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Causes of Recidivism Among Mentally Ill Prerelease Offenders from the Perspective of Former Correctional Mental Health Professionals

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Abstract

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Abstract

The move toward reducing the prison population was driven by an increase in the number of reentry programs that focