not exhibit signs of mental illness but were suspected to have engaged in similar crimes (Lurigio, 2011). Furthermore, the literature indicates that law enforcement arrested individuals experiencing mental illness for demonstrating signs and symptoms. Such occurrences often increased in severity during which the individuals engaged in more serious acts such as assaulting a police officer (Lurigio, 2011). Though this is a consideration, it is necessary to consider that this can also be due in part to mismanagement of such contacts (Lurigio, 2011).

Contrary to the concept of criminalization, law enforcement was proposed to have also conducted what was known as "mercy bookings" to obtain services for people coping with severe mental illness (Lurigio, 2011). As a product of being arrested, the individuals were afforded three square meals and a place to sleep. In some cases, it also allowed them to reside in what was considered a safe environment while they awaited an available bed in a treatment facility (Lurigio, 2011). Alternative perspectives further assert that not all arrests align with the concept of criminalization, as most individuals with SPMI who have been arrested, indicted, and sentenced for felonies are processed through the criminal justice system, not due to criminalization but rather because they engaged in criminal behavior that warranted arrest (Calhoun, 2018; Lurigio, 2011). With that, many scholars urge the acknowledgement and consideration of co-existing degrees of criminality and mental illness in individuals primarily understood to experience symptoms of mental health disorders (Lurigio, 2011). Some scholars encourage a

paradigm shift, recognizing the concept of criminalization as an antiquated notion, and urge society to begin to examine factors related to the involvement of adults with SPMI in the criminal justice system (Lurigio, 2011). It is then suggested to begin to ruminate on how criminal justice and mental health systems can respond effectively to the complex needs of this population in a preventative manner (Calhoun, 2018; Lurigio, 2011).

Prevalence and Sociocultural Influences in Diverse Populations

What often holds unattested about the forensic population diagnosed with SPMI is the apparent diversity in culture and environmental influences. It is therefore imperative when conducting social work with client populations from varying cultural backgrounds, for social work providers to practice with a sound foundation of cultural sensitivity and mindfulness of the diversity observed within the client population (NASW, 2021). Seeking professional knowledge about clients' cultures and social environment (NASW, 2021), fosters increased insight into sociocultural variables and offer value to social work practice. Moreover, identifying sociocultural considerations present social workers the opportunity to elicit a better understanding of clients, their social and cultural influences, how they view treatment, their cultural practices and history, as well as culturally influenced strengths and protective factors (Cooper & Lesser, 2015; Dulmus & Sowers, 2012). Gaining knowledge from a cross-cultural perspective then builds a substructure for ethical, culturally competent, and informed social work practice (Cooper & Lesser, 2015; Dulmus & Sowers, 2012).

Gender Differences

Statistical reports by such entities as the Bureau of Justice Statistics indicate that although the prison population is comprised of more incarcerated males than females, a higher percentage of female inmates reported experiencing a mental illness (Brandt, 2012). This may be partially attributed to the theory that the criminal justice system and the process of adjusting to the criminal justice milieu not only produce stress for many who are incarcerated but might also increase the likelihood of anxiety, depression, or other disorders to manifest. With that, it is suggested that women who have not otherwise dealt with mental health concerns might begin utilizing mental health services after involvement in the criminal justice system (Brandt, 2012). Moreover, this might also be indicative of trending research which concludes that incarcerated females have a higher probability of reporting that they receive mental health treatment than do incarcerated males. Furthermore, women are presumed to maintain less of a negative attitude or stigma towards treatment and are therefore more inclined to attempt to find and take advantage of available mental health services. Equally as probable is the idea that more females engaged in the criminal justice system merely experience mental health symptoms and disorders than their male counterparts (Brandt, 2012).

Variabilities in Race and Ethnicity

Researchers suggested that African American and Hispanic populations are disproportionately represented among individuals who are incarcerated (Brandt, 2012; Crutchfield et al., 2009; Jones, 2016). Despite the prevailing rates of overrepresentation among the forensic population, there is a higher probability that Caucasian inmates will

endorse mental health concerns (Brandt, 2012). Studies have focused on the reduced reporting of African American and Hispanic inmates experiencing mental health symptoms which has the potential to influence racial disparity in mental health reporting rates among the adult forensic population (Brandt, 2012). The literature suggested that sociocultural attitudes and stigma regarding mental health care, religious or spiritual influences, and mistrust of the healthcare profession in general, alongside other variables, might also impact help-seeking and symptom reporting among minority inmates (Brandt, 2012). Moreover, symptom presentation and associated misdiagnosing might also be a likely source of these trends. Nevertheless, the predominate consensus is that diversity remains a very relevant topic amongst the forensic population, especially those coping with or potentially experiencing mental health symptoms (Brandt, 2012).

Stigmatization: Barrier to Self-Concept and Mental Health Care

As SPMI maintains a high prevalence rate within the criminal justice system in comparison to the mainstream population (Barrenger & Canada, 2014; Brandt, 2012; West et al., 2015), it is not uncommon to observe the impact of stigmatization on adult offenders with respect to their psychosocial needs and self-identities (West et al., 2015). Individuals coping with mental illnesses and criminal offenders generally maintain parallel stereotypes and stigmas. They are often portrayed in the media and viewed by society as threatening, unpredictable, and inferior (West et al., 2015). With the overrepresentation of minorities in the forensic population and their disproportionate rate of mental health diagnoses, the concept of racial stigma is also relevant to the discussion of the criminal justice system and mental health (Brandt, 2012; Crutchfield et al., 2009;

Jones, 2016; West et al., 2015). Minorities, often assigned similar stigmas and stereotypes as criminal offenders and people with mental health disorders, are another social group impacted by the intersection of both mental illness and criminality (West et al., 2015). The converging of these separate but mutually reinforcing social constructs and combined identities yield multiple stigmas that negatively influence functional outcomes and social identities among the forensic population with mental health concerns (West et al., 2015).

Consequently, this stigmatized population, with consideration to both mental health and criminality, establish self-concepts, behaviors, and beliefs that are shaped by social roles and perceptions (West et al., 2015). Self-stigma is prevalent with regards to mental health. However, it increases exponentially when the individual is also part of multiple stigmatized social groups, such as those in the forensic population who experience mental health symptoms and identify as a racial minority (West et al., 2015). Not only is it suggested that the internalization of mental health stigma impacts overall quality of life but it also challenges self-concepts, impedes upon the willingness to engage in help-seeking behaviors, and stifles treatment outcomes related to treatment compliance and medication management. Furthermore, self-stigma among the forensic population is also suggested to be associated with homelessness and an increase in symptom severity (West et al., 2015).

When conducting a study on racial self-concept, mental illness self-stigma, and criminality self-stigma, amongst a sample of psychiatric patients within the forensic population, West et al. (2015) identified a direct correlation between these constructs and

a reduction in self-esteem. Moreover, the study concluded that self-stigma marked by criminal justice involvement amplifies and exacerbates the effects mental health and racial self-stigma have on treatment and functional outcomes (West et al., 2015). With that, it is valuable to consider this barrier when identifying service needs and offering comprehensive psychosocial support.

Service Needs

Clinical Perspective

In the absence of establishing consistent and applicable aftercare treatment upon release, adult offenders experiencing SPMI have a heightened potential of reentering the community with limited support and supervision with regards to treatment compliance and medication maintenance (Maschi et al., 2009; Vogel et al., 2014). Exposure to the criminal justice system is likely to strengthen disadvantage, vulnerability, and social marginalization among a population that is already met with challenges (Barrenger & Canada, 2014; Martin-Ayers, 2016; Prins, 2014). Stressors suggested to be confronted by people with mental health concerns include poverty, unemployment, homelessness, general health issues, benefit and service deficits, co-occurring disorders such as substance abuse, lack of family connectedness and family dissonance, social stigma, and victimization (Barrenger & Canada, 2014; Brandt, 2012; Martin-Ayers, 2016; Prins, 2014).

Defined by Prins (2011) as “entrenchment,” involvement of this vulnerable population in the criminal justice system gives rise to prolonged incarceration and diminishing approval for community supervision. Consequently, this may then prompt

the exacerbation of mental health symptoms, excite relapse, and increase the likelihood of criminal justice reentry or rehospitalization, otherwise known as criminal and psychiatric recidivism (Dieleman, 2014; Martin-Ayers, 2016; Vogel et al., 2014). Some literature posited that this is due in part to the fragmented continuity of care between state-run psychiatric facilities providing treatment for restoration of competency and mental health stabilization, correctional institutions to which the individuals return, and community mental health providers (Martin-Ayers, 2016; Maschi et al., 2009; Thompson et al., 2016; Vogel et al., 2014).

Literature also endorsed the notable correlation between recidivism and mental health concerns (Brandt, 2012). Furthermore, it was suggested that issues encountered by adult offenders experiencing mental health concerns, such as rehabilitation, offender reentry, and recidivism are attributed to insufficient treatment received while housed in correctional environments as well as the increased, exacerbated, and reinforced psychological impact of imprisonment and prison/jail milieu (Brandt, 2012). Therefore, it is inferred that correctional settings are not conducive to treatment and recovery, as they exacerbate the very issue needing to be addressed (Brandt, 2012). With proper mental health care and attention to co-occurring disorders, the reduction of recidivism rates among adult offenders coping with mental health disorders may become more feasible (Brandt, 2012; Maschi et al., 2009). Additionally, literature suggested that collaboration between the criminal justice system, psychiatric hospitals, and community mental health providers may not only mitigate recidivism rates but has the potential of narrowing social marginalization and relieving burdens experienced by this population (Fenge et al., 2014;

Martin-Ayers, 2016; Thompson et al., 2016; Vogel et al., 2014). Furthermore, it prepares the population for a more successful reentry back into the community (Brandt, 2012).

Though there is agreement in the literature that service provision is a relevant issue, Lurigio (2011) held an alternative perspective with regards to the causality between criminal recidivism or criminal behavior and SPMI. Lurigio (2011) cited that there is limited evidence that the simple alleviation of mental health symptomology positively influences the recidivism of adult offenders with SPMI who are involved in the criminal justice system. Instead, it is suggested that mental health treatment also needs to be augmented by interventions aimed at addressing criminogenic factors (Lurigio, 2011). Consequently, only attending to mental health would adversely increase rather than decrease risks of criminal behavior. Though it is proposed that merely providing mental health treatment may not directly reduce crime among individuals with mental health illnesses, it is also contended that mental health treatment may indirectly affect recidivism, as there is a consensus amongst research that co-occurring disorders, to include substance use disorders, precipitate criminal occurrences (Lurigio, 2011).

Treating and relieving symptoms associated with mental health concerns and co-occurring disorders (i.e., substance misuse), may help criminally involved adults with SPMI successively achieve sobriety, secure and maintain gainful employment, identify and sustain stable housing, and reengage in schooling (Lurigio, 2011). In addition, they may experience improvement in self-control and esteem, repair family relationships, and adhere to the parameters of supervision for parole and probation. This self-improvement, social growth, and recovery may inadvertently address identified criminogenic factors

(Lurigio, 2011). Moreover, tending to symptoms of co-occurring mental health and substance use disorders, through integrated treatment, increases responsiveness to interventions that have a positive outcome on criminal behaviors and help manage symptoms, in turn alleviating symptoms and altering criminal trajectories of adult offenders with SPMI (Lurigio, 2011).

Congruent with the claims made by Lurigio (2011), findings obtained through a study conducted by Calhoun (2018) concluded that there is rarely a direct correlation between untreated mental health symptoms and offending-onset and continued offending behaviors, as it relates to a sample population of parolees with mental health illnesses. According to Calhoun (2018) these findings are also supported by studies which infer that the provision of mental health treatment does not unequivocally yield a reduction in criminal offending or the pervasiveness of people with mental health disorders involved in the criminal justice system. It was concluded that even with providing mental health services to offenders with mental illnesses as a means of mitigating criminal behavior, recidivism rates continued to be higher than that of their counterparts who are without mental health symptoms (Calhoun, 2018). Calhoun (2018) proposed the reasoning for such findings is that offenders coping with symptoms of mental health disorders seem to partake in offending behaviors due to variables independent of the disorder. Furthermore, there are claims that such criminal factors as the comorbidity between substance use disorders and mental health disorders, as well as familial issues and history of criminal behavior, have a more profound influence on criminal and general recidivism of adult offenders experiencing mental health concerns than that of clinical-based factors

(Calhoun, 2018). Literature suggested that the attempt to abate criminal offending is most effective when the focus of interventions address both mental health and criminogenic need (Calhoun, 2018).

Additional importance lies in understanding and discussing underlying reasons for involvement in criminal activities, to include the identification of possible childhood offending-onset, as well as discerning whether mental health had some influence (Calhoun, 2018). Though mental health services afford symptom relief, an increase in efficacy can be achieved through comprehensive and supplemental psychosocial intervention, case management services, and prevention strategies that target such aspects as co-occurring diagnoses and other social, environmental, and economic risk factors (i.e., education, financial needs, homelessness and housing needs, familial problems, etc.) that might excite criminal activities and offending behaviors. By addressing such factors, both mental health and offending outcomes may be improved (Calhoun, 2018).

Client Perspective

To ensure client buy-in and commitment to mental health services, it is of critical importance to explore client priorities in service delivery. By obtaining client perspectives with regards to service needs, the insights gathered have the potential of supporting the promotion of active engagement and mitigating recidivist behaviors amongst the client population. Though much of the clinical perspective places emphasis on mental health service provision (Brandt, 2012; Maschi et al., 2009; Thompson et al., 2016; Vogel et al., 2014), ethnographic research conducted by Wilson (2013) highlighted an alternative perspective based on client priorities. According to the author's research

with clients and staff of a mental health reentry program, housing, financial support, medication management, social support, guidance with public assistance benefits, and case management, respectively, take precedence over mental health services in prioritization of service needs and when engaging in help-seeking activities (Wilson, 2013). While not negating the importance of meeting the treatment needs of this very vulnerable population, this research highlights the importance of basic needs from a client perspective. It is suggested, to comprehensively meet the complex needs of adults with SPMI, focus should be directed on both basic and treatment needs when facilitating transition between systems of care and reentry back into the community (Wilson, 2013).

Based on qualitative research with adults experiencing SPMI and criminal justice involvement Pope et al. (2013) found that successful community reentry relies heavily on the consideration of inconsistent and unreliable mental health service provision in jails and prisons, the exacerbation of mental health symptoms influenced by criminal justice settings, and the challenges presented through transition between systems of care (i.e., criminal justice system and the community). Many of the responses to the structured interview were anchored around the theme of housing instability (Pope et al., 2013). It was suggested that the lack of attainable and stable housing options often impacts various aspects of an individual's well-being and is a catalyst to such factors as disengagement in either voluntary or mandated mental health services, drug relapse, and parole violations. For those who were referred to mental health treatment and provided stable housing, being able to follow-up and follow-through with such services was underscored as particularly difficult. The challenge with following up with services and lack of

engagement was attributed to various factors such as the desire to remain around one's familial system and indifference towards service delivery (Pope et al., 2013). From a provider perspective, Pope et al. (2013) concluded that service coordination activities (i.e., mental health treatment, material support, financial assistance, housing, employment, and benefit reactivation), as well as client and provider attitudes and attributes pose barriers to working with adults with SPMI and involved in the criminal justice system. It is proposed that these factors are the focal point of consideration when addressing client needs and priorities, as well as effective approaches to care coordination between systems of care.

Summary

This comprehensive review and discussion, while not entirely exhaustive, offers a snapshot of related information and underscores the need for further research and examination of the role social work plays in addressing practice problems relative to discharge planning to and from inpatient mental health and correctional facilities, as well as during the community reintegration process. Additionally, the information offered in the literature review will begin to excite discussions and considerations regarding continuity of care for adult offenders coping with SPMI and possible co-occurring disorders. More specifically, with its focus on challenges experienced by social workers facilitating transition and discharge planning from inpatient hospitals to criminal justice settings, it fosters a dialogue aimed to improve upon social work practices and enhance the growth, recovery, and care of the forensic population coping with SPMI.

Section 2: Research Design and Data Collection

Introduction

The purpose of this action research study was to explore the challenges faced by social workers as it relates to facilitating continuity of care between inpatient psychiatric hospitals and correctional facilities as well as identify effective ways to minimize rehospitalization. This section will describe the nature of the study and action research design while highlighting how the design directly aligns with the purpose of the research study. I will discuss the role of the research facilitator and participants, identification and recruitment strategies, and participant sampling. Additionally, the action research methodology, to include instrumentation, will be addressed. This review will then contribute to the knowledge base of others and allow for the replication of research steps. A description of data collection and plan for the process of data analysis will offer an understanding of its contribution to the research purpose and associated questions. Lastly, this section will provide a presentation of ethical procedures.

Research Design

In this research study, I explored the challenges faced by social workers when facilitating continuity of care for adult offenders with SPMI between inpatient psychiatric hospitals and correctional facilities as well as identify effective ways to minimize rehospitalization. In addition, the research considered social work strategies, procedures, and/or practices that might aid in ensuring continuity of care and wrap-around services when transitioning from inpatient hospitals to correctional facilities and upon community reintegration. In doing so, I employed a qualitative research design. The conceptual

elements of action research are fundamentally built on the underpinnings of qualitative research (Stringer, 2007). Action research affords stakeholders the ability to garner a sounder understanding of an issue, problem, or question that confronts them and their community while receiving guidance by the facilitation of a researcher. Ultimately, the systemic nature of action research is the impetus for reaching localized and valuable solutions to specific problems routinely confronted by participants (Stringer, 2007).

Role of Researcher as Facilitator

Researchers employ a myriad of functions when conducting research processes and building working relationships with participants. Of those many functions, a facilitator presents as one of the most essential (McNiff, 2016; Stringer, 2007). With many other research methodologies, the researcher takes on a directive role during the research process, as they are deemed the expert. However, when it comes to action research or participatory action research, the researcher utilizes a bottom-up, indirective, and democratic approach, as they guide and facilitate the research process as an active learner (Stringer, 2007). This style allows the researcher not to appear as though they are governing the process and over-exerting their expertise beyond what is needed. Moreover, it offers the participants a sense of empowerment (McNiff, 2016; Stringer, 2007). Taking on a facilitative rather than a directive stance establishes a positive working relationship, demonstrating that all those involved are mutually vested and respected as collaborative participants (Stringer, 2007). Without rapport, genuine social interaction, sensitivity to culture and emotions, provision of respect, and acknowledgment of the stakeholders' worth and active contribution to the research

process, the researcher will not fulfill the primary intent of action research. It also helps to ensure that participants can gain increased insight into the perceived social issue and how to address it (Stringer, 2007).

The investigative process carried out by the research facilitator is often generated by the desire to gain a greater understanding of how different aspects of the issue occur and how community stakeholders respond to and acknowledge the problem and its associated components (Stringer, 2007). In doing so, the working principles of action research (relationship, communication, inclusion, and participation) must be implemented effectively to guide the research process. To build a quality relationship is to demonstrate effective interactions between the researcher and participants as well as among the participants themselves (Stringer, 2007). It is imperative that the researcher engages in and promotes a manner, style, and form of communication that is clear, forthright, socially and culturally appropriate, and displays active listening. This interaction will offer a sense of partnership and productivity among the researcher and participants. Collaboration is the driving force of action research (Stringer, 2007).

The principles of inclusion and participation help propel the research process forward (Stringer, 2007). Without perceived and actual involvement in the research process as valued contributors, there will not be buy-in or participation from the stakeholders. One strategy to develop buy-in from participants is demonstrating a genuine vested interest in obtaining clarity and facilitating an action plan, to assist in addressing problems that concern them (Stringer, 2007). This expression of interest establishes the researcher's role as a form of support and an advocate. Helping participants understand

that the researcher is not the only change agent, highlighting their importance as active collaborators might also aid in producing buy-in. Moreover, promoting a sense of empowerment and utilizing the "bottom-up" approach has the potential of influencing participation (Stringer, 2007).

Methodology

Prospective Data

I incorporated a qualitative research design and cluster sampling type for participant recruitment. I conducted two separate focus groups, among the randomly selected participants, utilizing a structured interview methodology. The focus groups were guided by open-ended interview questions and selective probing. The methodological components of this action research study allowed for the accumulation of pertinent research data.

Participants

The study population consisted of social workers who work or worked with adult offenders with SPMI in Georgia's inpatient psychiatric hospitals. Though the research study required a specific population of social workers to address the research question, exclusion criteria was not utilized in this study. During the first week of participant recruitment, I utilized a professional network that included social workers who work or have worked in Georgia's inpatient hospitals, thus meeting inclusion criteria. Social media (i.e., Facebook) was used as the recruitment platform. I direct messaged the recruitment letter to the prospective participant pool, via the above indicated social media outlet. The letter provided full and understandable disclosure of the research purpose and

other pertinent aspects of the action research project, allowing for informed consent. Additionally, both the recruitment letter and consent form explained the sample's inclusion criteria in such a way that the perspective participants could understand how and why they were being asked to participate. The recruitment letter also included the opportunity for members of the professional network to notify me of other potential participants to be contacted using the same enclosed recruitment letter.

Conforming to any restrictions the social media outlet imposed on posting a recruiting message, I restricted the use of Facebook to strictly a means of communication with those in my professional/social work network and those who may have been identified by individuals in that network to potentially want to participate in the research study. I did not post a recruitment message to a public and/or private social media page (i.e., social work group) or individual profiles that would allow for others to view correspondence between the prospective participant and me. All communication remained private between participants and me throughout the recruitment and research process.

Furthermore, contacting individuals in my professional network did not imply an expectation of participation and it was understood that it was not a personal gesture with future benefits. Participant recruitment was conducted via direct message on social media or through email to offer low-pressure communication, allowing the individual to easily opt out of participation without feeling coerced or obligated. These caveats were addressed in both the recruitment letter, as well as the informed consent document provided to the participants for review and signature, prior to participation in the focus

group. It was stressed that whether the individual agreed or did not agree to participate would, in no way, impact researcher-participant relationships.

Moreover, to preempt concerns of significant privacy and/or social risks presented by focus groups, specifically when asking participants to share their difficulties, I was very clear in the recruitment letter that the research study would be conducted via a group interview. This allowed individuals to self-select out of the pool of participants if this method prompted any apprehensions. It was noted that the sessions would be audio-recorded. To foster a sense of transparency and clarity as to what would be covered during the focus group session, I also included the Qualitative Interview Instrument (Appendix). The instrument outlined questions that would be asked during the focus group interview. Additionally, the informed consent document highlighted minor risks, particularly that others may potentially repeat what was said in the focus group, though they were asked to maintain confidentiality amongst group members. The consent form verbiage was also reviewed, and expectations were reiterated on the date of the recorded focus group session, after participants verbally consented to being recorded. I allowed for a week-long recruitment process, in which social workers had the opportunity to respond voluntarily to the direct message, after reviewing the provided documents. Upon identification of voluntary participants, I conducted a process of simple random selection to obtain a cluster sample.

The sample size of participants included 10 social workers randomly divided into two focus groups of five participants. This sample size allowed for more comprehensive input which gave quality to the data analysis. Furthermore, by arranging two focus

groups, I circumvented the potential emergence of "groupthink." "Groupthink" is a phenomenon that arises when the maintenance of group consensus and adopting the opinion of other group members, in lieu of expressing an alternative viewpoint or course of action, hinders objectivity, effective decision-making, and innovative or productive processes (Breitsohl et al., 2015).

I transmitted a follow-up email to those who were not selected, to inform them that all participants have been identified for the study, succeeding the random selection of social workers. Within the subsequent week, following the recruitment of participants, the focus group sessions were coordinated into Groups A and B, and held via a video conferencing platform. Should it have presented challenging to organize group sessions, I was prepared to arrange individual interviews.

The group of social work practitioners assumed the role of research participants and collaborators (Stringer, 2007). By taking on this function, the participants presented as experts of the social issue(s) impacting their community. Consequentially, this generated a sense of empowerment as a source of decision-making and stimulation of social change. As an essential component and driving force in the development, execution, and success of the action research project, it was imperative to elicit the support and participation of such stakeholders (Stringer, 2007).

To strengthen communication, I conducted a focus group (Stringer, 2007). The group allowed for a smaller and more comfortable forum in which the participants could openly share and collaborate. It also offered me the opportunity to obtain small samples and a depiction, from the hospital and community providers, of the latent problems

impacting the community (Stringer, 2007). Furthermore, the utilization of a focus group as a method of sampling afforded stakeholders the ability to engage in the research process and gave them the outlet to verbalize perceptions of the social problem in a way that they might not otherwise have had the opportunity (Ren & Langhout, 2010). This forum not only established collaboration in decision-making processes, but it also fostered a sense of empowerment for participants (Ren & Langhout, 2010; Stringer, 2007).

Instrumentation

I developed a structured interview, using eleven open-ended questions and some selective probing. The questionnaire offered the means to engage participants in a discussion of challenges and underlying issues relevant to the research problem. The utilization of these inquiries helped me gather data and gain increased insight into what issues might be impacting the forensic and mental health community and their perception of those issues (Stringer, 2007). Both the questions and their resulting answers aided in laying the foundation and setting the stage for the research process. Furthermore, by gathering information through the questions in the inquiry process, it allowed me the ability to establish a framework from which to proceed (Stringer, 2007).

Table 1 provides a visual depiction of the relationship between the interview questions and the broader research questions. With the research questions listed on the left side of the table, their related interview questions are listed on the right side. For example, interview questions two, eight, and nine are directly related to research question one. Whereas the first interview question posed to research participants during the focus

group sessions was not intended to address either of the study's research questions and is therefore placed next to a blank cell in the table. Instead, the objective of interview question one was simply to gain an understanding of how participants define "Severe and Persistent Mental Illness."

Table 1

Research and Interview Question Flow Chart

Research Questions	Interview Questions
	Interview Question 1. How do you define Severe and Persistent Mental Illness (SPMI)?
RQ1. What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with severe and persistent mental illnesses from inpatient psychiatric hospitals to criminal justice facilities?	Interview Question 2. What challenges do you experience or have you experienced in working with adult offenders coping with SPMI?
	Interview Question 8. What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to an effective discharge planning process? (See below for additional probing questions)
	Interview Question 9. What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to successful reintegration back into the community? (See below for additional probing questions)
RQ2. From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?	Interview Question 3. What discharge planning practices and procedures are you currently using or have you previously used in working with adult offenders coping with SPMI?
	Interview Question 4. From your perspective, what has been effective with using these discharge planning practices and procedures? Please explain your answer.
	Interview Question 5. From your perspective, what has not been effective with using these discharge planning practices and procedures? Please explain your answer.
	Interview Question 6. If any changes could be made to the current discharge planning practices and procedures, what might those changes be?
	Interview Question 7. If any changes could be made to the overall continuity of care for adult offenders coping with SPMI, how might those changes look?
	Interview Question 10. In working with adult offenders with SPMI, what service needs have been identified as priorities from a client perspective?
	Interview Question 11. As a social work practitioner, what contributions have you made to the promotion of social change and the field of social work? (See below for probing question)

Data Analysis

Data Collection Procedures

Data was collected utilizing a focus group of social workers who work or worked with the forensic population, guided by open-ended, structured interview questions. The focus group was held online via Zoom, a videoconferencing platform. This was due to the geographical location differences between participants and me, as well as to prevent safety concerns presented by the global pandemic experienced during the time of the research study. Audio recording was used to identify recurrent themes. Additionally, by recording participant dialogue, it ensured accuracy of thoughts, ideas, opinions, and verbiage presented in the session(s). Informed consent was obtained from each participant before recording the focus group sessions. The audio-recorded sessions were transcribed into a written transcript to allow for the coding process to occur. The data and content were subsequently analyzed to deduce shared themes presented during the focus group sessions.

Analysis of Collected Data

When guiding action research, the interpretation and analysis of information obtained from research participants present as a vital component of the investigation process (Stringer, 2007). The method of data analysis is a requisite for the identification of themes demonstrated in the perspectives and experiences of participants. Categorizing key concepts allows the researcher the ability to obtain clarity regarding the nature of the social problem impacting community stakeholders. Moreover, it fosters the identification of associated and underlying issues (Stringer, 2007).

The data attained through both focus groups were analyzed based on patterns and themes presented in participant responses. To strengthen research and maintain accurate documentation of the discussion and phrasing, while identifying and analyzing themes, I formulated a typed transcript of the audio-recorded, focus group sessions. I then used the written transcript to complete a data analysis in NVivo, a computer software used to aid in organizing qualitative data (Walden University, 2021). Subsequently, sentences documented in the written transcript were segmented into key points to further illustrate the presented concepts. I utilized this step to identify any subcategories that arose in the focus group discussions. Those phrases, sentences, or words were then more concisely categorized and coded (Stringer, 2007). In addition, I highlighted the existence of correlations made between those subcategories. My goal was for the data analysis to aid in ascertaining response-driven solutions to the research problem. The themes obtained through the data analysis will be presented in the subsequent section.

Ethical Procedures

As a social worker, values and ethics are an integral consideration in practice procedures, to include action research. To effectively facilitate and promote social change, is to generate knowledge through the attainment and implementation of research with ethical standards at the forefront of the process (Bogolub, 2010). When conducting action research, upholding the social work profession's ethical obligations to the research population and stakeholders is paramount (NASW, 2021). In doing so, it not only offers a layer of protection for research participants (NASW, 2021) but also preserves the integrity in the research process.

Action research, utilizing a qualitative design, fundamentally emphasizes the use of transparency in the research process (Stringer, 2007). It was therefore imperative that I acquainted research participants with each aspect of the action research process and my intentions for the research data. In doing so, I obtained voluntary and written informed consent from participants. Moreover, participants were made aware of their right to refuse participation and withdraw at any stage of the process.

To ensure ethical protection of participants, I adhered to their fundamental right to confidentiality. Participants were assigned a number as an identifier, rather than utilizing their names. The allocation of assigned numbers allowed for the maintenance of anonymity throughout the research process to include during the focus group interviews, in written transcripts, analyses, and documentation of research results. Participants were also not asked to disclose the organization in which they provide or have provided applicable care. It was understood, however, that the social workers provided care in the state of Georgia. Furthermore, access to the collected data was restricted from being viewed by anyone else other than myself. All audio was only heard by me and was not shared. To uphold ethical protections and integrity, I did not disseminate the research data. Participants were also highly encouraged to maintain confidentiality of other participants and focus group discussions. However, they were cautioned that due to the research being conducted in a group setting I could not fully guarantee confidentiality as it relates to the actions of other participants. This privacy risk was highlighted in the informed consent documentation to be agreed upon prior to voluntary participation in the focus group.

All recordings/electronic data were stored on my password-protected laptop and backed up on a password-protected hard drive. I did not transfer the data to any other devices, media sources, or electronic outlets. All research notes, documentation, and interview transcripts (physical data) remain in my personal possession in a locked file cabinet at my home and will be stored for the duration of 5 years. Email addresses used to contact prospective participants in the recruitment process and to provide consent forms are also kept on a flash drive stored in the locked file cabinet. Upon the 5-year timeframe, the recording(s) will be wiped clean from my password-protected laptop and hard drive, and the physical data will be redacted and shredded.

In action research, there is an established agreement between participants and the researcher, with the participants having a respected voice throughout the process (Stringer, 2007). As a result, participants have more of an active role in decision-making. Furthermore, in action research, rigor or verification of trustworthiness in research outcomes is greatly underlined. Adhering to this concept ensures that the biases or perspectives of the researcher does not obscure the obtained information and that the research analysis is in-depth (Stringer, 2007). Utilizing the strategies of reporting data directly obtained from participants, while avoiding the integration of my values, thoughts, and opinions, as well as member checking, helped make certain that my personal values did not overshadow the process. Moreover, it guaranteed that the voices and values remained those of the research participants (Stringer, 2007). Although social workers and researchers take from their foundation of personal values, skills, and professional knowledge (NASW, 2021), it is essential that those values are not put before that of the

worldviews and values of participants. Furthermore, it is vital that the values, skills, and knowledge of the social worker are not utilized in a way where participants perceive judgment, manifest conflicting thoughts and feelings, or are divested of their right to self-determination in the research process (Stringer, 2007). With these considerations and the governing body of the Institutional Review Board (IRB) to ensure the protection of participant rights, the integrity and viability of the research process and study are protected (Brydon-Miller & Greenwood, 2006).

Summary

The goal of this research study was to identify social work practice challenges as it relates to discharge planning and continuity of care between inpatient psychiatric hospitals and correctional settings, as well as methods in which to improve these processes and afford a successful community reintegration and recovery for adult offenders with SPMI. Utilizing a qualitative research design with a structured interview approach, the research study garnered the experiences of a randomly selected group of social workers. The accumulated data was interpreted to pinpoint themes. The data and analysis will be discussed and synthesized in the subsequent section. Through its processes, the investigative aspect of action research fosters the ability to procure a sound understanding of the social work perspective, offering a foundation for social change.

Section 3: Presentation of the Findings

Introduction

I aimed to explore the challenges faced by social workers as it relates to facilitating continuity of care between inpatient psychiatric hospitals and correctional facilities as well as identify effective ways to minimize rehospitalization. This was achieved using a qualitative research design. Data were collected by conducting structured interviews with two focus groups of five current or former social workers in Georgia, which helped answer the research questions:

- What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with SPMI from inpatient psychiatric hospitals to criminal justice facilities?
- From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?

This research study offered former and current social workers in Georgia the opportunity to discuss and explore challenges, experiences, and processes, as well as systemic, environmental, and psychosocial influences, while strengthening the capacity for social change and influencing social work practice. The research questions gave way to an in-depth qualitative interview process. It afforded a framework from which to garner a sounder understanding of the challenges social workers face in social work practice and

discharge planning from inpatient hospitals to correctional facilities, with adult offenders experiencing SPMI.

Section 3 will discuss data analysis techniques, with specific focus on the time frame for data collection and the recruitment process as well as validation procedures and limitations to the research study. Additionally, this section will address procedures that I implemented to conduct a thematic analysis of the data for common themes and patterns, while integrating a constant comparative method. I will then transition into a descriptive analysis of the research findings and how those findings answer and correlate to the action research questions.

Data Analysis Techniques

Grounded Theory: Constant Comparative Method

A qualitative research study and its research process relies on the soundness of the data analysis (Braun & Clarke, 2006; Maguire & Delahunt, 2017). It is therefore imperative that focus is directed toward conducting a thorough thematic analysis for emerging themes and patterns within qualitative data (Maguire & Delahunt, 2017). With respect to the data analysis process for this action research study, I utilized thematic analysis while integrating the constant comparative method, a component of grounded theory. Developed by Glaser and Strauss (1967), grounded theory is one of four approaches often implemented in qualitative research (Fram, 2013; Ho Yu et al., 2011; Kolb, 2012). Grounded theory involves formulating hypotheses through data collection and comparative analysis (Ho Yu et al., 2011; Kolb, 2012). The objective is to glean constructs, themes, and concepts from a set of qualitative data that is relevant to the

research participants in the field of study, thus grounding both the concepts and generated hypotheses and theories (Glaser, 2016; Ho Yu et al., 2011).

An integral component of grounded theory, the constant comparison method is a systemic approach for exploring and analyzing qualitative data by formulating constant comparisons to derive a theory grounded in the data (Boeije, 2002; Kolb, 2012). Through constant comparison, the researcher generates concepts by simultaneously and recurrently coding and analyzing research data (Kolb, 2012). Though a fundamental component of grounded theory, it suggested that the constant comparative method is not exclusive to this theory and can be applied independently (Fram, 2013; Glaser, 1965). This is due in part to the fact that it predates the development of grounded theory (Fram, 2013; Glaser, 1965). Four stages are encompassed in the constant comparative method: "(1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory" (Glaser, 1965, p. 439). During the stages of the constant comparative method, the researcher collects data; repeatedly sifts through and examines collected data; discovers patterns; analyzes, categorizes, and codes data; and strengthens theory generation to develop a theory as it emerges in the research (Boeije, 2002; Glaser, 1965; Kolb, 2012). New information obtained from data can be compared to information garnered through previously collected data (Boeije, 2002; Kolb, 2012). For example, during the research study I compared data between interview responses within the same focus group and compared data between the two focus groups (Boeije, 2002).

Time Frame

I accomplished the participant recruitment process and conducted data collection over a 3-week period. A recruitment letter to voluntarily participate in the research study was sent to my professional network of social workers who met the inclusion criteria for participation in the research study. The recruitment letter and interview questions were sent to prospective participants via Facebook messenger. Upon obtaining volunteers' email addresses, further communication was held through email.

Within 2 days of initiating the recruitment process, 20 potential participants expressed interest in engaging in the action research study. Of the potential participants, 10 individuals were randomly selected utilizing a lottery method by drawing names. Through their preferred method of communication, the 10 volunteers were then contacted and informed that they were selected for participation in the study. I asked those who had not already provided their email for their email addresses. Subsequently, participants were individually sent an informed consent form, via email, to provide further information and solidify their desire to participate in the research study. I allowed until the day prior to the scheduled focus group date for participants to review the informed consent forms and interview questions. Inquiries regarding the study such as the information outlined in the informed consent form and the data collection process were highly encouraged. My goal was to not only offer time for participants to feel comfortable with the research study but to ask questions if there was anything that was unclear or uncertain to them.

The remaining participants were contacted and informed that they had not been selected. They were asked if they would mind being on an alternate list in case an unforeseen situation occurred where a selected participant was unable to engage in the research study or requested to discontinue participation prior to the start of the focus group sessions. The volunteers were informed that they were under no obligation to agree to be an alternate. All but one volunteer who was not selected agreed to serve as alternates if necessary. If a participant withdrew participation during the focus group session, I intended to continue the session with the remaining participants. I determined that alternate participants would not be added to the focus group session after it already commenced.

The social workers who volunteered to participate in the study and were randomly selected, all reviewed the informed consent form and provided a signed consent at the bottom of the form prior to the start of their assigned focus group session. While awaiting receipt of all consent forms via email, I established dates during which the two focus groups would be held. One focus group was scheduled per subsequent week. For instance, a focus group session was scheduled one week and the second was scheduled for the following week. Participants were equally split among two focus groups, depending on their availability. They were later assigned a number and letter combination (i.e., 1A). The number was based on the number of participants in the group, between one and five. This number was randomly assigned to each participant. The letter indicated the focus group in which the participant was assigned. Focus Group 1 was designated the letter “A” and Focus Group 2 was designated the letter “B.” This helped me easily

identify to what focus group the participant was assigned. Participants were informed that the purpose of being assigned an identification number was to allow for confidentiality during the focus group as well as all other research-related activities and documentation following data collection.

Two days after the initial recruitment and on the same date Focus Group 1 was scheduled for their impending virtual session, I identified a concern with the initial videoconferencing platform, Google Hangouts. With Google Hangouts, I would have had to utilize a separate recording application to audio-record sessions. With this consideration, the session for Focus Group 1 had to be rescheduled, causing the scheduled date to follow that of Focus Group 2. During the week that was initially set for Focus Group 1, I completed a Request for Change in Procedures form and submitted it to the Walden University IRB for approval (approval # 04-10-20-0657336). This form requested a change in the videoconferencing platform that would be used to facilitate the virtual focus group from Google Hangouts to Zoom. In addition to completing a Request for Change in Procedures form, the recruitment letter also had to be updated. Upon receiving IRB approval of this change, the session for Focus Group 1 was rescheduled. The session date scheduled for Focus Group 2 was maintained, as it was projected further out which allowed time for the IRB to approve the change. All participants were notified, post-IRB approval, that Zoom would be the new platform used for their virtual focus group session. The two focus group sessions were conducted a week apart, with both sessions lasting for about an hour and 30 minutes.

Data Analysis Procedures

During the focus group sessions, participants were asked a total of 11 open-ended interview questions, with some integrated probing questions. Probing questions were employed in this study to stimulate more in-depth and specific feedback from the research participants regarding the subject matter. My goal was to generate an exhaustive and rich set of data to help bring forth further insight into the research problem. To circumvent viewpoints from being interjected into the interview process, skewing the research data, I solely acted as the facilitator of the research questions. Once the participants completed their discussion, I proceeded to the next question until the focus group session concluded. I did not offer any additional dialogue or input during each session. Upon collecting data via audio-recording, I transcribed the data into text, and then organized the qualitative data utilizing the NVivo software program. NVivo is a computer software used for both qualitative and mixed method data analysis, allowing the user to import and analyze an array of mediums from audio and video files to text and emails (Walden University, 2021).

Both focus group interviews were recorded using the audio-recording component of the Zoom platform. The audio files were then transcribed into word documents. I accomplished transcription through repeatedly listening to the audio files, both group and individual, to confirm that what was typed directly mirrored that of all participants' responses in their respective focus group. This ensured accuracy in documentation. Upon completing a separate transcription for both focus groups, I reviewed the audio once more for accuracy. Transcribed documents were then imported onto the NVivo software to

begin the coding process. The transcriptions were labeled according to the focus group (i.e., “Focus Group 1” or “Focus Group 2”). This was also reflected when labeling in NVivo. Text from both focus group sessions was separately and manually coded for themes. Common themes or concepts were coded using words and short phrases. This process is known as a thematic analysis (Maguire & Delahunt, 2017). By conducting a thematic analysis of each focus group interview, it offered me the ability to analyze themes within the respective focus groups as well as perform an analysis of shared themes between the focus groups. This fostered the examination and interpretation of data among and across participant groups. The research data and its subsequent analysis was then utilized to form a hypothetical inference.

Data Analysis: Step-by-Step

With constant comparison as a methodological foundation and while following aspects of Braun and Clarke’s (2006) 6-step framework for thematic analysis, the data analysis procedures included steps outlined in the following sections. It is important to note that additional steps were incorporated to strengthen accuracy and relevance within the action research study.

Step 1: Review Research Questions

I prepared to analyze the qualitative data via NVivo by first reviewing the research questions once more to ensure that they were clear and directly aligned with the interview questions facilitated to the research participants. By doing so, this allowed me to refamiliarize myself with the research questions to help guide the analytic process. Furthermore, it offered me the ability to verify that the data to be analyzed was in direct

correlation with the study, thus ensuring that the themes and concepts brought about through thematic analysis would be both sound and relevant to the study.

Step 2: Read Transcripts

Prior to beginning the analytic process, I read over the transcripts for Focus Group 1 and Focus Group 2, in their entirety, to obtain an overview of the qualitative data. Consequently, I gained a broad sense and understanding of themes and shared insights discussed among the participants. Key points were identified, and notes were taken. I also highlighted observed themes that initially emerged during the review of transcripts.

Step 3: Import and Organize Qualitative Data in NVivo (Coding for Themes)

After completing the first two steps, I imported both transcripts into NVivo and labeled them accordingly. Once the transcripts were successfully imported and labeled, I initiated the coding process by identifying and categorizing the emergent broad topic areas, also known as themes (Braun & Clarke, 2006; Maguire & Delahunt, 2017). Rather than utilizing the interview questions as themes, which is a fairly common problem in qualitative research (Clarke & Braun, 2013), I conducted an analysis of the data to generate themes.

I coded for themes by extracting common, key points made by participants and then identifying a word or short phrase verbalized by the participants. The word or phrase was then used as a "code" heading in NVivo. When a coded theme is selected, an overview shows how many times the coded theme was referenced under each interview question. To be sure that this process remained organized, I created a heading per Focus Group, then a subheading per interview question. Under each of the subheadings, I then

added the “code” headings or themes that emerged in the participant responses. I was able to simultaneously catalogue the codes with this process. The data analysis resulted in a total of 38 “code” headings between both focus groups, with data from Focus Group 1 producing 21 codes, Focus Group 2 generating 15 codes, and both focus groups sharing two of the 38 codes. The codes or themes will be reviewed further in the discussion of research findings as well as in Table 2.

Under the respective “code” headings, participant quotes were housed. These verbatim responses from which codes were produced are referred to as “references” in NVivo. “References” were transferred to the coded theme by highlighting the word or phrase used by the participant, dragging, and then dropping the highlighted text onto the coded theme. These steps were followed for both focus group transcripts.

Step 4: Review Themes

After the data was coded and thematically analyzed I reviewed the themes, familiarized myself with the resulting data, and evaluated whether the data supported each theme (Braun & Clarke, 2006; Maguire & Delahunt, 2017). I also assessed for theme overlapping, possible subthemes, and if there were themes that might have been overlooked during initial coding. This step offered me the ability to not only ensure distinctiveness between themes and that all themes were identified but to develop sound knowledge of the emerging themes and their correlation to the research questions. It also gave broad and, in some respects, specific insight into shared areas of concern and social work-related challenges within the field of study. As an alternative visual, I also created a chart and comparison diagram of the data. This overall process allowed for an initial

interpretation of the data and for me to begin identifying and examining underlying topics (Braun & Clarke, 2006; Maguire & Delahunt, 2017).

Steps 5 and 6: Define Themes and Write Up Analysis

During the next step, I defined identified themes. In doing so, I was able to arrive to the meaning of each theme while further exploring and interpreting what the theme conveyed. This step included finding relationships between themes as well as how they might have interrelated between focus group sessions. Furthermore, the goal of this step was to refine themes and establish a better sense of understanding (Braun & Clarke, 2006). The final step included composing a comprehensive report of the findings resulting from the thematic analysis (Braun & Clarke, 2006; Maguire & Delahunt, 2017).

Validation Procedures

To protect the scientific merit of qualitative research studies, it is imperative that there are sound validation procedures (Ho Yu et al., 2011). Moreover, validation procedures should be performed continually throughout the qualitative research process (FitzPatrick, 2019). Traditional validation procedures consider both broad concepts of reliability and validity to evaluate the quality and goodness of the research (Ho Yu et al., 2011).

Reliability is the consistency of a method, measure, or technique across varying points in time, diverse circumstances, and researchers (Ho Yu et al., 2011). In other words, the same results should be yielded regardless of circumstance, time, or the researcher performing the same steps. Reliable data allows for valid inferences and conclusions to be made from the research findings (FitzPatrick, 2019; Ho Yu et al.,

2011). Whereas validity considers whether the study accurately reflects the ideas and concepts it intended to examine (Ho Yu et al., 2011). Reliability is contingent upon validity (Ho Yu et al., 2011) and validity helps establish trust in the research (FitzPatrick, 2019). The validation procedures used in this study included that of purposeful sampling, taking steps to prevent groupthink, accuracy checking and analytic rigor as well as peer debriefing and researcher reflexivity (FitzPatrick, 2019).

Purposeful sampling, or the use of appropriate sampling, includes the strategic selection of participants who have relative knowledge of the subject matter and are therefore suitable to respond to the intent of the research study (FitzPatrick, 2019). For this study, I recruited a specific demographic of social workers. It was important that the research participants had firsthand experience in providing social work practice to the research population. This helped strengthen the validity and credibility of the information obtained during the data collection process (FitzPatrick, 2019). Furthermore, by recruiting participants with such substantial knowledge of the research topic, it allowed the obtained information to reach the point of data saturation. It is suggested that reaching saturation of data strengthens validity, as it offers a sense of comprehensiveness and integrity to the research which is often a requisite for drawing valid inferences and conclusions (Fitzpatrick, 2019).

To further enhance credibility of findings, research participants were provided the interview questions prior to their respective focus group sessions. This not only offered transparency in the research but also allowed participants time to review the questions and essentially answer them ahead of time. Moreover, they were able to formulate a

response to the interview questions prior to the introduction of other participant responses. This form of preparation fostered the potential for participants to feel a sense of confidence and completeness in their responses. It also aided in preserving participants' uniqueness in their feedback, potentially reducing the possibility of "groupthink."

Accuracy checking was also conducted when listening to the audio-recorded, focus group sessions and transcribing the data into text. I listened to the recordings several times at different points in the transcription process. The objective was to ensure exactness in the transcriptions by verifying what was documented was verbatim to what was verbalized by the research participants and adequately capturing the nuances. Through accuracy checking, I was able to initiate a form of analytic rigor. In doing so, I began the process of forming a more profound and scholarly awareness and understanding of the participant feedback and challenges faced by social workers, while transcribing the focus group data (FitzPatrick, 2019).

To decrease the potential for interference of researcher bias on the research process and study findings, I engaged in peer debriefing and researcher reflexivity (FitzPatrick, 2019). I debriefed and consulted with my Chair as a committee member and trusted peer in the field of social work. Discussions were held regarding the study, research methods, and theories, as well as data collection and analysis. Also a form of debriefing, with specific focus on my point of view about and reactions to the study, researcher reflexivity was conducted (FitzPatrick, 2019). This allowed me the opportunity to partake in conversations with my Chair that yielded self-reflection on how

my beliefs regarding the research topic might have the potential to shape the data and subsequent conclusions made (FitzPatrick, 2019). Engaging in researcher reflexivity afforded me a space to reflect and acknowledge biases to ensure precautions were taken when performing research processes, thus inhibiting such occurrences and fortifying validity within the study. It was critical that I remained objective throughout the research study, especially during the data collection process. Accordingly, these procedures helped strengthen credibility and further establish an ethical standard within the research (FitzPatrick, 2019).

Limitations

One limitation of this study is the demographics of the research participants with respect to gender diversity. Although age range, practice experience, and other demographics varied among the participants, gender did not. It is widely known that the social work profession is heavily saturated with those who identify with the female gender. Moreover, there are few people who identify with the male gender represented in certain social work settings. Therefore, the participant pool lacked male representation. This was not my intention but rather seemingly based on the overall demographics that compose the field of social work.

Another limitation of the study was that it was conducted during a global pandemic. Due to the unexpected circumstances, scheduling and recruitment, though timely, was hindered. As a result of work schedules and day-to-day operations being impacted by changes related to the pandemic, adjustments and accommodations had to be made. For instance, one participant asked to switch to the other focus group due to

scheduling conflicts, noting the desire to participate but not having the ability to do so in the focus group initially agreed upon. Despite swapping sessions, the number of participants in each focus group remained unaltered. Though this aspect of the research process presented as a constraint, I maintained the intent for there to not be any changes to the overall function and purpose of the focus groups. I was able to accomplish this goal.

Additionally, one of the interview questions lost its inclusivity which impacted participant responses and potential contribution to the dialogue. For instance, participants were asked in question number 6, "If any changes could be made to the current discharge planning practices and procedures, what might those changes be?" This question specifically focused on "current" discharge planning practices and procedures and did not consider those participants who were no longer engaged in social work practice with the research population. The question could have been modified prior to the focus groups being conducted to be more comprehensive, in turn strengthening the possible wealth of knowledge and richness of data that might have been obtained by a simple adjustment in wording.

Furthermore, based on participant responses during the focus groups, it appeared that some participants might have misunderstood or lost sight of the research population. The study focused on adult offenders with SPMI who are discharged from inpatient psychiatric hospitals back to correctional facilities (i.e., jails or prisons). Whereas some of the responses appeared to be directed towards those being discharged from a psychiatric facility directly into the community (i.e., individuals found not guilty by

reason of insanity; NGRI). The concept of my research was that the research population would ultimately be reintroduced to the community and require continuity of care but not without transitioning from inpatient to jail or prison first. This potential misinterpretation became evident in some of the participant responses. I indicated the population on which this research study focused at different points in the recruitment and focus group process. However, this might have been further mitigated through a more thorough reiteration of the research population at the start of each focus group and within the interview questions, to offer clarity and emphasis, respectively. It is my assessment, however, that this did not critically impact the data or its validity. Continuity of care upon community reintegration is still an applicable and relative factor to consider when addressing discharge planning for individuals transitioning between facilities.

Another limitation was the number of interview questions. While offering comprehensiveness to the research study and findings, the number of questions may have been too exhaustive. Participation in Focus Group 2 started to decrease as the session neared the end. A break was offered to each focus group to allow participants to regroup and prevent burnout or fatigue due to the extensive nature of the interview questions. However, I might have also condensed the interview questions or made them more concise. Furthermore, this could have been mitigated by splitting each focus group into two sessions. Moreover, I noticed that not every participant answered some questions during the focus group sessions. Though only a probable suggestion, this may have been due in part to participants feeling as though their response was already given or enough responses were given to answer the interview question. It might have also been that

participants simply did not want to answer the question or did not have a response. Nevertheless, this may have taken away from the potential richness or saturation of the research data.

Findings

This section offers a presentation of the findings derived from a thematic analysis of the research data. Data was obtained through the facilitation of focus groups guided by a structured interview methodology. The study implemented a qualitative research design to address the research questions:

- What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with SPMI from inpatient psychiatric hospitals to criminal justice facilities?
- From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?

Sample Demographics

Prior to the discussion of findings, demographics of the participant sample will be highlighted. To best address the objectives of the research study, purposeful sampling was applied to the participant recruitment process. This resulted in a sample size of 10 social workers who either currently or previously engaged in social work practice and discharge planning, from inpatient psychiatric hospitalization to correctional facilities, with adult offenders experiencing SPMI. Though not my intent, the sample was

comprised of all females. It was, however, my intent to recruit participants who work or worked in the state of Georgia while conducting the aforementioned social work practice with the research population. The state in which the participants resided was not relative and remained unknown. Though it will not be specified to maintain anonymity of the research participants, the age range and ethnicity of the sample varied across the spectrum. Ages of participants ranged from mid-twenties to over fifty years of age. Minimum age was congruent to someone who would hold a master's level degree in social work. All participants were awarded a Master of Social Work degree. Social work licensure status (i.e., no license, Licensed Master Social Worker, or Licensed Clinical Social Worker) and years of practice experience with the research population also varied.

Research Findings Through Thematic Analysis

The following section offers a presentation of the research findings from the eleven interview questions presented to participants to address the two research questions. The presentation of findings also includes the use of tables as visual components. With two broad research questions as a foundation, structured interview questions were developed and utilized to facilitate the two focus groups comprised of former and current social workers in Georgia's inpatient hospitals. The data was then analyzed to draw forth shared concepts or themes, thus resulting in the key findings to be summarized in this section.

The discussion of findings is organized with respect to the themes that emerged during the data analysis process. In qualitative research analysis, themes are aspects of participants' narratives denoting specific ideas, perceptions, topics, and/or experiences

recognized by the researcher as pertinent to the research question (Belotto, 2018). The emergent themes will be depicted in the form of words or phrases. Themes will be highlighted as they relate to the interview question and further supported by associated participant responses or "references," as titled in NVivo. It is important to note that in some instances, not all participants responded to all questions during the focus group sessions. Therefore, themes and inferences were only drawn from verbalized, rather than implied, participant responses. Each interview question will be ordered numerically under the overarching research question it aims to address.

Table 2 illustrates the emergent themes identified during the thematic analysis of participant responses. The themes represent the social work practice challenges faced by social workers when discharge planning for adult offenders with SPMI as they transition from inpatient hospitals back to correctional facilities. They also depict suggested practice improvements, strategies, procedures, and services that might enhance the planning process and strengthen transitions and community reintegration. Themes are recorded based on the numbered interview question to which they correspond and between focus groups, 1 and 2. It is important to note that, in addition to offering a visual depiction of the themes presented in the findings, Table 2 highlights the shared themes amongst both focus groups. This further demonstrates how conducting two focus groups potentially aided in reducing the occurrence of "groupthink" as a phenomenological construct. Themes that are shared among focus groups 1 and 2 are centered between both columns in the graph.

Table 2

Emergent Themes Per Interview Questions

Interview questions	Focus groups	
	Focus Group 1	Focus Group 2
Interview Question 1: How do you define Severe and Persistent Mental Illness (SPMI)?	impaired functioning	
Interview Question 2: What challenges do you experience or have you experienced in working with adult offenders coping with SPMI?	lack of community resources	
	basic needs	
	criminal charges/forensic status	
	court system	
Interview Question 3: What discharge planning practices and procedures are you currently using or have you previously used in working with adult offenders coping with SPMI?	recovery-centered approach	communicating patient discharge needs
	person-centered care	transition visits
	biopsychosocial assessment	supportive services for family
		schedule mental health appointment
		building rapport with community providers
Interview Question 4: From your perspective, what has been effective with using these discharge planning practices and procedures? Please explain your answer.	building community rapport	awareness of client needs
		inform family
		empowerment
Interview Question 5: From your perspective, what has not been effective with using these discharge planning practices and procedures? Please explain your answer.	meeting service needs	multidisciplinary perspectives
	stigma	
Interview Question 6: If any changes could be made to the current discharge planning practices and procedures, what might those changes be?	improve collaboration	multidisciplinary input
Interview Question 7: If any changes could be made to the overall continuity of care for adult offenders coping with SPMI, how might those changes look?	ensuring accountability	transitioning to least restrictive settings
		educating and training
Interview Question 8: What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to an effective discharge planning process?	concerns for discharge outlook	no themes identified
Probing Question (A): What social issues might impact their discharge outcome, if any?	no themes identified	
Probing Question (B): What cultural issues might impact their discharge outcome, if any?	stigma	no themes identified
Probing Question (C): What economic issues might impact their discharge outcome, if any?	no financial support	no themes identified

(table continues)

Interview questions	Focus groups	
	Focus Group 1	Focus Group 2
Probing Question (D): What political or legislative issues might impact their discharge outcome if any?	political agendas/motives	funding for mental health services
Interview Question 9: What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to successful reintegration back into the community?	no themes identified	
Probing Question (A): What social issues might impact their reintegration outcome, if any?	no participant responses provided	
Probing Question (B): What cultural issues might impact their reintegration outcome, if any?	no themes identified	no participant responses provided
Probing Question (C): What economic issues might impact their reintegration outcome, if any?	no themes identified	no participant responses provided
Probing Question (D): What political or legislative issues might impact their reintegration outcome, if any?	judicial consequences for non-compliance or inability to comply	no participant responses provided
Interview Question 10: In working with adult offenders with SPMI, what service needs have been identified as priorities from a client perspective?	basic needs	psychoeducation
Interview Question 11: As a social work practitioner, what contributions have you made to the promotion of social change and the field of social work?	building therapeutic relationships	advocacy
	psychoeducate to destigmatize	
Probing Question (A): What social changes can be made by you or other social work practitioners concerning the population of adult offenders coping with SPMI?	education	no themes identified
	advocacy	

Eleven questions were posed to participants that addressed the two research questions. Apart from the first interview question, the following discussion addresses the findings as they relate to the research questions I aimed to explore. The subsections will highlight the themes that emerged in the participant responses for each interview question and offer the "references" from which I coded the themes during the thematic analysis. To honor confidentiality when addressing the findings, research participants will not be referred to by name or any other distinguishable characteristics but rather cited in accordance with the numerical and alphabetic identifiers that I created (i.e., 1A).

Interview Question 1

As previously mentioned, the objective of interview question one was for me to gain an understanding of how participants defined SPMI. This offered some insight into the participants' knowledge and perspective of the term that is referenced in both research questions and throughout the focus group interview. By having this understanding, I gained a better idea of the conceptual foundation from which the participants were responding to the subsequent questions regarding individuals experiencing SPMI and the associated social work challenges.

As it relates to the first interview question, data revealed that SPMI may be defined or viewed among social workers with particular focus on the "impaired functioning" of an individual. Of the five participants in Focus Group 1, two of the three participants who offered a definition for SPMI made some type of reference to an individual's "impaired functioning." Participant 2A shared that one way to identify or define SPMI, "in addition to the actual disorders," is when "the symptomology as it's

presenting is hindering that person from being able to function in a way that they would say is their normal or baseline, so its disruptive to their daily life." Participant 4A added, "In addition to what the other two participants said, any mental disorders that significantly impact a person's psychosocial functioning in various aspects of their lives like educational, occupational, or social." Data collected from the interview with Focus Group 2 indicated that 100% of the participant responses echoed similar sentiments. Participant 4B highlighted the concept of functional impairment as it relates to SPMI:

> I would say that SPMI... I would define it as an impairment in the individuals overall functioning like whatever the diagnosis, whether it be bipolar or schizophrenia it has a bearing on how that person functions on a day-to-day… normal day-to-day activities. Whatever the case may be, housing or how they take care of themselves, there is an impairment in the functioning.

Participant 5B agreed with Participant 4B and compounded upon the response by stating, "I feel like just whatever their ADLs, or whatever their diagnosis, their mental health disorder is, it's disabling to them, and it also requires for them to have therapy." Agreeing with both participants, Participant 1B also offered an additional perspective that emphasized the chronicity of the illness and its ability to encroach upon various aspects of one's life, though not always concurrently:

> I'm in agreement with both participants. I would also add that it's an ongoing illness that interferes with their ability to function adequately in different areas of their lives. It doesn't necessarily mean it hits all areas but it's an ongoing persistent issue that requires intervention in order for them to manage and

maintain their lifestyle.

While verbalizing concurrence with all prior participant responses in Focus Group 2, Participant 2B shared that SPMI "is a dysfunction to one or more areas in a person's life dealing with ADLs, work, social, whatever the case may be, it's a disorder that cause a dysfunction, a persistent dysfunction." Participant 3B reiterated and summarized the other participants' statements:

> I agree with what everybody said. It basically impedes like everyone said on daily functioning, where to the point it effects their schooling, if they're in school, work, and family relationships, just as a typical person they're not able to function at the same level without therapy or medication.

The research participants' focus on impaired functioning as a diagnostic component or definition of SPMI parallels that of the fundamental intent of social work practice. Social workers aim to address the psychosocial needs of vulnerable populations, from a strengths-based approach, while empowering the individual and offering guidance from which to cultivate recovery and improved functioning (NASW, 2021). To practice social work effectively, it is imperative to identify service gaps, practice improvements, policy issues, and all other factors that may impede upon the continued provision of care for the population. This concept, in turn, directly aligns with the purpose and nature of this doctoral action research project.

Research Question 1

What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with SPMI from inpatient psychiatric hospitals to criminal

justice facilities?

Interview Question 2

During exploration of the data obtained from the second interview question, four themes emerged among both focus groups: “lack of community resources,” “basic needs” (i.e., income/benefits, housing, food, etc.), the “court system,” and “criminal charges/forensic status.” As it relates to “criminal charges/forensic status,” the participants more specifically discussed the way in which an individual’s forensic status thwarts his or her attempt to attain necessary services or resources. Though one may say that all four themes give way to the overarching topic of resource and service provision, each theme offers its own level of importance to the discussion of social work practice challenges when working with adult offenders coping with SPMI. Moreover, the themes address the research question in that they bring to head some of the obstacles confronting social workers as they begin to facilitate discharges and transitions from inpatient units to criminal justice institutions, as well as during community reintegration.

Three of the five participants in Focus Group 1 expressed that the lack of community resources has presented as a challenge when conducting social work practice with adult offenders experiencing SPMI. The subject emerged as a topic of discussion in Focus Group 1 when Participant 1A explained that, in addition to the barrier the lack of community resources creates, an individual’s forensic status coupled with having a diagnosis associated with SPMI has also proven to hinder their acceptance into residential placement:

I guess you can say the lack of community resources for those individuals, that

> when you put the forensic on top of them having an SPMI, a lot of group homes tend to not want to take them because they are afraid of the charges that they have and that can create a barrier.

Participant 4A agreed with the lack of community resources and criminal charges/forensic status as challenges to social work practice but homed in more specifically on concerns regarding an individual's ability to meet his or her basic needs:

> I agree with the other participant, I think that the lack of income and benefits when they're transitioning out of a hospital is a barrier. Lack of housing can be a barrier because of, like participant 1A said, they are unable to find housing easily without income and their forensic status and other lack of resources in the community.

Participant 3A echoed the sentiments of Participants 1A and 4A by mentioning lack of resources or "access to services" in the community. The participant also alluded to challenges associated with meeting basic needs, similar to Participant 4A. However, Participant 3A offered a different perspective by highlighting an individual's innate "need to survive" which might present as a challenge for social workers when working with adult offenders coping with SPMI:

> I find that a lot of my offenders need to survive before they can even help themselves in the community, so yeah access to services, that's a problem but also where you're going to get your next meal, you know, even if you're not in a group home or CIH it's where you're gonna get your meal, where you're gonna get your food, if you're a drug user it's where you're gonna get your drugs before even

> looking at their mental health status and getting the correct services, so just basically survival is something that is a challenge.

Among the four out of five participants in Focus Group 1 who either referenced the court system as a challenge faced by social workers when working with adult offenders with SPMI or verbalized agreement with responses supporting this theme, Participant 5A shared the following:

> I agree with all of the participants who answered the question, but I also think the challenges come from the court systems as well with someone who is severely suffering from severe diagnosis because I tend to see that they're not supported. They think throwing them in a facility may help them or throwing them into jail may help them instead of providing the resources right then and there and instead of them going to the next level of care if needed, if not then engaging more. I also think that it starts at the court system and if there are more resources given then it wouldn't go to the extent as inpatient or any other higher level of care.

Participant 1A reengaged in the discussion and endorsed Participant 5A's response, suggesting that the role the court system plays in directing discharges to one type of residential placement further limits that placement as a resource. This feedback not only underscored how the court system produces inadvertent challenges for social workers when attempting to facilitate successful discharges but circled the conversation back around to the topic of limited resources:

> That is very true what she [Participant 5A] just said. I just want to piggyback off of that as well. Especially when you have an individual that has one of those

> deadly sins, the court only sees the CIHs [Community Integration Homes] that we have here in Georgia and that's where they want us to send them and that's a limited resource. It's not that many CIHs in Georgia, so you have a person staying in the hospital longer who no longer fits the…meets the inpatient criteria waiting on a bed to open at a limited resource, if that makes sense.

Participant 4A and 2A agreed with Participant 1A's feedback, providing a brief verbal acknowledgement. Two participants in Focus Group 2, Participant 2B and Participant 3B, elaborated on the topic of "criminal charges" while calling attention to how adult offenders' charges or forensic status impede upon service attainment. Participant 2B addressed the challenges social workers face when attempting to highlight an adult offender's mental health needs while it is overshadowed, in the eyes of others, by his or her criminal charges:

> I haven't been working with the forensic population long, for [a duration of time] now, but that challenges that I have noticed thus far one of them are trying to separate the crime from the mental health, you know, addressing both, rather… well instead most people just look at the crime. The crime trumps the mental health part, and they forget about the mental health and that kind of is overlooked a lot of times, so the proper therapy that they need is not being provided to them because of the crime. Even if it's heinous, or even if it's like a mild crime, they, well the population or the community normally overlooks, you know, their need for mental health services and they kind of focus on the crime, which we're supposed to look at the whole person, rather than just what they have committed,

> why they committed it, what caused them to commit it. I think that's a challenge for the individual itself and that's a challenge for the social worker to try to help connect them with services in the community because some people are kind of hesitant when it comes to offenders.

Considering the points made by Participant 2B, Participant 3B inserted financial instability as an additional challenge and cause for difficulty when engaging in social work practice with adult offenders experiencing SPMI:

> I agree, with what was said. Basically, the community sees them as a triple threat. They are criminal first and foremost, they have mental health issues, and then more than likely they have no income, so it's like they feel that, 'you're saying you want us to help this person who's committed a crime, who's mentally unstable, and they have no income?,' and so that makes it more difficult.

Participant 2B agreed with the statement made by Participant 3B. Participant 1B echoed sentiments expressed in all the prior participant responses in Focus Group 2. Though the concept addressed by Participant 4B did not present as a theme when conducting a data analysis for Focus Group 2, I find it important to mention, as it did align with one of the themes that emerged in Focus Group 1, which was the "lack of community resources." Participant 4B stated the following:

> I think it's… for me it's lack of additional supports and in addition to that, I think certain individuals they have more than one issue. So those comorbidities, you know, being diagnosed with not only mental health but also too with maybe medical issues or intellectual disabilities, things of that nature, so trying to find

> those necessary supports in the community that helps and targets all those things can be a challenge. I'm not gonna saying it's not possible but it's definitely challenging for myself when I've worked with folks that…that are being discharged back into the community.

The next two interview questions, eight and nine, included four additional probing questions. The original question and its subsequent probing questions were individually analyzed for themes. This analysis resulted in the following discussion.

Interview Question 8

Probes A-D focused on social, cultural, economic, and/or political or legislative issues that can impact their discharge outcome. As it relates to environmental influences or stressors that are viewed as obstacles to an effective discharge planning process, one theme emerged during the dialogue between two of the four participants in Focus Group 1 who responded to the interview question. When discussing this topic, an individual's overall concern for his or her discharge outlook was most predominately highlighted by the participants. This theme calls attention to challenges that the first research question aimed to address. Furthermore, the discussion that supported it provides compelling insight into how such factors as an individual's personal feelings towards his or her discharge outlook my hinder or play into mental health stability, progression, and personal or professional relationships.

Participant 4A began the conversation regarding discharge outlooks by agreeing with Participants 1A and 2A who discussed environmental stressors related to the presumed lack of training for floor staff on the forensic inpatient units to properly address

mental health concerns, as well as how the milieu and acuity of these units are not conducive to recovery, respectively. However, Participant 4A added that in addition to those environmental stressors presented by the other participants, it has been observed that some adult offenders are often concerned about the uncertainty and unknowns associated with their discharge outlook. Participant 4A went on to address the lack of community involvement as an environmental influence impacting the discharge planning process for adult offenders with SPMI:

> Yeah, I agree with both participants [Participant 1A and Participant 2A] and I think also other than the stressors right there, the environmental stressors of the unit or the hospital itself, just having constant worries regarding what's to come once you discharge and I mean these patients are already suffering from anxiety, and depression, and paranoia and then you add the uncertainty, the unknown… 'am I gonna be approved for income, for benefits, where am I gonna live.' So they constantly have that in the back of their mind and I think that, that can make the discharge planning process more difficult, and then for me, just lack of involvement from the community, whether it's because they're too busy because of the lack of staffing or they just flat out don't want to give these individuals a chance. I think somebody mentioned it earlier that the community as a whole, they're afraid of individuals that have mental illness and also committed crimes, so they're less likely to be open to receiving them once they're released from prisons or inpatient settings. So yeah, just a combination of everything, all of the above. It just makes our jobs more difficult and it makes it difficult for the

> patients, for the individuals, to really focus on getting better.

Expounding upon Participant 4A's points, Participant 3A tied together monetary and payee concerns, the associated distrust caused by such adverse financial situations, and stressors experienced by the research population when engaging in the discharge planning process. These challenges also appear to impede upon the individual's discharge outlook:

> I just wanna go off of what 4A just said… the economic issues, 4A touched on the SSDI/SSI, where you get your money from, another huge thing that I've noticed as an obstacle is the payee situation. I've had multiple people that have had very bad experiences with payees, and it makes them distrust even their family members or the community providers.

Conversely, of the three participant responses in Focus Group 2 to the question regarding environmental influences or stressors, there did not appear to be any emergent themes. Each participant offered diverse responses. Participant 4B started a thought-provoking discussion by sharing the following regarding the attainment of gainful employment as an obstacle to effective discharge planning:

> I think for… from my perspective, this is 4B, employment. A lot of folks who have offenses, of course there's a stigma associated with that. So, one of the goals that I've found a lot of my individuals wanted was to work. For those folks that don't have family, they kind of depend on personal care homes or they have to pay for wherever they end up being discharged to. So I think, unemployment causes a lot of stress. For those that have the desire to do so but are kind of being

> barricaded, they can't secure work because they do have these offenses, much like a regular…you know, when you have felonies or anything on your record, it makes it that much more difficult, so I would say employment and the ability to work is definitely a barrier with ongoing care and then being able to maintain themselves so that they don't go back to crime, so that they don't go back to doing the things that they were doing that got them there in the first place.

On the other hand, Participant 5B shared that the location of residential placements presents as an obstacle to an effective discharge planning process. The participant expressed that this is especially true in cases where the geographical location is not conducive to the individual's recovery or overall well-being:

> I think one obstacle that I face is the location of places. Sometimes they tend to be in an area that is either… has a lot of crime or one thing that really a lot of the locations where the semi-independent apartments are, you'll hear other disciplines or whoever say, 'well they can't go there because their…that area is drug infested or whatever.' So that makes it really difficult and has a big effect on discharge planning is the location of the places because they may not be in the best of places or best of areas.

Offering an alternative perspective, Participant 3B discussed how factors associated with immigration status or the absence of a therapeutic relationship between the adult offender and unit or placement staff may hinder discharge planning:

> I totally agree with that from those other disciplines and also when they are discharged to certain places or certain staff members, I don't know it's hard to

> say. They may not be…they may not like them very well. They may not vibe with them or with their personality and I know that can block the discharge planning, because they're not… even with the visitations or whatever, I know that, that can…if a certain staff member or someone is not very fond of them, I know that can block the discharge process. Also, working with a lot of individuals with certain situations regarding their immigration status, like I've had an individual who was a U.S. ci…well he was born overseas but he did everything he was supposed to do to become a citizen of the U.S. However, when the mental illness took over, he didn't renew all of his forms and all of his paperwork and so there was some question about having him… his mental illness just totally took over, and there was some question about sending him back to his original… native country, when he came over here originally for asylum. So that is also an issue that is very stressful to them, especially if they came over here on asylum. They remember it being war torn as young adults or children and the stress of just thinking that I might have to go back, yeah that, that causes them a lotta stress and discomfort.

PROBE (A). There were no themes that emerged when conducting a data analysis of the first probing question under interview question eight. This was due to limited data resulting from only one participant responding in each focus group session. Although there were no identified themes related to the probing question about possible social issues impacting discharge outcomes, Participant 2A's contribution to the interview question reiterated the common topic of "stigma" associated with SPMI and

forensic status. This directly aligned with "stigma" being a theme brought about by other participant dialogue:

> I think kind of the thing that's been weaved throughout all of these questions this far has been stigma and the effect of stigma, and these particular individuals have the stigma of having a severe and persistent mental illness and having committed a crime, so just the stigma of being involved in the criminal justice system and having a mental illness is a significant barrier all around.

Another contribution from Participant 5B, in Focus Group 2, underscored the importance of social support and how restrictions on visitation while transitioning to community placements (i.e., Community Integration Homes, etc.) might present disadvantageous to discharge outcomes:

> I know, for me, in the past I've discharged people to community integration homes [CIH] and for the first… I don't…I think it's like the first 30 days or something, they're not able to see their families or they're not able to have visits with their families, or I can't remember exactly but it's something similar to that and I think that, that's a big disadvantage to them and it would impact some of them that do have families and have that support. They can still talk to them but at CIHs…I just remember specifically one case that I had, the treatment team wanted him to go to a place that was a CIH that was close to his family so that he could be around them because family was very important to him, and that support was there for him, and it was a really good support system for him and once he got there he anticipated seeing his family and doing all the… you know, being

> around his family and all of that and he couldn't for however long it was. So, I think that sometimes…I think sometimes that is…well, it impacts them and it's hard, it makes it difficult for them to transition. Thinking that they're going to see their family and all that and then they get there and they're not able to. So, having that social aspect for them would be beneficial but it's not always there.

PROBE (B). Data analysis of feedback to the second probing question, in Focus Group 1, also suggested "stigma" to be a cultural issue that might impact discharge outcomes for adult offenders with SPMI. One hundred percent of the participant responses contributed to the emergence of this theme. This theme aligns with the research question in that stigma is a social paradigm often experienced not only during social work practice but across the full gamete of systems with which individuals challenged by mental health and/or criminal history interface daily (West et al., 2015).

Dissimilarly, an analysis of the data from Focus Group 2 did not result in any themes, as a total of two participants responded and offered diverse feedback. Participant 2A melded a discussion of political and cultural concerns, highlighting the "conservative nature" of Georgia as well as the stigma associated with mental health, and their impact on the mental health system in the state:

> Well, I wasn't sure if this would be cultural or not, maybe it's more political but Georgia is a red state and more conservative and because of that, and then this is also kind of linking to the stigma piece, but because of the conservative nature of this state, it can be quite difficult to get people to think creatively about the recovery process for people with mental illness and are involved in the criminal

> justice system…the forensic system…There's not as much money allocated to resources, thus not as much staff and it's just, it's really difficult to kind of navigate the system and the conservative culture of this state.

Agreeing with the points made by Participant 2A, Participant 5A shared cultural issues related to the stigma associated with mental illness and criminal background:

> I agree with 2A, I think a lot of the culture stigma would be to people who have criminal charges and suffer with mental illness, I think a lot of the stigma is to keep them hospitalized, like let's keep 'em in the hospital forever and let them die there sometimes and I think that's the cultural concern and just Georgia period! Like when it comes to that stigma of trying to discharge somebody it's like, no they're dangerous to society so we must keep them in the hospital and they're sick.

Participant 3A offered a unique perspective, calling attention to the stigmatization of mental health among ethnic minorities who may already experience institutional and economic adversities:

> So for cultural, working in the prison system and the inpatient hospital system I've noticed even just like the cultural background, such as race, ethnicity, I've noticed that some different cultures will stigmatize mental illness more due to the fact that they are, you know, institutionally discriminated against. So if you are a race other than white and you have an economic background other than middle class, you already have so many things stacked against you and then to put the stigma of mental health medications and going to mental health appointments and

> then of course the criminal backgrounds, you have a lot of people that will say, you know, 'I'm not mental health' or, you know, 'I don't need to follow up with this because it's gonna put me in a bad light.'

An additional and interesting topic presented during the discussion was that of "immigration" as it relates to cultural issues impacting discharge outcomes. After verbalizing agreement with the feedback given by Participants 2A, 3A, and 5A, Participant 4A offered the following perspective:

> Yeah, I agree with what everyone said and I made a note here about language barriers. Sometimes with individuals we receive from different countries or their English is not their first language, that can be a barrier because, yes you know the hospital I work at, we can provide interpreters because they have the right to be able to communicate with us but what about when they're discharged. And a lot of times our worries are, can they receive an interpreter at their outpatient service provider and also something that I faced is when a patient is not a U.S. citizen they have so much working against them. They might be stable, they might, you know, be deemed appropriate for discharge by the hospital treatment team but they can't go anywhere because they're not a U.S. citizen. They can't receive housing. They can't receive benefits, so that's been a challenge for sure. We don't get a lot of those patients but every so often, you know, that one or two and it's very challenging.

Participants 1A and 2A expressed agreement. Participant 1A followed up by stating, "My comment was gonna be about immigrants as well but 4A said it all, so I agree." In Focus

Group 2, Participant 1B asserted that cultural competency among the multidisciplinary treatment team, within the inpatient hospital, presents as a cultural issue that might impact the discharge outcome of an adult offender with SPMI:

> With cultural issues, I would say maybe just not really… we talk about cultural competency all the time but I don't really think it really encompasses culture from many different perspectives. Many of the patients that I've worked with have come from…majority of them were from America but some of them came from other parts of the world and really just being able to understand different culture's ways of communication because a patient speaks loudly, what appears to be aggressive to the Western culture doesn't necessarily mean that they are being aggressive. It's just their culture's way of expressing themselves and so some of th…that's been some of the issues that I've found and so…in having that patient just understand…well, really having the team understand that there are cultural differences that cause the patient to behave a certain way because I've seen a situation where a patient's been diagnosed antisocial because there wasn't really understanding of his cultural background. So, that's one of the things that I've found stressful.

Conversely, Participant 2B suggested the lack of familial psychoeducation as a cultural issue that might also influence discharge outcomes for adult offenders coping with SPMI. The participant stated:

> Also, the family not knowing much about SPMI. The lack of education that they have regarding that. A lot of 'em kind of look at it in perspective of religion

> versus how we looked at it. So that can cause an issue or it can impact their discharge.

PROBE (C). Through an analysis of the data for the third probing question, one theme emerged among the discussions in Focus Group 1. The inquiry about economic issues impacting discharge outcomes fostered an understanding that "no financial support" often presents itself as a hinderance in the discharge planning process and, essentially, to the success of community reintegration. Focus was placed on the interdependence between SSI benefits and length of stay in the hospital or jail, as well as financial instability and the means to obtain prescribed medications. Of the four participants who responded, three either mentioned "no financial support" as an issue that impacted discharge outcomes for the client population or agreed with those who provided a lengthier response. The highlighting of concerns regarding financial stability supports the research question in that it underscores a significant hurdle that often impacts various aspects of the discharge planning process to include the person's ability to finance food, housing, clothing, medication, transportation to and from mental health appointments, etc. Finances are one of the most prominent concerns from a client perspective (Wilson, 2013). Moreover, the lack of financial stability has the potential to interfere with a person's mental health and overall sense of financial security and safety (Pope et al., 2013). With regards to this topic, Participant 1A communicated the following:

> Well for a lot of forensic individuals it's depending on how long they have been in jail their SSI probably was suspended and by the time they come to the hospital they're there longer and then it's terminated. So now you have to start the process

> but if they're on a unit where they're gonna go back to the jail then it's hard to start the application process for the SSI, which if they have a misdemeanor they're probably gonna be released and now they're back at square one of no income, limited resources, and just having to survive and most probably have no family support. They burnt those bridges and it's hard to get family to help them because, I think 5A said about just not wanting to support them, so that's a big barrier.

Participant 4A concurred with the entirety of Participant 1A's feedback. Participant 2A added an additional consideration with regards to the financial aspect of medication management, to which Participant 1A verbalized agreement. Participant 2A stated the following:

> Well, I was just gonna mention that along the lines of finance, the medication, some of these medications that work really well for our individuals are expensive. So you have to go through that process of getting like, the preauthorization and tryna get the support from the different organizations that offer financial support for some of the medications but sometimes that falls through and you're not able to ensure that, that individual is gonna have the medications that they need or the access financially to medications that they need, so that's another barrier too.

Barrenger & Canada (2014) suggests that termination of benefits offered through the SSA, such as SSI, due to prolonged length of stay in psychiatric and/or correctional facilities, may adversely affect one's ability to obtain, maintain, and manage different components needed for a successful reintegration once released from jail or prison such

as various services, basic needs, medications, and other resources.

Though no new themes emerged in Focus Group 2, as one participant responded, the participant did share similar sentiments to that of Focus Group 1 participants. Included in Participant 4B's response were lack of financial stability, limited social support, and lack of employment opportunities due to location and/or "prior history:"

> No monies. You know a lot of people depend on social security income or SSI, and just not being…not only not having money but not having any supports to where they can kind of stay with them or get back on their feet. Like everything is really all up to the individual. In addition to whatever area they're discharged to, it could be rural, there may not be any opportunities to get employment or there may not be any jobs that would have folks who have the prior history that they have.

In addition to the responses that aligned with the theme of "no financial support," further feedback was offered by participants in Focus Group 1 that presented interesting and thought-provoking. Participant 5A provided an alternative perspective by highlighting the managerial side of the argument and underscoring institutional influences that hinder discharge outcomes:

> I have a different perspective on this question as well. I agree with 1A's answer, but I've also sat on the management side of things as well and I've sat in treatment teams where I literally heard people say 'we can't discharge so many people because if we have the low numbers then we will get in trouble' because they get paid so many…so much a day per bed that is in use and if there's a low

> number on the census then I literally heard people say 'we're gonna push this discharge off.' So that's an economical barrier not because of the individual because of the institution that they're in is not wanting to reduce their funds from the state and the government that they receive per person or individual that they receive or per bed that they receive that is occupied.

Participant 4A concluded the discussion brought forth by Participant 5A by stating, "Yeah, that's a really good point. I think going back to the higher ups…the management, the system as a whole and how it's a huge barrier that leads to other tiny barriers for these individuals."

PROBE (D). When asked this probing question, participant responses revealed that "political agendas or motives" and "funding for mental health services" appear to be commonly viewed as impactful to discharge outcomes for adult offenders coping with SPMI, from a political or legislative standpoint. Of the four participants who responded in Focus Group 1, 100% agreed that "political agendas or motives" were of concern and negatively influential to discharge outcomes for the client population. Participant 1A concisely reiterated and applied a comment made by Participant 5A earlier in the focus group session to the question of political and legislative impact. She shared the following: "I think it's what 5A mentioned earlier about having to fill those beds for income, I mean for money to help pay for the state hospital." Participant 4A reinforced Participant 1A's reply and formulated a term for the topic of concern, noting "Yeah, I agree. A lot of the issues seem to be stemming from political agendas and yeah political motives, so that effects the individuals and the recovery but, yes." Participant 5A stated further:

> I also think that it depends on what governor that you do have in office at this point, or do you have somebody that's in support for mental health reform or someone who's not, because someone who's in support of it will put the resources, such as financial resources, in place to help individuals thrive or put the resources in place so that individuals have those options to obtain resources, especially in our rural communities in Georgia.

Participant 1A concurred with the point made, while Participant 2A offered an additional yet similar perspective regarding the motives of local judges:

> And if we think about the local level, these judges are the ones that are signing off of these discharge plans for our individuals in the hospital and no judge wants to be responsible for letting the person with schizophrenia that stabbed their aunt 37 times out of the hospital and then God forbid that same type of incident happens again and their name is on the discharge plan. That is like a career ender for one of these judges that is seeking…may be seeking reelection, so there's that political motive in that they don't want to be responsible for a tragedy on their watch and so there is a lot of caution when it comes to discharge and sometimes there's just an absolute 'no' from that judge that they will not allow the person to discharge because of the crimes this person committed while they were experiencing increased symptomology.

Almost equally as unanimous as Focus Group 1, three of the four participants who responded to the above probing question in Focus Group 2 indicated "funding for mental health services" as impactful to discharge outcomes. Participant 3B commenced the

discussion regarding the cut in funding for mental health service provision by sharing the following:

> I don't know what exactly…what the bill is or the exact verbiage of the law but I know just the cut for mental health services in itself impacts them. Even once…yeah especially in the community, once they're discharged and they're getting services in the community, some programs have to end or whatever the case may be. They're not getting everything that they need and the more and more that they cut funding for mental health services, it's just… the worst that it gets.

Both Participant 2B and Participant 5B expressed agreement with Participant 3B's statement. Used to indicate agreement based on the tone of the sound, Participant 5B expressed "mm-hmm" following Participant 3B mentioning "the cut funding for mental health services." Similarly, Participant 2B stated, "I agree. Not enough funding for the mental health population. The government is not giving enough funding."

Though not directly aligning with present themes, Participant 1B made the following insightful comment regarding the legal system and its perceived impact on discharge outcomes:

> I'd also add to that, I think it goes from the very beginning with the whole legal system, with the patients having committed a crime, not having understanding of their back…their mental health background and then them being transitioned into the hospital and then being stuck in the hospital for some time because again, now they're here for a legal issue but it all started because there was a mental health issue. Well, for the most part. And so that's been one of the influences…political

> influences that I've noticed. I really don't know how to change it but I…It just seemed like the legal system has their view of people, in general, and whatever their decision is that's how we move forward and then we just have to follow whatever their lead is.

Interview Question 9

Probes A-D focused on social, cultural, economic, and/or political or legislative issues that can impact their reintegration outcome. Although there were not any specific themes that emerged from participants' responses in Focus Group 1, to the first part of interview question nine, the feedback did parallel themes highlighted in other interview questions. Those themes include "stigma," "social support," and "psychoeducation/training." For instance, Participant 4A started the discussion by expressing that one of the environmental influences that present as obstacles to a successful community reintegration for adult offenders with SPMI is stigma: "I think what someone said earlier, just that stigma being there for having a mental illness and also having committed a crime or crimes." Participant 2A addressed the protective factor social support offers in the treatment and recovery of someone experiencing mental health symptomology and how severed social ties might impact reintegration:

> Also, we talked about the importance earlier of having family support and friend support and often times these individuals have been experiencing their symptomology for many years, decades, and they have unfortunately burnt those bridges with their family. The families cannot sustain being a part of an active role in that person's life because it just requires too much energy of them or too

> much time and they don't have the time that, that person needs or they have friends that are no longer friends or they've had people take advantage of them in the past, and so just not having the social environment to support their recovery is also a significant barrier to reintegration.

Participant 3A expressed agreement with both participants, then called attention to the seemingly insufficient psychoeducation and training among society and law enforcement concerning mental health, respectively:

> I agree with both of those ladies. I also feel that the lack of education in our society regarding mental illness is a problem. For example, police are called when you see someone on the street who's talking to themselves or responding to internal stimuli and those police might not even need to be called. That might be baseline for that person and as long as he's not acting aggressively then you know you can just let him be and I feel that law enforcement and police are brought into situations that they themselves are not trained for and if we had more education on mental illness in our society that wouldn't necessarily be an issue.

Participant 4A and 2A echoed "I agree" and "I agree as well," in response to Participant 3A's sentiments. Similar to Focus Group 1, an analysis of Focus Group 2 responses did not yield any themes for the first part of question nine but did offer insight into structured living and "housing, finance, and wraparound services" as environmental obstacles to successful reintegration back into the community. Participant 3A stated:

> Basically again, housing, finances, and wraparound services. Those, to me, seem to be the…I'm sorry, I was rereading the question to make sure I was answering it

> correctly. With those things it really does help the individual reenter back into society, having the appropriate housing, finances, social security, or help from family members and those wraparound services…[inaudible]…they're in the community to integrate them into group therapy, individual therapy, vocational rehabilitation, so on and so forth. But those are the three main things that I see would be priority.

Participant 5B then expressed that a structured living environment might also be a factor associated with reintegration concerns, which excited a sound of agreement (i.e., "mmhm") from Participant 2B:

> I think, sometimes for the patients it's really difficult for them to go to something that's so structured where they're being told what to do, how to do, when to do it to. I guess a normal, quote unquote, living style where it's definitely not as structured, would be hard for anybody I would think.

PROBE (A). The facilitator did not receive a response from any participant in either focus group, regarding this probing question. In Focus Group 2, a participant began speaking but before fully making a statement, they determined that they were responding to the wrong question or realized that the question was asking something dissimilar to how they were answering.

PROBE (B). Although the response(s) to this probing question did not produce any identifiable themes, one participant response, in Focus Group 1, did reiterate the topic of immigration and language concerns presented in other participant responses. More specifically, Participant 2A expressed:

> It was already stated previously, I think, I can't remember the participant's number but the issue with not being an American citizen is huge and then the language barriers, I think those are like the key ones that would keep people from being able to fully reintegrate.

No one in Focus Group 2 responded to the question, despite the facilitator offering a period of silence to allow participants to speak when they were ready.

PROBE (C). Comparable to the other probing questions in interview question nine, this probing question did not result in any themes, upon completion of the data analysis. In Focus Group 2 the question did not receive a response. It did, however, offer some insight by way of a participant response in Focus Group 1. With Participant 4A in agreement, Participant 3A highlighted concerns regarding resources that might aid in an individual's ability to continue with mental health care outside of the inpatient hospital:

> With regards to economic issues, I know we already touched on medications costing money, but I think just the basic continuing with mental health appointments really takes time and resources. You have to think about the resources these people might not have, such as vehicles or ways to get to appointments and also copays if they have any. Just 5, 10 dollars to you and me might not be a lot but to them that could be a huge deal. To get to the appointment, spend the money and the time to make that happen, take time off work, it could be a real big issue.

PROBE (D). Among the three participants in Focus Group 1 who responded to the above probing question, an analysis of the data yielded one theme. One hundred

percent of the participants who engaged agreed that "judicial consequences for non-compliance or inability to comply" was a political or legislative issue that might impact the reintegration outcome of adult offenders experiencing SPMI. There were no contributing responses for Focus Group 2. When addressing political or legislative issues, Participant 2A commenced the discussion of non-compliance with treatment plans and its association with court orders, with particular focus on those adult offenders with SPMI who are discharged from the inpatient hospital directly into the community:

> I think a significant one is the fact that their discharge plan is a court order. So if they violate their discharge plan for any of the barriers that have already been mentioned before, then that can have legal ramifications for them as opposed to just, you know, the symptomology ramifications. So I think that's a significant barrier that they can face, further judicial action for not being able to comply with the treatment plan.

Participant 1A verbalized agreement, while Participant 3A added:

> Yes, going off of that…I'm currently a mental health provider at a prison and the amount of times that I get people back in prison due to not being able to pay probation fees or not having a probation address or breaking some sort of… some sort of rules to their, quote unquote, discharge or release due to the fact that they have limited resources is huge. I get people who come back for 5 years because they couldn't pay a certain fee or because they didn't have a certain address and also going off that, when you have people who have felonies for things such as like…someone stole for example, one of my guys stole a bike that was less than

> $100 and he got a felony for it and now he has to register as a felon and now he can't find housing or jobs or certain jobs and that really does…those legislative barriers really set people up for failure instead of helping them.

Though the ninth interview question and its first three probing questions did not yield data that contributed to key findings, the responses were instrumental in strengthening the discussion of several themes that were previously explored, such as stigma, social support, psychoeducation/training, and limited resources as it relates to funding medication, paying copays for mental health appointments, and transportation to scheduled appointments. The topics of "immigration" and language barriers were also iterated. Moreover, feedback excited further insight into the concept of transitioning from "structured" living in inpatient hospitals and prisons/jails to independent decision-making in environments that require less structure. Additionally, perspectives were offered regarding the lack of "housing, finance, and wraparound services" being environmental obstacles to successful reintegration back into the community. This discussion is consistent with literature and its assertion that offering a foundation of appropriate support and adequate wraparound services directed towards the population's psychosocial needs, while considering the nature of their criminal offenses, would foster an environment in which adult offenders with SPMI may discharge and transition successfully between facilities and back into the community (Prins, 2011). In doing so, criminal and psychiatric recidivism and the occurrence of reinstitutionalization may be substantially reduced (Prins, 2011). As it relates to political and legislative concerns, data suggested that issues impacting the reintegration outcome of adult offenders coping with

SPMI include judicial consequences for non-compliance or an inability to comply with treatment/discharge plans and stipulations associated with the individual's release from jail or prison due to limited resources and other barriers. This is consistent with literature and previous findings which ascertain that these aforementioned factors, seemingly related to shifts in social paradigms and policies, appear to contribute to the historical overrepresentation of individuals experiencing SPMI in all facets of the criminal justice system, as rearrest is probable and, in most cases, imminent if an individual is non-compliant with mandated treatment regardless of whether non-compliance was intentional (Barrenger & Canada, 2014; Brandt, 2012; Davis et al., 2008; Lurigio, 2011; Prins, 2014; Seltzer, 2005; Torrey et al., 2014; Vogel et al., 2014).

Research Question 2

From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?

Interview Question 3

As it relates to interview question three, the data analysis yielded three themes among the three participants who responded to this question in Focus Group 1. The themes are as follows: "recovery-centered" approach, "person-centered" care, and biopsychosocial assessment. Of the three participants, two communicated that a recovery-centered approach and biopsychosocial assessments are or have been used by them when planning for the discharge of adult offenders with SPMI. Additionally, two of the three

participants indicated person-centered care as a discharge planning practice or procedure. Participant 5A suggested the use of biopsychosocial assessments and a recovery-centered approach when discharge planning with adult offenders experiencing SPMI:

> I mean it's a process. So when we're thinking about discharge planning we already automatically know…if any social worker knows that you know that discharge starts at admission, so seeing what their charges are, where they came from, what county they came from, what the resources are in that county, what level of care they're going to need after their hospitalization and what family support they have and you're trying to factor that in and pull the team together to create the best possible discharge as possible for the client and just trying to wrap around services and just trying to ensure that this is not recidivism coming back or somebody coming back to the hospital or even being reincarcerated and someone that has the support in the community to help them function with their severe mental illness.

Among the three participants who responded in Focus Group 1, one participant's response incorporated all three themes. Participant 2A added to the topic of a recovery-centered approach, highlighted biopsychosocial assessments, and expanded the conversation into a discussion on person-centered care:

> I agree with that [5A's response] and then I also remember, because it's been a little while since I've done this, but I remember that it felt as if the social worker's role, within the team dynamic, was really around being recovery-focused as opposed to being punitive like the court system can be or the medical model that

> maybe some of the other practitioners like the psychologists, or the psychiatrists, or nurse practitioners would fall within. So I really saw our role, in addition to kind of doing that really good biopsychosocial assessment piece, was conceptualizing this person and presenting that person in a way so that the team can see that individual's strengths and see that individual's ability to recover and be prosperous and live the life that they want to live and then conveying that in a meaningful way to the psychologist that then went to court and represented our individuals to the judges, to the FCCs, so that we could advocate for the least restrictive way for this person to live outside of the hospital. So I really saw that as a big component because it was very easy for the judges, or I mean even some of our team members, to really heavily rely on like CIHs [Community Integration Homes] and stuff like that and like it was said before it is a very limited resource, so trying to be creative and thinking about that person as a whole person and thinking about them as a person in recovery I thought was the key piece of what we were doing in that discharge process as social workers.

Participants 4A and 5A verbalized being in concurrence with the response offered by Participant 2A. Participant 4A then went on to add:

> So just being person-centered and having the IRPs, individual recovery plans, instead of calling it the treatment plan but having the individual involved in their treatment and their discharge planning from the very beginning. You know taking their feedbacks and their interests into consideration. Where do you want to live, where do you want to live in GA after you discharged or you're released from jail

> and just getting the individuals involved in the discharge planning process, I've found it's very important but sometimes hard to do.

An analysis of the responses from all five participants in Focus Group 2 resulted in the emergence of five additional themes: communicating patient discharge needs, transition visits, supportive services for family, schedule mental health appointment, and building rapport with community providers. With regards to the concept of communicating patient discharge needs, three out of five participants in Focus Group 2 conveyed that this is or was a discharge planning practice they are you currently using or have previously used in working with adult offenders coping with SPMI. Participant 1B expressed her appreciation for engaging in transition planning meetings where she can communicate patient progress and needs to community providers from a social work perspective:

> As challenging as it was at times, I did appreciate being able to share social work findings with the team, the multidisciplinary team, but also then being able to transition and make sure that everything is set in place, so that we can have the TAP [Transition Action Plan] meetings, and please forgive me because I forget the term but the last final meeting before the patient actually leaves, I enjoy being able to speak with the community so that they can be aware of what the hospital has done and what we believe the patient will continue to need out in the community.

Participant 4B also addressed the communication of patient needs during transition and discharge meetings but called specific attention to the challenges medication management presents when discharge planning and the importance of communicating the patient's

medication needs to ensure continuity of care:

> I agree with the last participant [1B], I think the TAP, and it is the TAP, the final TAPS meeting with the team…that, you know, where the client is being discharged from, being able to speak with them I think definitely improves the continuity of care. From my experience, medication is a big challenge. Many places don't necessarily send the patient or the individual home with a surplus of meds, so making sure that wherever that person is being discharged to, not only that they're prepared for that but the community agency they're going to has the medications that they need and that they're informed about this individual and their discharge because in my experience I've noticed that we may discharge…they may discharge a person but the place that they're going doesn't even have the meds that they need in their formulary. So that can pose some issues as well. Definitely speaking with them and being just upfront, going through that chart and just kinda seeing what barriers are there and how we can better assist that individual in the community.

Participant 2B concurred with Participants 1B and 4B, while emphasizing the significance of Transition Actions Plans. The participant noted:

> I agree with all participants [1B and 4B]…and having the Transition Action Plan meeting, making sure that the individual has everything that they need before they leave the hospital because once they discharge then the responsibility is put up on the community and if they don't know what's going on or if that individual still needs some type of services and they can't follow through with it then the

> discharge plan has failed. So, to do service to the individual and make sure you have a smooth transition from the hospital to the community that Transition Action Plan meeting is very important and that's when everyone comes together and see what's best for the individual, what's in the best interest of the individual.

With two out of the four fellow participants agreeing and providing similar responses, Participant 1B offered additional feedback, contributing to the emergence of transition visits as a theme within the research data. The following was expressed:

> Just adding to that, one of the other practices that I used while working in the hospital was being able to set up visitations and the patient to go into the facil..or not facility or the homes so they can get a better idea of where it is that they're also going rather than just the social worker in the hospital and everybody else making these decisions for them, they too can get an opportunity to just experience for themselves what it would be like to be in that home but also just step away from the hospital for a short moment.

To further extend the response offered by Participant 1B, Participant 4B underscored supportive services for families as a discharge planning practice that she has used when working with adult offenders experiencing SPMI. Participant 4B stated:

> I think to piggyback on what the last participant [1B] said, a lot of times, individuals may return back home with family members. It may not necessarily be a personal care home but if they're going home and those relationships have been strained, you may need time to get that family prepared if they're opening their doors again to that individual, they may need some type of interventions, or in-

> home interventions to kind of prepare them as well to have that individual come back and live with them, so that the cycle is not repeated and then they're triggering each other or whatever the case may be and then that individual comes back. So I think continuity of care is not just for the hospital but also making sure that those natural supports are there as well.

Participant 2B expressed one's support for Participant 4B's commentary and then provided additional insight to the discussion:

> Mhm, I agree [with 4B]. And another practice, just feeding back on the last participant, to kind of add to that is family therapy. That can be done inside the hospital with the individual and with the family to kind of get them prepared for them to return back home, if that's an optional placement for them. That will kind of get them to identify triggers for each other, identify preventive methods and ways to cope with that individual's symptoms and how to deal with that individual, so I really agree with that.

In the feedback below, Participant 5B also made mention of familial psychoeducation and potential referrals for family therapy when discharge planning with adult offenders experiencing SPMI. Additionally, while reiterating other points made during the dialogue amongst the focus group participants, Participant 3B agreed that family therapy and in-home familial services would be beneficial to add to discharge planning practices and procedures but has never observed it being offered within the hospital aside from "mediation." The participant more specifically noted:

> …another thing that was mentioned was the clients going home and not going to

> the a outside provider, going back home, having that in-home therapy, or I should say, that therapy within the hospital. I think it's an awesome idea, I just have never witnessed it myself. It would make more sense. I've seen more of the social workers do the mediation between the family and the client. I…we…there was counselors available, but it didn't happen. So, I saw most of the social workers provide that service, but I agree it makes the most sense...

Furthermore, there was almost a resounding consensus amongst the participants, represented by verbal indications of agreement, regarding scheduling mental health appointments as a discharge planning practice employed when working to help adult offenders with SPMI and prevent recidivism. Participant 5B summed up the discussion by stating the following:

> I think one of the [inaudible] I currently am using is going ahead and scheduling those mental health appointments whether it's outpatient, going ahead and educating the person or the family members about potential things that might, that they might benefit from, whether it be individual therapy or family therapy like one of the other participants said, whether it's trauma-based therapy, whatever it might be, I mean, I know depending on the location and where you work that can be difficult sometimes but I found that going ahead and putting those things those therapies and things like that in place helps to prevent rehospitalization.

Additionally, Participants 2B and 3B suggested "building rapport" with community and/or placement providers as a discharge planning practice they were currently using or have previously used when working with adult offenders coping with SPMI. Participant

3B elaborated on the topic by stating:

> The thing that helped me the most was, once I found them placement, once you can build rapport with the potential placement, whether it be the managers, or the coordinators or everything, then things kind of transition pretty smoothly. 'Cause once you have the potential placement, then you can find the community service board or any wrap around services within that area. But when you make that connection with those potential placements, it also helps you out and sets you up for potentially sending other clients. You know, they feel comfortable with certain case managers or certain social workers, and they're like 'okay, I know they wouldn't send me someone I couldn't handle.' So that helped me out the most, once I can find placement then I can find everything else around it.

Interview Question 4

As a result of participant responses to the fourth interview question, data revealed a myriad of themes. Among the four participants who responded to this question in Focus Group 1, building community rapport emerged as a theme. Focus Group 2 resulted in the emergence of three themes from four participant responses. The themes were, "awareness of client needs," "inform family," and "empowerment."

Participant 3A expressed that the identified practices and procedures brought forth in the previous interview question have been effective in that they have helped to build community rapport. Furthermore, the participant goes on to express how this enhances and humanizes the discharge planning process, offering a sense of dignity to the individual being discharged into the community:

> From my experience having personal relationships with providers in the community is the most important. So you know, you can talk to them on the phone or in a conference call but actually going out to these homes and these day treatment centers and meeting the people and having a face-to-face interaction, showing that you care about the offender or the patient it really goes a long way to humanize the process and also when you go to follow up with someone to see how this person is doing on a visit or on a discharge, they can put your face to your name and it's just more of a humanizing experience.

Participant 4A agreed with Participant 3A and further expounded upon the concept of offering dignity to the individual being discharged by addressing the significance of including him or her in his or her discharge planning process, in addition to working with community providers to act in the individual's best interest:

> I think, you know like 3A just said, the likelihood of the individuals being successful following their discharge or release is higher when you include them in the discharge planning instead of making your own plans and you know releasing them and telling them good luck. So, you know, working with the community providers and working to choose the best plan for your individuals that they approve of, that they agree with, I think the success rate is higher for them in the community or it can be.

Participant 1A took the conversation a step further by highlighting the importance of not only the inpatient social worker building rapport with community providers but community providers establishing strong working relationships with the individual prior

to discharge:

> And I just want to add…I also think if a community provider can start a relationship with that individual before they discharge, that would be successful. I have a lady now who at first she was kind of iffy about the ACT [Assertive Community Treatment] team and after she talked to the person she was happy and said 'oh he's gonna call me, you know, every week so we can just talk.' And he didn't make it seem like it was a service for her. He made it seem like they were building a relationship. And she liked that more. So I think just community providers building relationships with individuals before they discharge will also be more affective for them to trust the individual because you know a lot of our individuals are paranoid and just haven't had good luck when it comes to community providers, they don't trust them, so I think that would be good as well.

In addition to building community rapport presenting as a theme during the discussion held by Focus Group 1 regarding interview question four, one of the research participants also offered feedback that further expanded on the theme of supportive services for family, introduced in interview question three. The response by Participant 5A was as follows:

> Yeah, I agree with the last two participants [3A and 4A] but I also want to add to…any study that you looked at has shown that when you increase family support, you increase the likelihood for an individual to be more successful. So, I also think just you know, building that rapport with the family, and providing that education, and putting in the supports in addition to help the family to help the

> individual stay stable while they're in the community is also a way or a method to increase the likelihood of reducing recidivism.

As previously mentioned, Focus Group 2 participants identified that the previously discussed discharge planning practice and procedures have aided in increasing awareness of client needs, informing the individual's families to keep them aware of behaviors and giving them necessary tools to manage behaviors, and offering a sense of empowerment to the individual. Over 50% of the participant responses addressed the social worker's acknowledgement and sensitivity to client needs. Of those responses, Participant 4B stated:

> Definitely planning; I think the more prepared you are the better so, with some clients or individuals you have the luxury of being notified well in advance, months in advance and you're able to kind of start putting things in place and I think really doing your research. I think in my experience, I was working with an individual that was intellectually disabled, so of course I had to do a little bit more digging to find programs in that person's area, things that would stimulate him … and making sure that he was able to engage in different activities. So definitely preparing and being just like I said, being prepared, being aware of what those clients' needs are.

Participant 2B and 5B also agreed with the points brought forth by the above participant, with specific focus on being aware of client needs. Participant 5B made a connection between building rapport with one's client and the clinician's ability to gain insight into his or her needs:

> And I actually really liked the last part that she [4A] said, just being aware of what your client's needs are which one of the things that I wrote down for this was knowing who you're working with and being able to build that rapport. I know people that have been in the hospital for a long period of time have really, you know, they've become institutionalized sometimes and they have an issue with just reintegrating into the community. And so if you have built that rapport with the person, then and … allowing them to be a part of the plan, then it's a lot easier. I've found that a lot easier and more effective in the discharge plan. You don't have as much resistance from the person as you would if you didn't have the rapport with somebody, because they trust you more I guess.

Additionally, two of the four participants addressed the involvement of the familial system. Participant 1B suggested that by keeping the family informed of the behaviors the individual is demonstrating and his or her improvements towards recovery, the social worker is better able to serve the individual and meet his or her discharge planning needs:

> To continue on, I would kind of touch back on some of the things that we addressed earlier but for me I would also say, for those patients who discharge home, being able to maintain contact with the families and let them know the different behaviors that the patients are exhibiting but also the improvements that they've made, because sometimes it's easier to just address the struggles that the patients are having but letting the family members know that there has been some cha…there are some changes that are taking place, so the patients are becoming more aware of their situation or the consequences of their behaviors. For me, I've

found that very useful in the past.

Participant 4B expressed a similar thought to Participant 1B, while adding a discussion about safety planning and the involvement of family:

> I agree. I think what the last participant [1B] said is a good point and when she said that I thought about the crisis and safety plan as well. I know we…you know, people say that all the time and we do that…really using that as a tool. Like she said, making the family aware of what to expect so that way when they do see those behaviors they're not alarmed and not only that they're not alarmed but they know how to handle the issues and are not in a hurry to kind of discard the client or discard the individual and send them back but giving them the tools and the skills necessary to kind of manage the behavior in the home.

Participant 2B also verbalized concurrence with the above feedback offered by participant 1B and 4B, indicating a shared thought process regarding the importance of informing the family or providing familial education. To further add to the discussion brought about by interview question four, two of the participants alluded to the topic of empowerment when discussing the efficacy of the discharge planning practices and procedures outlined in the previous question. Influenced by Participant 5B's dialogue regarding the institutionalization of adult offenders experiencing SPMI and in agreement with her mention of "allowing them to be a part of the plan," Participant 1B articulated the following sentiment:

> One of the participants, I believe 5B, mentioned the fact that many of the patients have become institutionalized and I definitely agree. So one of the things that we

know social work harps on is advocacy and so I've found it very empowering for the patients to be able to advocate for themselves 'cause they've been so used to being told what to do, when to do it, how to do it, that when we actually start talking about discharge and exploring different options with them, whether they're going home with family or going to a different group home or, you know, to a group home I found it very…it's been beautiful for me to see their growth and to watch them be able to articulate their thoughts and know that someone is actually listening.

Interview Question 5

Conversely to interview question four, this question revealed that the discussed practices and procedures reported in response to interview question three has presented ineffective in meeting service needs due to potential community provider concerns as it relates to their utilization of resources or "systemic barriers," altering stigmas associated with the research population, and changing multidisciplinary perspectives. As they pertain to the second research question, interview questions four and five aid in examining the efficacy of current discharge planning practices and procedures used by social workers when facilitating discharges between inpatient and criminal justice settings.

Through further exploration of the data set garnered from the responses given to the fifth interview question, the following themes emerged during Focus Group 1: meeting service needs and stigma. These themes resulted from responses given by all five research participants in Focus Group 1. One hundred percent of the participants agreed

that the discharge planning practices and procedures previously discussed are not always effective in meeting service needs of the client population when attempting to counter against concerns presented by community providers. Participant 3A commenced the discussion of meeting service needs by highlighting her observance of dishonesty among community providers as it relates to service provision and utilization:

> …what I've run into is community providers are not always honest about what they're gonna do, so instead of asking for additional assistance, some providers have been dishonest about services or show a lack of respect or care for the offenders or patients. For example, I've had people…I've had providers of group homes say that they're going to quote, unquote "street" my…like one of my individuals because they didn't pay like right on time. So just kind of jumping to that disrespect and also a lot of providers will not utilize resources at hand like the ACT team or ICM [Intensive Case Management] and I've had experiences where levels have been dropped after a level has been agreed on, like an ACT level was agreed on and then they were just dropped down to an ICM or dropped down without our knowledge. So, it's just kind of a passive dishonesty.

Participants 1A and 4A verbalized agreement with this viewpoint. Participant 2A agreed but added an alternative perspective:

> I agree with that as well, wholeheartedly. I would also add the caveat that I'm not particularly sure if it's rooted in dishonesty in so much rooted in, lack of resources or maybe not having a good understanding of the intensity of the service required of the practitioner maybe and maybe I'm just extending too much

> grace but I would like to hope that maybe these community organizations didn't realize that maybe they didn't have quite the staffing that they needed or that there were other kind of systemic barriers that got in the way of them being able to provide the actual service that they agreed to.

Participant 5A expounded by stating the following:

> And to the extent I do think the lack of effectiveness can be when it's pertaining to discharge on the provider… community provider perspective could be that they're overwhelmed and then the pressure that they take…they get because I mean, I had the experience where you can't stay in the hospital…an individual can't stay in the hospital, they have to go, and then they get in the community and then they don't have the support either to provide the services or even some of them don't even have the experience or the education to provide the intensity of the level of care that is recommended because of other factors…and then I agree with 3A too, some of it is just…some of it is just dishonesty, saying they're going to do this just to get the person out of the hospital or placed here and then kind of knock them down as they see best fit and then you see that the person decomps and then they end up right back in the hospital, we're starting this cycle over again.

Participant 2A reengaged in the conversation by adding an alternative perspective from the vantage point of service provision in rural areas noting, " Yeah and if you're thinking about like the state of Georgia, like most of Georgia is rural, outside of Columbus and Atlanta, so the service providers, like just having service providers that want to live in, I

don't know, Greenville, GA, or you know just having the service providers in those particular areas that are going to be available to service much of the state that is relatively rural with the exception of a couple places so that makes it difficult too."

A common topic brought up during responses to multiple interview questions, stigmatization also presented as a theme either mentioned or agreed upon by four of the five participants. Participant 5A revisited the topic of stigmatization, relating it to the impact that it may have on discharge planning practices and procedures and their efficacy:

> …I also want to add that, when you're discharging someone who has been hospitalized for multiple times, the community providers tend to have this label about them and already feel like… I've sat in several discharge meetings, 'well they're just going to do this anyways or they're not going to do this anyways,' so having that negative perspective of them before they even discharge can…is not as effective because they've already halfway set that person up for failure because they feel like they're not going to achieve or this is going to be a successful discharge because they already have this notion about them based off of previous discharges or failed discharges.

Three participants expressed concurrence with the point made by Participant 5A. Further demonstrating the transcending of themes across interview questions, this topic and discussion was also later revisited by another participant when addressing interview question eight. During the dialogue, Participant 4A stated:

> …somebody mentioned it earlier that the community as a whole, they're afraid of

> individuals that have mental illness and also committed crimes, so they're less likely to be open to receiving them once they're released from prisons or inpatient settings…

Data obtained from the feedback of 100% of the participants in Focus Group 2 resulted in multidisciplinary perspectives as an emergent theme. Participant 1B started the discussion on multidisciplinary perspectives by addressing the challenges presented by the differences of perspectives among disciplines in treatment teams and the need to offer a social work perspective in the advocacy of our clients as social workers:

> I think that's a good question and I don't really know how to answer it because we're coming from a social work perspective but as social workers in that type of facility, we're also talking about us working as a team with other people. Some of the challenges that I've experienced is, being able to advocate for the patient while psychology and other disciplines are not seeing the patient from the perspective that we see them and so having to deal with the court system, who really just receives a report. You know I haven't been there in a while but from my last experience it's they receive an annual report on how the patient's behavior has been within a year but in between the year's time there's a lot of development that takes place that's not reported, and so my challenge has really just been being able to help the other disciplines see what we see with these patients.

Participant 5B went on to add:

> I agree, there's a lot of pushback sometimes because of different disciplines and

> kind of going back to one of the other questions, we get other people in other disciplines, they have different things that they look for, so instead of us looking at the whole picture or looking at the individual, whereas like the other participant said where psychology would look for more of a legal standpoint and look at the person and the crime that they did versus their mental health and the crime and all of that, so I feel like there's just a lot of pushback from other disciplines, just back off of their perspective and their education, you know, background.

With two other participants in agreement with Participant 5B's point of view, Participant 3B offered additional insight to the discussion. She stated:

> I agree with everything that was said and to piggyback on that too when they were talking about the multidisciplinary team and all the pushback, this is how I personally feel. It's been frustrating not being able to attend the actual court hearing and therefore I'll have a little reservation of what was said, like I just really don't believe that they really advocated for the client in court like they said that they would do while in the team meeting and that's one thing. And another thing that I found frustrating as well is with those essential workers, those techs and nurses or whatever, other nurses not being involved in the team meeting, so they don't know exactly what's going on and therefore they may say something to the client like 'See that's why I'm gonna go report that to the social worker and you're not gonna be able to discharge' and that in itself will frustrate the clients too because they weren't made aware of the total discharge plan and everything like that like they may hear bits and pieces of it and so if the clients say 'Well I'm

> gonna discharge soon,' and then let it be a tech or a social worker, I mean I'm sorry, a tech or a nurse that was not involved in that team meeting who rarely ever are involved in that team meeting, and then they will say something to discourage the client and therefore the client will go ahead and sabotage and say 'well I'm not leaving anyways' because they said because they're going by the last thing that they heard.

In response to Participant 3B, Participant 5B reengaged and added to the dialogue, reiterating the concern regarding limited perspectives offered to the court system when addressing potential discharge:

> I agree and also somebody mentioned the reports that are done for the court and I feel…I've always felt like that's one…just one perspective, and we don't always know if they're working, like somebody said, to advocate for the client, so I do feel like it's a disadvantage to have one discipline write up the report that's going to the court because it doesn't always portray the individual. You know it often times portrays the individual's crime and then the…maybe the bad behaviors that they've done but not why the behavior was done. I know sometimes things happen at the hospital and there's always a reason why. And, the reason, you know, if somebody punches me and I punch them back their…I mean, they only get one side of the story and I just feel like it's a disadvantage to the person and ultimately effects their discharge plan.

Participant 3B added how medication changes might impact an individual's ability to wake when medications are being administered, in turn being perceived as a refusal and

being documented as such. The participant goes on to discuss how this type of documentation or write-up in reports to the court presents as a challenge when attempting to plan for discharge:

> … To piggyback off of what was said, I totally agree, another thing that really frustrates me is when, like for instance I had a client who was put on new medication and the medication made him very sleepy, very groggy in the morning, so when he had morning call for medicine, he wouldn't get up. Like you would have to go in there and like physically touch him and say 'Hey I need you to get up' or he would sleep through it. They would call that a refusal. That's something that's documented and then we have to send to potential placements and that also…I'm pretty sure that they will put that somehow in their report to say 'oh he hasn't been compliant with medications.' Instead of saying 'Well client didn't make it to the first med call due to,' no they don't even have to do that. They can call it a complete and utter refusal and they'll walk away. That is very frustrating because I actually had to really advocate for a client for placement because I'm like, he's never done this before, it's a change in medication, that is very frustrating, how the nurses, and not all of 'em, some of 'em, are really good with it and then there's those few that will not say 'Hey he did not come because of,' you know, and then just making it an utter refusal. That is very frustrating.

Though not necessarily presenting as emergent themes within the responses to interview question five, Participants 1B and 2B offered some additional and intriguing commentary on the topic of discharge planning efficacy. Participant 1B addressed the frustrations

experienced by both the client population and the social worker when discharge is prolonged for various reasons:

> If I could add to that, I think for many of the patient's, their discharge process is prolonged for so long that in the process they get angry and they get frustrated, that's been one of my frustrations as well. We talk about discharge planning from onset but at the same time, as human beings we naturally mess up from time to time and I think the pressures of the system and the scrutiny that's placed on the patients I think makes it more difficult for them in the discharge process and of course you all know there's the different levels I believe with forensic. A patient does something and it drops them all the way back down, when in my mind I don't think it should have been something that was treated so harshly. So that's been one of the other challenges that I've experienced is just, patients are…we tell them 'Yeah we're working on discharge' and then they make one error and then it penalizes them for another 6 months or a year.

Participant 2B also addressed prolonged discharged as a challenge and revisited a point brought up by another participant in earlier discussions about "institutionalization." She stated, "Just adding on to that, someone spoke about institutionalization earlier and that can cause a client to sabotage their discharge because they have been there for so long and that is what they're used to, so allowing the client to be involved in their discharge plan can kind of backfire because they can see 'ok I can sabotage in this way or I can sabotage in that way' and that can cause a delay in discharge proceeding and progressing. So, I would say sabotaging; individual sabotaging is one of them."

Interview Question 6

During a thematic analysis of the data obtained from the above interview question, one overarching theme emerged in Focus Group 1: improve "collaboration." Of the five participants, four mentioned or alluded to the need for heightened "collaboration." The discussion in Focus Group 2 also resulted in the emergence of one theme: multidisciplinary input. It is important to note that of the five focus group participants, three responded to the presented interview question in Focus Group 2 and two of their responses yielded the identified theme.

When asked about the changes that can be made to discharge planning practices and procedures, participant responses indicated the need to improve collaboration "between inpatient settings (i.e., hospitals or prisons/jails) and the community (providers) prior to discharge" and amongst the multidisciplinary treatment team during the discharge process, as well as strengthen multidisciplinary input in "reports" and during court proceedings during which discharge planning is discussed. These findings support the second research question and parallel that of previous literature which maintains that collaborative efforts between psychiatric facilities, the criminal justice system, and community mental health providers may reduce psychiatric and criminal recidivism as well as mitigating psychosocial challenges and reducing marginalization (Fenge et al., 2014; Thompson et al., 2016; Vogel et al., 2014).

With regards to the improvement of collaboration between inpatient settings and community providers, as well as amongst multidisciplinary treatment team members, Participant 5A offered some insight into this topic, in addition to a brief discussion on the

social worker's need for increased support from upper management. Participant 5A expressed the following:

> There's a lot of changes that I feel like should be made but I think the changes come from a higher level of care or higher level of management than the average social worker could make. Just the way we do our discharge…or just the perception of discharging when you're in an inpatient hospital it's like discharge, discharge, discharge and half the time we're checking off boxes and trying to gather and pull resources together to have an affective discharge and it's just the lack of support that the social worker can receive from… to provide a proper discharge instead of just like maybe just the number of discharges we have per month. So the changes that I would make is increasing support with the social worker who's performing the discharge. And also too, a lot of the times social workers in inpatient hospitals they struggle to bring the community together because the community only wants to get involved in certain times of the discharge when we know that it's best for the discharge…the community to get involved earlier so that we can build that rapport and so that the success of the discharge can be more effective…just a systems change too…the way we look at discharge from an inpatient or outpatient should be changed too, like more not just another number but another person who is trying to gain the recovery and sustain his or her recovery.

Participant 4A added to the discussion of collaborative efforts while emphasizing the need for staffing, training, and state funding to improve service provision amongst

community providers:

> Yeah, I agree with all of that, those points, and that's what I had in my notes that better collaboration is needed between inpatient settings whether that's hospital or prisons and the community prior to discharge and also that the, going back to I guess question number 5 where we briefly discussed the lack of staffing, lack of training, lack of funding in the state, which makes it pretty difficult for the community providers to follow through with their end if you don't have funding, you know you can't hire as many staff or you can't train them as well and so you get the bare minimum from the community providers and that's how the individuals wind up…end up coming back to an inpatient setting because they're not able to get the adequate care in the community. So I completely agree with all of what 5A said, we need better collaboration and the whole…I'm not sure what a group of social workers can do without some sort of change coming from the higher ups with being…with the state being provided more money for the mental health system, um yeah.

Participant 3A went on to extend the conversation into the topic of multidisciplinary collaboration and its contribution to the discharge planning process:

> I agree with everything and, on a team level, if…speaking of collaboration, a lot of my barriers when I worked inpatient were the providers, and the collaboration or lack of collaboration during the team process of discharge, where what the provider said goes and then you know, it wasn't really a team it was more of a one person telling everybody what to do, so yes collaboration I believe is the most

important part of discharge planning.

Participant 1A summed up the group exchange by underscoring how a lack of continuity of care and provider collaboration may negatively impact an individual returning to jail for a brief period following inpatient hospitalization:

> And I just want to piggyback off of what 4A said about collaboration, I guess that's gonna be a hot topic, especially for those individuals who we know return back to the jail and have misdemeanors, who are not going to be in the jail, a lot of times we are seeing that the community providers dropping the ball on them and they're already homeless and we have set up everything for them to be successful once they leave the jail and the ACT team or ICM doesn't follow up on their end, and I feel like no one is there to hold them accountable and then we see the individual back in the hospital because they go back to what they knew or they just didn't have that support and the community provider didn't do what they said they were supposed to do…they were gonna do, so that's a big issue.

In Focus Group 2, an alternate perspective arose with the discussion of multidisciplinary input. Participant 2B circled back to a point made in earlier conversations among the group. She asserted, "I think what 5B stated earlier about having more than one perspective in the reports would be a good change in the discharge planning process." Participant 5B affirmed the idea of multidisciplinary input by expressing the following:

> Obviously I agree with that but I also feel like, other disciplines being able to go to the court and advocate for the patients would be beneficial, because it sometimes tends to be that the people like Psychology that don't always interact

> with the patients very often are the ones that go. So having the social worker, a nurse, or even an FST [Forensic Service Technician] or tech or whatever you wanna call them, go because they're the ones that are around them most often would be beneficial in the discharge planning, and it might be a good change.

Interview Question 7

The research data obtained from the seventh interview question suggested that, if changes could be made to the overall continuity of care for adult offenders coping with SPMI, those changes might include "ensuring accountability" is maintained amongst inpatient and outpatient treatment providers, group home providers, and legislatures, actively transitioning individual's to "least restrictive settings," and "educating and training" community providers who offer placement options.

The theme of "ensuring accountability" in Focus Group 1 was supported by 100% of the participants' responses. The concept emerged when Participant 2A underscored her perception of a systemic issue where providers lack accountability as it relates to their role in pitfalls that arise in the process of continuity of care:

> I would also say ensuring that the individuals are, or excuse me not the individuals, ensuring that treatment providers, whether they're inpatient or the community setting, are being held accountable. It just seems like people are out here doing these things with no accountability whatsoever, like just completely dropping the ball and no one is saying 'hey, like what are we going to do to ensure that this is not going to happen again, what are we going to do to ensure that this person is going to be able to prosper.' Like there's none of this kind of

> circling back to problem solve things that happen, 'cause I mean we're a system of human beings, so we're not going to be perfect. Human error exists. But it seems like people are just sometimes being grossly negligent and then there's no accountability for that. So I would certainly build in some checks and balances that actually function as checks and balances and can help create a system that actually functions well.

Participants 1A, 3A, and 5A verbalized agreement, with Participant 3A offering additional thought-provoking feedback, highlighting funds as an ulterior motive for some group home providers, insinuating the need for accountability at it relates to this concern as well:

> I hate to be the downer in this group because I feel like I am, but I've seen people with motives that are opening up group homes or have community groups or day groups that their motives are not necessarily pure or, [sighs] I don't know, it's more about making money. It's more about the income that they're receiving for each individual person and that is truly distressing at times.

Participant 1A supported Participant 3A by starting:

> I don't think you're being a downer. I think that is absolutely true that a lot of group homes…we talk about this all the time amongst me and the social workers on my unit, how everybody wants to be Mental Health but they want the perfect person or the person that receives a lot of money. No one wants the guy who needs a lot of help. They just want the model. I guess they just want it easy and I just don't understand that.

Participant 4A expressed agreement, while Participant 5A circled all of the aforementioned discussion points back to the topic of "accountability," noting that everyone involved in some aspect of mental health from inpatient and outpatient providers, and those offering placement options, to state legislatures:

> I think it goes back to…and I agree with 3A, 1A, all the ladies actually but I think it goes back to what 2A specifically said, putting everybody accountable, inpatient, outpatient, group homes, heck even state legislatures or providers as well because it does seem like a lot of negligence is happening, especially when you discharge somebody to a group home and then they move them to a boarding home; one of their boarding homes. Like that's inappropriate. Or you discharge somebody and then they end up passing away. Or even if you don't discharge somebody and they end up passing away in a hospital or running away from an inpatient locked facility with locked…double locked doors. Like where are the accountabilities there? And not just sweeping it under the rug.

The discussion in Focus Group 2 yielded two themes: transitioning to "least restrictive" settings and "educating and training." Four out of the five participants who responded to the interview question regarding changes that could be made to the overall continuity of care for adult offenders coping with SPMI were in consensus with the topic of "least restrictive" settings. Participant 5B started the conversation while expressing the following:

> …with the more individualized care, sometimes we discharge patients, and they go to a group home. Well just because they go to a group home doesn't mean two

> years from now that's where they need to be. So I think if we…if the community could help assist in getting that person the care that they need to go from a group home to maybe a semi-independent apartment and eventually be on their own, that would be helpful to them as well but I think sometimes they stay stuck whether they need to be in a group home or not, they just stay stuck in a group home which is sad to me.

Participant 4B indicated concurrence with Participant 5B's sentiments and noted:

> I agree, I think the language we use… I think it's called least restrictive setting, but some of the settings are more restrictive. They don't offer the best environment, they're not…it's not comparable to the level a lot of times that the client is on in terms of functioning and giving them the ability to be autonomous and to function on that level, so I agree.

Participant 2B then went on to add:

> Yeah, and 5B just what she stated kind of brought up another point with the treatment team changing their perspective of our individuals. Yes, they committed a crime. Yes, you know, but they are in the hospital for recovery, not jail time. They have been NGRI or whatever the case may be but when it's time to find them placement, they shouldn't have to stay in a group home forever because the community is afraid of them or they are afraid that they may go out and commit another crime. Yes, we need to be aware of that. Yes, it needs to be in the discharge planning process. However, I don't think that should stick with them and that should cause them to be confined to a restrictive environment when the

> plan is to discharge them, so they can go out into the community and be the best that they can be in their recovery.

Subsequently, Participant 3B communicated that she agreed with all prior viewpoints on the topic and went on to discuss the need for and importance of a team, aside from the ACT team or forensic coordinators, that might be able to assist in establishing continuity of care for the research population, as well as need for additional placement or housing options, with specific focus on sex offenders:

> I agree with everything, I know that a lot of the clients that were discharged before when they had access to the ACT team and forensic coordinators, I think they had a better continuum of care, if there was some kind of team or something that was put together to really help those individuals, I think it would be better. I think it wouldn't be so many people that fall through the cracks. And like everybody stated, if they're going to this housing and they're…this specific placement and they're doing way better, then they can move on to a lesser level of supervision, which will give them more freedom, I totally agree. I've seen that happen with like certain teams, like I said the ACT or intensive case management, or the light team. The light team is like a team that's coordinated only for adults that are like 18-25 and so if they have something like that, that can follow them from the hospital, at least for the first year of discharge, I think it would be very beneficial but everybody that we refer to ACT may not qualify. Another thing that I think would be very helpful, is more housing because now they're just tryna play this game like…they're just tryna, you know, you're gettin' in where you're

> fittin' in. It may not necessarily be the best but it's either that or homelessness. So, more housing, especially for sex offenders. That is the most difficult population to try to place because the housing is so limited.

The other common thought that surfaced during the discussion among Focus Group 2 participants was the need for "educating and training." This was indicated in responses given by three of the five participants. Participant 4B began the conversation by highlighting how "fear" impacts potential placements and the way in which community providers relate with the client population. The participant also addressed the critical need for psychoeducation to address such issues:

> I think fear. I think…someone alluded to it earlier, from community providers, again they…I think they…the way that they see the individuals makes a difference. Because again, when they only know them by their offense or when we're only reaching out to them when we need something I think having like maybe quarterly or whatever amount of time to educate them, the community providers, about SPMI and what things look like and how to handle…giving them more tools to equip them to handle different types of individuals with SPMI. I think one of the challenges that I've faced in the past as a social worker is actually finding placement. When you send that chart over or when you give them the information, a lot of them are afraid, and they have every right to be, but some people's charges are a little bit more heinous, but getting them to see the individual as a person and not as their charges but I think education would help a good deal, getting them to understand what mental health illness is, getting them

> to understand that this is something that plagues a great deal of the U.S. So like I said, just talking to them and getting them to understand.

Along with Participant 1B expressing agreement, Participant 2B echoed similar sentiments while expounding on the topic and reiterating the call for education and training to help enhance continuity of care for adult offenders with SPMI:

> I agree. I totally agree and just to kind of add to that, giving them…providing them with training to deal with SPMI… individuals with SPMI, also with offenses as well because the community do not know how to deal with our individuals. Like the previous…the last participant stated, they need to be educated on how to address their symptoms, their triggers, and also be able to look at their offenses in a different way so they can be able to help them more effectively.

Interview Question 10

When addressing the service needs that were identified as priorities for adult offenders with SPMI, those that were most mentioned were "basic needs" (i.e., housing, finances, food, safety, clothing, etc.) and "psychoeducation." Both themes emerged from the three participant responses to interview question ten from Focus Group 1 and Focus Group 2, respectively. Offering further support to the second research question with respect to needs assessments aiding in the facilitation of wraparound service and facilitating continuity of care, these findings appear to be congruent to research findings of Wilson (2013). His findings concluded that housing, financial support, medication management, social support, guidance with public assistance benefits, and case management, respectively, are prioritized over mental health services when addressing

service needs among adult offenders experiencing SPMI (Wilson, 2013). Also consistent with the study findings was previous literature resulting in the understanding that, by addressing environmental, economic, and social risk factors, such as the ones mentioned above, mental health and criminal offending outcomes may be enhanced (Calhoun, 2018).

With 100% of the respondents agreeing that "basic needs" were or are identified as priorities from a client perspective, Participant 3A established a dialogue among the participants when she expressed that individuals she worked with prioritized basic needs over mental health treatment:

> I would love to say that most of my people at the hospital and in prison are really concerned about mental health treatment but a majority of them don't really care about following through with their mental health treatment. They care about their housing and their funds. They care about where they're gonna live and where they're gonna get their money. And this really connects with basic survival. If you do not have…like Maslow's Hierarchy of needs, if you do not have shelter, if you do not have food, if you do not have safety, you're not going to really be too concerned with the second level of his pyramid, right, of support, of helping themselves. You just want to be able to survive. And I believe I would love them to be very concerned about their mental health treatment but for the most part they're really not.

Participant 4A went on to concur that "basic needs" have been a top priority among the client population that she has worked with and added that transportation and medication

were also subsequent concerns:

> Yeah, I agree with that. I found a lot expressing their concerns regarding where they're gonna get their food, clothing, where they're going to live…so their basic needs they're concerned about the most and then after comes where can I get my meds and transportation is a big concern as well. So, I think the basic needs, needs to be covered like participant 3A said, and then you know they're better able to think about other needs like medications and getting to their group treatment and things like that.

Participant 2A followed up by stating, "I agree with that." With "psychoeducation" presenting as a theme among 100% of the participants who responded in Focus Group 2, Participant 1B expressed the need to educate individuals on how to properly manage hygiene and maintain good hygiene practices:

> I don't know that it's necessarily been…always been identified as a priority from a client perspective but I would say services that are needed definitely is hygiene. Teaching them… educating them on how to maintain hygiene because that's one of the things that we often find challenging in the hospital itself is them being able to maintain and understand the way you present yourself people will know something's off. Whether they're just malodorous or they're not washing their face, brushing their teeth, we had…we've seen dental issues with many of those patients because of lack of self-care. So, I would say hygiene, as a priority.

Also aligning with psychoeducation as the focal point of the discussion, Participant 4B added the importance of educating the client population on

"decompensation" and their "triggers," as well as the mental health diagnosis and its associated "signs and symptoms." She specifically stated:

> In addition to that, I would say helping them understand what decompensation looks like for them. I think them noticing or being aware of their own triggers, I mean of course we wanna equip their supports with those tools but helping them to identify like 'hey this is what it looks like when I'm startin' to go downhill or when I'm startin' to decompensate.' So, making sure they're also very much educated about their mental health diagnosis and what those signs and symptoms may look for th…may look like for them individually.

Participant 3B discussed "peer mentorship" and how the peer mentors might be able to offer education while relating to the individual through shared experiences:

> I agree with both of what the young ladies said and then it makes me think if they had some kind of peer mentorship. I know peer mentorship would help them…you…I guess because the peers would help them…I don't…they have a certain way of talking to them and where they trust them a little bit more than anyone else because they've had prior experience and they know exactly what it is that they're going through. So, they're more apt to listen to what they say like they can talk to them on a certain level that I don't think anyone who hadn't experienced it can't. And so, with that being said, I know a lot of peer mentors have approached clients…individuals and said 'hey, you know, you need to work on this.' They can help them identify those triggers for decompensating, educate them on hygiene, tell them… kind of give them hope of what to look for…like 'I

> was where you were, but I'm doing much better and you can have the same thing, if you just follow these steps,' you know, 'these are the tools that you need.' So, I agree with both of what the young ladies said.

Moreover, Participant 3B provided additional commentary that aligned with that of the emergent theme in Focus Group 1: basic needs. The participant first requested clarity that the question asked was interview question ten, to which I simply responded "yes." Participant 3B then reported providing one of her responses to interview question ten prematurely in her response to another question. The participant added, "Okay, I'm sorry. I apologize everyone. That's the one that I was saying that housing, finances, and wraparound services would be beneficial to the clients upon discharge."

Interview Question 11

PROBE (A). Amongst the contributions made by the participants to promote social change and the field of social work, data revealed building "therapeutic relationships," "advocacy," and providing psychoeducation to "destigmatize" mental health, improve service provision by providers in the hospital and community, and provide crisis intervention training to law enforcement. Amid the social work contributions listed by the participants, literature alludes to the importance of psychoeducation for law enforcement, noting the need to stimulate dialogue about how systems such as criminal justice can effectively respond to this population's complex needs, with mental health at the forefront, as they are often ill-equipped and untrained to address such needs (Calhoun, 2018; Lurigio, 2011). Stigmatization due to mental health concerns and forensic status, a concept riddled throughout the data obtained during both

focus groups, is proposed by West et al. (2015) to negatively influence one's self-identity, psychosocial needs, and functional outcomes. This understanding gives way to the critical need for continued advocacy, psychoeducation and training across all systems with which the forensic population come in contact, and additional efforts to destigmatize mental health and criminal justice involvement. Data obtained through this research project also indicated that, of the social changes that can be made by the participants or other social work practitioners concerning the population of adult offenders coping with SPMI, education and advocacy were the most prominent.

With regards to Focus Group 1, the emergent themes, building "therapeutic relationships" and offering psychoeducation to "destigmatize," were equally divided between the four participants that responded. Alluding to its ability to aid in the establishment of a therapeutic relationships with the client population, Participant 1A discussed her desire to humanize the individual. The participant expressed:

> Now just …what I like to do with my individuals is, just treat them like a person and not like a mental …a person with a mental illness. That's all they want, is to be treated like a person and that's what I try to do when I work with them and hope that, that promotes change as well.

Participant 4A tied together both the responses from Participant 1A and Participant 3A, which is provided below, by stating:

> I agree with both [3A and 1A] … and also just instilling motivation and hope, and hoping that maybe this will be the time that they're able to get what they need but all of that what the two participants said matters, and you know treating them with

> respect and I think that… and you know forming that good therapeutic relationship. That's the key to success in my opinion.

Participant 3A brought forth an alternative thought process through her discussion of psychoeducation to destigmatize mental health:

> I think going back to touching on stigma, I really feel like that's the basis of a lot of issues in our system, to provide mental health education is really important to not only the people that have these severe and persistent illnesses but to family, friends, support systems, even kids in school. They really…people really need to learn about mental health and destigmatize, reduce the guilt and shame that they may feel. If there is a stigma people are not going to receive mental health treatment. So, when I talk to my offenders and my individuals it was more of a 'hey listen, I understand, a lot of people go through this, this isn't just you, this is a common thing that happens and a lot of people utilize these things to get through it and know that you're not alone.' That's mostly what I tend to touch on when I talk to somebody with a severe and persistent mental illness.

Also, with respect to the concept of using psychoeducation to destigmatize mental health, Participant 2A homed in on law enforcement and added:

> l agree and along the lines of just stigma and educating law enforcement, I spend months educating law enforcement on crisis intervention training, where if they did encounter someone that was experiencing symptomology, what they should do in order to deescalate the situation and maintain their safety and maintain the safety of others, educating them on when a person is not actually doing anything

> that is breaking the law, then how you can route them to the appropriate service provider as opposed to sending them to jail because if they're essentially not breaking any laws there's no reason for them to go to jail. So, I've invested a lot of time in doing that piece as well as just working as a part of a team, a system of care, and utilizing that opportunity to educate other service providers within the hospital or within the community, educating like the frontline, day-to-day on the unit staff members about what they can do to help influence positive outcomes for the individuals that they're looking after and just being that voice to help support the system of recovery that the person is in.

Of the four participants who responded in Focus Group 2, the theme that emerged among three of them was "advocacy." Additional topics presented by the participants also included psychoeducation, developing work relationships with other social workers, and promoting social work as a profession. On the subject of "advocacy," Participant 1B reported the following with regards to her contribution to the promotion of social change and to the field of social work:

> I would say, advocacy, both for the patient and for social work as a whole. As you all know, working with a multidisciplinary team, there a lot of pushback and challenges that we face. So, I would say just being able to speak up and if certain things do not get addressed in a timely manner, then taking it up to the next person in the chain. Sometimes it's …I've had the experience where I felt like I've been all by myself because no one wanted to speak up but still understanding that, at the end of the day, if we're talking person-centered then we should all be

> intentionally working to better the patient's situation and not be more concerned about what the team…what the team's concerns are, whether it be personal or professional.

Participant 2B verbalized agreement and Participant 5B ventured to add the following:

> I agree with that participant [1B], but I also think for just…for social work in general, just educating. I know sometimes we as social workers, people will find out what we do and will say 'Oh well bless you, I can't believe that you can do what you do and blah blah blah.' And I think just…and they'll say 'I couldn..,' you know, I've heard people say 'I couldn't work with people like that. I couldn't work with crazy people,' but just educating them so that stigma isn't as large as it was. Just educating people on SPMI and forensic status and what it means and all of that, has been something that I've done.

Additional participant commentary from Focus Group 2 included that of Participant 3B who expressed the opportunity she had to self-reflect, as other participants responded, and conclude that she does promote social change and the field of social work, contrary to her original belief, but does not acknowledge herself the way she should. The participant went on to discuss her contribution as a "self-proclaimed social work recruiter:"

> In listening to what the…the ladies that just gone before me said, I actually was gonna remain quiet because I'm like, 'I didn't do anything to promote social work or assist with change' but that's another thing. I think, well I'm gonna say, just me as a social worker, I don't give myself credit for what I've done. I think because it

> was on a small scale, like I helped this person or I helped that person, then I didn't even think of it in that manner but also, with that being said, I am a self-proclaimed social work recruiter at my church [chuckles]. So, anybody at my church and they're saying that they wanna go to school, I'm like, hmm let me talk to you about the [inaudible] of social work. So, that's my contribution [laughs].

Participant 1B also offered an additional thought by stating:

> That's awesome. I would also say that group supervision has been significant for me. I can't speak for anyone else but being able to find a space where we can come in and address certain things that we're not always able to get off of our chest, and have a supervisor who's willing to listen and support us and encourage us and give us different ideas on how to address the issue or at least how to cope while facing the challenges, understanding that sometimes the system is just not going to change but you do your best. The other thing that I've noticed that I've started to do, maybe right before leaving the hospital was, gathering with a group of social workers and just being able to connect and support one another on an individual basis. So not just talk to one another when we're at work but I used to be intentional in stopping by people's offices, even if it's just to say hi or if I notice something going on with them I would acknowledge. They didn't have to tell me, but I would at least let them know that it would be okay, but also extending that to being able to develop a personal relationship with them whether I'm still employed at the same facility or if I've moved on, or if they've moved on.

PROBE (B). Of the three participant responses to the probing question, in Focus Group 1, two themes emerged: "education" and "advocacy." Both Participants 3A and 4A agreed that providing community, mental health education might aid in strengthening the efficacy of social work provision. Participant 3A began the conversation by stating:

> I feel that…I think we already covered it thoroughly but just community education and also getting people involved in legislation and political issues like, why are we defunding mental health treatments, why are we?...what can we do to prevent the defunding of mental health so that our community providers can prosper and do their jobs efficiently and effectively, but just the education piece is something that I think that we all can do.

Participant 4A expressed a similar thought while adding a discussion on the importance of also providing education to not only the community, but the client population, their families, and law enforcement agencies. The participant noted, "I agree with that. Providing education to individuals, but also their family members, and definitely the community providers and law enforcement agencies just being more educated…I think we can provide better service."

With respect to the topic of advocacy, in addition to participant 3A indicating "getting people involved in legislation and political issues" as a social change effort that can be made by her/him or other social work practitioners concerning the population of adult offenders coping with SPMI, participant 2A expressed:

> I think also just by being that squeaky wheel like asking questions, asking 'why is this happening, what are we doing about it,' and really trying to be that fierce

> advocate on behalf of the individual I think would just be a little tiny change but it would get people to thinking.

The above probing question generated only one participant response in Focus Group 2, thus resulting in no notable themes. The participant did, however, offer insight into program development as a social change effort concerning the population of adult offenders coping with SPMI. Participant 2B articulated the following:

> I would say program developments. Like developing programs that address the issues that we as social workers know are problematic. No, we can't change the system of the hospital but, however, we can make a change individually by using our expertise, and credentials, and educational background to develop programs in the community to help individuals with SPMI and offenses to kind of just provide that extra service in the community.

By eliciting critical thought about the importance and impact of contributions made by social workers, the interview question resulted in themes that speak to the strategies aimed at not only strengthening the profession and service provision, but promoting continuity of care, facilitating successful reintegration, and improving the lives and well-being of the populations for which social workers serve.

Summary

The research interviews conducted with both focus groups were intended to provide a thorough exploration of social workers' perception of social work practice challenges experienced when conducting discharge planning and promoting continuity of care between inpatient psychiatric hospitals and correctional settings. Furthermore, the

goal was to identify methods in which to improve these processes and elicit successful community reintegration and recovery for adult offenders with SPMI. In doing so, the practice-focused research questions were addressed:

- What challenges do social workers face when attempting to facilitate successful discharges for adult offenders with SPMI from inpatient psychiatric hospitals to criminal justice facilities?
- From a social work practice standpoint, what strategies, procedures, practices, and services might aid in ensuring wraparound care for adult offenders with SPMI transitioning from inpatient hospitals to correctional facilities and preparing for community reintegration?

The findings addressed the research questions by supporting the need to understand and confront social work practice problems relative to discharge planning to and from inpatient psychiatric hospitals and correctional institutions, as well as during the community reintegration process. Additionally, it underscored the importance of practice strategies, to include multidisciplinary interactions and approaches, integrated services, interagency collaboration, education, and advocacy. It is my hope that these key findings will help further expand the growing body of research related to adult offenders with SPMI and their respective psychosocial concerns. It is also my hope that this action research study will excite continued dialogue regarding possible solutions to this social issue. Through discussion, expanded knowledge, and informed actions, social change can begin to exist for this vulnerable population. In Section 4, the findings give way to a discussion of recommendations for social work practice with the research population and

underscore implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this qualitative research study was to explore social work practice challenges impeding continuity of care for adult offenders with SPMI transitioning from inpatient mental health facilities to correctional settings. Moreover, the study aimed to identify effective and efficient ways to minimize rehospitalization. The participants in the study were former and current social workers who practiced social work in Georgia with the research population. With the understanding that one of the most pronounced social change issues impacting this population is the gap in continuity of care between inpatient psychiatric hospitals (i.e., forensic units) and criminal justice settings (i.e., jails and/or prisons; Martin-Ayers, 2016; Vogel et al., 2014), this information is imperative in eliciting dialogue regarding proposed actions, practice improvements, policy changes, and program provisions.

In Section 4, I will discuss how the social work practice problem addressed in this action research study is applicable to professional ethics in social work. Second, I will outline recommendations for social work practice as they relate to the research findings. The final subsection will explore the implications both this study and its findings will have on social change.

Extending Social Work Knowledge

The NASW code of ethics suggests that social workers should promote and/or facilitate research that contributes to the knowledge base of the profession and can be utilized in practice to establish the use of effective, evidence-based interventions and

services (NASW, 2021). This aspect of the code of ethics directly corresponds with the nature of action research. Action research is an evaluative process and systemic approach to inquiry during which previous knowledge is applied and new knowledge and theories are generated to not only help improve social change issues but to expand the knowledge base of specialty fields, such as social work, and to strengthen the profession's practice (McNiff, 2016; Stringer, 2007).

Though prior literature indicated risk factors and predictors associated with psychiatric and criminal recidivism and began to address those factors, there appeared to be a gap in literature that addressed successful and collaborative interventions between psychiatric facilities, criminal justice institutions, and community providers (Gonzalez, 2018). Furthermore, literature also lacked a thorough discussion of effective and innovative strategies, processes, and potential policy changes that may be put into action to foster resiliency, enhance psychosocial recovery, and reduce recidivism rates among adult offenders with SPMI (Gonzalez, 2018). The current action research study offers a more thorough understanding of the social change issues impacting transition and reintegration processes for adult offenders with SPMI who are discharged from inpatient mental health facilities to correctional institutions. More specifically, it pinpoints social work-related challenges experienced when working with the research population, as well as social, environmental, cultural, political, and economic factors influencing discharge planning processes and subsequent community reintegration upon the population's release from jails and prisons. Additionally, it highlights discharge planning practices and procedures used in the field of social work with the research population, and their related

efficacy in mobilizing positive change and recovery. Moreover, the key findings allow for increased knowledge of the prioritization of service needs from a secondary, client perspective.

The research findings further expand the body of knowledge in that it develops a foundation from which to propose changes to current discharge planning practices and procedures used to facilitate transition from inpatient mental health facilities to correctional institutions, and the overall continuity of care for adult offenders with SPMI upon community reintegration. Equally as important, knowledge gained from the research can help define the impact that social workers might have on improving this social issue. It empowers social workers to continue and strengthen their contributions to social change efforts for this marginalized and vulnerable population. It is through the research findings and the extension of knowledge in the field of social work that real change can happen in closing service gaps between inpatient psychiatric hospitals and correctional institutions, facilitating integrated services, and initiating constructive interagency and interdisciplinary collaboration when facilitating transitions across facilities and impending discharges into the community.

Application for Professional Ethics in Social Work Practice

A collection of standards intended to offer social workers guidelines for professional conduct, decision-making, and sound clinical practice, the NASW (2021) code of ethics underscores the significance of ethical principles, standards, and core values within the social work profession. Social work has six core values: service, integrity, competence, social justice, importance of human relationships, and dignity and

worth of the person (NASW, 2021). Though this action research project encompassed all core values at varying points in the research process, allowing me to uphold ethical responsibilities to the research participants, academia, and the profession (McNiff, 2016), the two core values most related to the social work practice problem include service and social justice.

Based on social work's core value of service, the NASW (2021) code of ethics highlights helping those in need and addressing social problems as an ethical principle and fundamental goal of the social work profession. In doing so, it is suggested that a social worker puts service to others over their self-interest and makes use of their expertise, knowledge, and values to be a change agent for individuals, couples, families, groups, and populations in need (NASW, 2021). In conducting this action research study, I not only drew upon my professional knowledge but also that of other social workers in the field who were familiar with the challenges faced when facilitating transition and discharge planning for adult offenders with SPMI from inpatient mental health facilities to correctional institutions. Moreover, through insights offered from the research findings, one can begin to address the social problems impacting the research population and contributing to gaps in service provision and continuity of care. With this core value and ethical principle at the foundational forefront of this action research project, the research findings might aid in directing clinical social work practice through the lens of newly acquired knowledge in the field of social work.

Also related to the social work practice problem addressed in this action research project is the core value of social justice. The ethical principle supporting this core value

emphasizes the significance of social workers confronting social injustice on a micro, mezzo, and macro level (NASW, 2021). This includes promoting social change efforts that establish equitable and unbiased opportunities, broadening and guaranteeing access to resources and services, promoting participation in decision-making that is purposeful for everyone, and enhancing the overall functioning and quality of life for vulnerable, oppressed, and marginalized populations (NASW, 2021). The nature and purpose of the action research study parallels this fundamental concept of social work practice. The study's findings help bridge the gap in literature and services, thus improving access to service provision and offering the research population an equal opportunity to thrive. As social workers become more attentive to challenges that impede their work with adult offenders experiencing SPMI and continue to fortify their knowledge, they can develop and implement practice strategies that are more effective, excite interagency collaboration, influence and shape policy changes, and expand social work knowledge through further research.

Recommendations for Social Work Practice

The research findings support the need for change in service provision for adult offenders with SPMI transitioning between inpatient mental health facilities and correctional institutions, with the primary objective being to make progress toward a successful community reintegration upon release. State and local agencies (i.e., mental health facilities, correctional institutions), government appointed judicial and legislative leaders, community providers, and social workers alike are in a unique position to play a critical role in providing collaborative and integrative services as well as improve the

transition and discharge process for adult offenders with SPMI. The research participants suggested that service needs, challenges with discharge planning practices and procedures, and continuity of care could be addressed by improving collaboration between institutional settings, like psychiatric hospitals/units and jails/prisons, and community providers. They also highlighted the importance of encouraging multidisciplinary input in discharge planning and correspondence with the court system, ensuring inpatient and outpatient treatment providers, group home providers, and legislatures are held accountable, and transitioning individuals to least restrictive settings as soon as it is appropriate. Furthermore, the research participants underscored the need to provide education and training to families, law enforcement, placement providers, and communities, to not only eliminate the stigmatization of mental health and criminality but also nourish a strong understanding of mental health.

The findings resulting from this study have the potential to strengthen the knowledge base and enrich social work practice with adult offenders experiencing SPMI. Recommendations for social work practice, as they relate to the research findings, are addressed in the subsequent subsections. The driving force behind the forthcoming practice recommendations is the idea that continuity of care and service provision, when discharging from inpatient psychiatric hospitals to correctional institutions, are often inadequate and fragmented which may be attributed to various factors such as those brought forth by the research participants during the study.

Actions Steps for Social Work Practice

Based on the findings of this action research study, three action steps are recommended for social workers who work with adult offenders experiencing SPMI and transitioning care from inpatient psychiatric hospitals to correctional institutions with hope to reintegrate into the community upon release from jail or prison. The recommendations will accent practice, research, and policy considerations. As previously discussed, a thorough review of the literature concluded that, among the factors contributing to the psychiatric and criminal recidivism rates of adult offenders with SPMI, are fragmented and insufficient service provision and continuity of care across institutional settings (i.e., local and state inpatient mental health facilities, correctional institutions, and mental health providers) as well as upon release back into the community (Brandt, 2012; Calhoun, 2018; Lurigio, 2011; Maschi et al., 2009; Thompson et al., 2016; Vogel et al., 2014); inadequate wrap-around services (Prins, 2011); outdated, ineffective, restrictive, and/or exclusive policies (Barrenger & Canada, 2014; Brandt, 2012; Seltzer, 2005; Torrey et al., 2014); an absence of funding to mental health and community resources (Barrenger & Canada, 2014); reentry and court-based diversion programs not necessarily addressing the source of the social change issues surrounding individuals with SPMI involved in the criminal justice system (Seltzer, 2005); criminalization, "mercy bookings," or the coexistence of criminality and mental health concerns (Lurigio, 2011); "entrenchment" (Prins, 2011); and the impact of stigma on an individual's quality of life and self-concept (West et al., 2015). Through the findings of this action research project, I was then able to foster and strengthen insight into

challenges faced by the social workers that set out to facilitate transition and discharge processes. With those findings, action steps were developed.

Action Step 1

The first action step is addressing factors impacting discharge processes of adult offenders with SPMI transitioning between inpatient hospitals and correctional institutions. The NASW (2021) encourages social workers to continually strive to be competent in the field of social work, seeking professional development and maintaining awareness of growing knowledge within the discipline. Findings brought about by this action research study can contribute to social workers' need to remain competent in the field and apply newly acquired knowledge to clinical social work practice. This not only allows social workers to practice more effectively but to better serve the client population with which whom they work and uphold their fundamental responsibilities as social work practitioners (NASW, 2021). With heightened knowledge, social workers are then able to begin making and advocating for practice improvements to better navigate systems impacting their clients, addressing factors associated with social injustices experienced by their clients, and enhancing their clients' overall sense of well-being and quality of life.

Action Step 2

Also aligned with contributions the research findings have on clinical social work practice, the NASW (2021) promotes interdisciplinary collaboration as it relates to participating in and contributing to decision-making processes affecting client populations. With this understanding enhanced by insight derived from the research

findings, it is recommended that social workers prioritize interdisciplinary and interagency communication in social work practice, fostering a collaborative environment that focuses primary attention on the client's well-being, continuity of care, and recovery as well as challenges providers and agencies to put the client's psychosocial needs above personal preferences and biases. Furthermore, based on the findings, it is also imperative that social workers continue to practice with a person-centered, strengths-based, and person-in-environment approach and perspective by communicating with their clients to educate themselves while advocating to ameliorate these considerations.

Action Step 3

These findings might also be useful to social workers seeking to further develop social work knowledge and refine practice, policies, and programs. It is suggested that social workers should examine and assess practice interventions, program implementation, and policies (NASW, 2021). Moreover, it is encouraged that social workers should think critically and consistently seek out relevant knowledge. Then apply that knowledge to clinical practice (NASW, 2021). As a third action step, it is recommended that social workers take the knowledge gathered from the findings of this action research study and not only apply what is known to professional practice but further advance the knowledge base of social work through research, as it relates to the subject matter. Further research renders further evaluation of social injustices impacting adult offenders with SPMI as they transition between inpatient mental health facilities and correctional institutions and begin community reintegration. Additionally, it aids in exciting and strengthening dialogue among helping professions, government agencies,

community members, and political legislators related to practice interventions, implementation of programs, and applicable policies that may benefit from reform. Furthermore, with a sound foundation of research, social workers may then mobilize that knowledge to advocate for policy reform and program improvements.

Impact of Findings on Personal Social Work Practice

As a result of exploration driven by action research and qualitative procedures, the findings will enhance my social work practice as an advanced social work practitioner. This research study allows me the opportunity and a platform from which to disseminate the findings to stakeholders with vested interests. Sharing these findings will provide insight into the lineal relationship between continuity of care from inpatient psychiatric hospitals to correctional institutions and recidivism, both psychiatric and criminal. It will also foster an understanding among stakeholders regarding the significance of advocacy, accountability, linear care, and attentiveness to psychosocial and service needs across these agencies. Moreover, it will bring further attention to the need to for interagency collaboration and multidisciplinary input, as well as heighten consideration for factors impeding upon successful planning procedures and discharges. Moreover, the findings produce a better understanding of the challenges faced by social workers facilitating transition and discharge planning for adult offenders with SPMI between inpatient psychiatric facilities and correctional institutions. Additionally, the data offers insight into successes and pitfalls of discharge planning practices and procedures, as well as systemic, environmental, economic, social, cultural, and political factors presenting as obstacles to those processes. The knowledge obtained through the

emergent findings can then be leveraged to inform my practice as a social work practitioner.

As a social worker, I might enhance my social work practice with individuals impacted by this issue through both integrating the knowledge I gained from research into practice and attending relevant trainings/continuing education that will further inform my practice and offer me additional strategies to help address the issue from a social work standpoint. In accordance with the NASW code of ethics and with the desire to uphold its outlined social work responsibilities, ethics, and values, the research findings also give me the standing to influence social change and advocate for policy reform and advancements in practice. With the knowledge and potentially through further research, I might also have the foundation from which to implement programs aimed towards bridging the gap in service provision between inpatient psychiatric hospitals, correctional institutions, and community mental health providers that target and attend to various considerations that other programs may not address or are lacking.

Transferability of Findings

When conducting action research, it is important to consider the transferability of its findings. Though further research is necessary, the findings of this study can inform the research base in the field of social work. Equally as significant, the findings can also offer valuable information to other states and their stakeholders. Additionally, the research can be replicated in other states experiencing similar social issues and social work practice challenges related to the transition and discharge process of adult offenders with SPMI from inpatient psychiatric facilities to correctional institutions. Utilizing the

broad perspectives highlighted in the research findings will offer an outset for social workers across the United States to consult regarding challenges experienced during social work practice and the development of interventions and strategies to mitigate said challenges. However, it will be important for social workers in other geographical locations to consider state-specific concerns or initiatives when applying these findings to their practice. Moreover, it is possible for the findings of this study to be transferable across other aspects of social work practice. For instance, a social worker working with an individual admitted on an adult mental health unit but is not bounded by criminal charges might find some of the information useful when planning for the person's discharge back into the community and addressing challenges that may present themselves when trying to facilitate continuity of care. Similarly, this can be said for social workers working with individuals who are incarcerated but are not experiencing symptoms of or have not been diagnosed with a SPMI.

Recommendations for Further Research

This action research study was intended to examine the challenges faced by social workers as it relates to facilitating continuity of care between inpatient psychiatric hospitals and correctional facilities, and to identify effective strategies, procedures, practices, and services to mitigate rehospitalization. When conducting further research, it is recommended that focus is subsequently narrowed to further explore practice challenges specific to facilitating the reintegration of adult offenders with SPMI from correctional institutions into the community. One might also delve deeper into gender and ethnic/race variabilities within the client population and their relationship to service

barriers and social work practice challenges when performing discharge planning processes. As it relates to the limitations of this research study, future research should be more intentional about obtaining male representation within the participant sample. Furthermore, research questions might be adjusted to offer more clarity and/or a reminder of the research population and purpose of the study throughout the focus group session. To address the lengthiness of the study with regards to the number of interview questions, future research would benefit from dividing each focus group into two sessions or one session per day. This will allow participants a break and potentially strengthen participation as the end of the focus group approaches.

Dissemination of Information

Action research is fundamentally built on the concepts of participation and collaboration in which stakeholder groups and their perceptions of the social problem play an active role in the research and action processes (Stringer, 2007). To expand knowledge, excite productive dialogue, and mobilize change, focus must be placed on the way in which the findings of the study are disseminated. Dissemination is the act of reporting data and findings that were collected and derived, respectively, while conducting research (McNiff, 2016). Dissemination of the research findings, through the perspective of the participants, not only strengthens the validity of the study but also helps transform knowledge (McNiff, 2016; Stringer, 2007). Consequently, the storytelling process of disseminating research findings have the potential of influencing the way stakeholder groups think about and understand social issues impacting the client population and community at large.

One of the first steps of reporting information gathered during the research process is to consider the course of action one should take to disseminate the findings. As it relates to this research study, findings can be disseminated through the construction of a written report. The report would be presented to various stakeholder groups (i.e., social workers, agencies, local and state government, etc.) in a manner that captures and stays true to the perspectives of the research participants. Furthermore, when disseminating information through a written report, it will be important to ensure that it is written and presented based on each stakeholder group and its relevance to their contribution to the action planning process (Stringer, 2007). This allows for concepts to be viewed and addressed from each stakeholder's diverse frame of reference. For instance, with regards to a stakeholder group of state and local government officials and politicians, the findings would be presented in terms of a topic most relevant and impactful to them, the economy. This might lead to discussions regarding economic impact and how addressing various aspects of the social issue might foster social and economic risk reduction within the state and its communities. Moreover, when formulating the written report, identifying how these key concepts align and are interrelated within and across stakeholder groups might help invoke a common goal towards change.

Another way to disseminate the findings of this study is through a presentation at chapter and national NASW conferences, held annually. Social workers would then be able to utilize the knowledge and insight they have gained though the research findings to inform their own practice as social work practitioners and incite social change efforts through information applicable to their communities. This cycle of knowledge is

important and action research contributes to the perpetuation of growth through knowledge. Steps toward change, elicited through the dissemination of information can lead to discussions, decision-making, and a process of action that is impactful.

Implications for Social Change

Action research in social work aligns with the NASW (2021) code of ethics, as research brings about awareness to social issues impacting individuals, groups, populations, and communities on a micro, mezzo, and/or macro level. Within the framework of social work theory, social work practice is informed and guided through a multi-system level (micro-, meso-, and macrosystem) approach, which fosters a holistic and ecological perspective (Leonard, 2011). By practicing and conducting research from these perspectives, a social worker can identify the interconnections of multiple systems functioning within that client's social environment. Furthermore, it helps the social worker identify what social environmental conditions affect and help shape the client's identity, behavior, functioning, and overall development (Leonard, 2011). This will assist in the provision of services and interventions, aimed at improving the relationships between the client and the multiple systems with which they interact.

The primary implication of social change will begin at the micro level with social workers who experience challenges when conducting transition and discharge planning processes for adult offenders with SPMI, such as those who participated in this study. Through social work practice with clients, guided by knowledge gained from the findings of this study, social workers may be better able to think critically and comprehensively about factors and service barriers hindering a successful transition between facilities and

reintegration into the community. By doing so, they are then able to develop and enact strategies, procedures, practices, and services that might aid in ensuring wraparound services and continuity of care.

Additionally, reaching as many stakeholders as possible will be vital to promoting positive social change. This may be done through disseminating the findings to clinical social workers in public and private mental health and correctional sectors in Georgia who may play some intricate role in service provision for the client population. At the mezzo level, it is hopeful that this approach will not only help inform practice across a broader range of social workers but excite more buy-in to establishing an action plan that addresses the various challenges and considerations presented through the research findings.

On a macro level, positive social change may arise through policy reform. For example, when discussing the disproportionate representation of adult offenders diagnosed with SPMI, across all components of the criminal justice system, it is critical to address the evident and pervasive need for a more seamless reintegration process with respect to social and mental health services (Barrenger & Canada, 2014; Vogel et al., 2014). Social workers might therefore advocate for the amendment of such public policies as the MIOTCRA, which demonstrates positive intentions to address recidivism and community transition issues for those individuals in the forensic population with mental health disorders but presents with fundamental shortcomings (Fisher, Grudzinskas, Roy-Bujnowski, Wolff, 2011; Seltzer, 2005). Social workers might also advocate for the initiation of alternative policy proposals. By conducting local, state, and

federal advocacy for policy reform, new policies, or program implementation addressing the need for integratory, collaborative, and comprehensive continuum of care between inpatient mental health facilities and correctional institutions targets social injustice and establishes movement towards social change.

Summary

Of the many social issues and risk factors negatively influencing the well-being, social welfare, and community reintegration of the forensic population with SPMI, one of the most unmistakable and alarming is the gap in continuity of care between inpatient psychiatric hospitals and correctional institutions (i.e., jails and prisons) (Martin-Ayers, 2016; Vogel et al., 2014). Equally as notable is the void in literature pertaining to collaborative interventions and functional strategies to facilitate productive transitions and discharges between inpatient psychiatric hospitals and correctional institutions. Though seemingly insufficient in literature, this discussion is vital to fostering a successful outcome as it relates to the community reintegration, psychosocial recovery, and reduction of psychiatric and/or criminal recidivism among this vulnerable population.

It was therefore imperative to gain insight into social workers' perceptions of the challenges associated with discharge planning between inpatient psychiatric facilities and criminal justice institutions. Furthermore, it was necessary to promote dialogue regarding the practices, service interventions, strategies, and procedures that might support wraparound care for adult offenders with SPMI preparing for community reintegration and transitioning from inpatient hospitals to correctional facilities. It is hopeful that from that vantage point, social workers can excite change.

This action research study aimed to fill the void in literature and expand the knowledge base needed to bridge the gap in continuity of care for the research population. In doing so, data revealed several key findings. Among those key findings, it was indicated that when working with adult offenders coping with SPMI, many social workers are challenged by the lack of community resources, an individual's ability to meet his or her basic needs (i.e., income/benefits, housing, food, etc.), the court system, and criminal charges/forensic status and the way in which an individual's forensic status thwarts his or her attempt to attain necessary services or resources. Some strategies suggested to mitigate concerns regarding discharge planning included improving collaboration between inpatient settings (i.e., hospitals or prisons/jails) and the community (providers) prior to discharge, as well as among the multidisciplinary treatment team during the discharge process. Moreover, strengthening multidisciplinary input in documentation and during court proceedings when discharge planning is addressed was also proposed.

The findings from this research study offer a contribution to existing literature and a foundation from which social workers can promote social justice. With the knowledge garnered through the research findings, improvements can be made to clinical social work practice, collaborative efforts to strengthen service provision, and social policies impacting adult offenders with SPMI and discharge planning processes, on a micro, mezzo, and macro level. With heightened awareness and continued dialogue centered around stifling social issues impacting the forensic population experiencing SPMI, social change is bound to follow.

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Appendix: Qualitative Interview Instrument

The following interview questions pertain to your discharge planning experiences when working with male and female adult offenders (18+) coping with Severe and Persistent Mental Illnesses (SPMI) in Georgia. Please respond to the questions at the extent to which you feel comfortable. If the questions present uncomfortable at any point, inform me, and we will move on to the next question. When responding to the questions, please speak clearly. If you need the question repeated, let me know. The question will be repeated in the manner in which I wrote them and without alterations to the language used. If at any point you would like to discontinue participation in the interview, please let me know. I will terminate the interview. Your responses to the questions will be recorded, via audio recording, for me to transcribe at a later date. Following transcription, the recording will be wiped clean. As an important reminder, all information provided is kept and will remain confidential. If you would like a break at any point during the interview, please let me know and it will be accommodated.

Do you provide consent to be audio recorded for this research interview?

REQUEST VERBAL CONSENT TO BE RECORDED.

TURN ON DIGITAL RECORDING DEVICE.

REVIEW INFORMED CONSENT FORM VERBIAGE (PREVIOUSLY SIGNED AND SUBMITTED BY PARTICIPANTS) AND REITERATE THE ABOVE INFORMATION UNDER THE QUALITATIVE INTERVIEW INSTRUMENT HEADING. -- REQUEST VERBAL CONSENT FOR PARTICIPATION IN FOCUS GROUP.

VERBALLY AND CLEARLY IDENTIFY RESEARCH PARTICIPANTS BY DESIGNATED IDENTIFICATION NUMBER.

INITIATE INTERVIEW QUESTIONS.

Have you been informed about the nature and purpose of the research?

Do you fully understand the nature and purpose of the research?

1. How do you define Severe and Persistent Mental Illness (SPMI)?

2. What challenges do you experience or have you experienced in working with adult offenders coping with SPMI?

3. What discharge planning practices and procedures are you currently using or have you previously used in working with adult offenders coping with SPMI?

4. From your perspective, what has been effective with using these discharge planning practices and procedures? Please explain your answer.

5. From your perspective, what has not been effective with using these discharge planning practices and procedures? Please explain your answer.

6. If any changes could be made to the current discharge planning practices and procedures, what might those changes be?

7. If any changes could be made to the overall continuity of care for adult offenders coping with SPMI, how might those changes look?

8. What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to an effective discharge planning process?

    PROBE: What social issues might impact their discharge outcome, if any?

    PROBE: What cultural issues might impact their discharge outcome, if any?

    PROBE: What economic issues might impact their discharge outcome, if any?

    PROBE: What political or legislative issues might impact their discharge outcome if any?

9. What environmental influences or stressors, if any, do you or the adult offenders that you work with view as obstacles to successful reintegration back into the community?

    PROBE: What social issues might impact their reintegration outcome, if any?

    PROBE: What cultural issues might impact their reintegration outcome, if any?

    PROBE: What economic issues might impact their reintegration outcome, if any?

    PROBE: What political or legislative issues might impact their reintegration outcome, if any?

10. In working with adult offenders with SPMI, what service needs have been identified as priorities from a client perspective?

11. As a social work practitioner, what contributions have you made to the promotion of social change and the field of social work?

    PROBE: What social changes can be made by you or other social work practitioners concerning the population of adult offenders coping with SPMI?

CONCLUDE INTERVIEW QUESTIONS AND STATE:
This concludes the interview. Thank you so much for your time and participation!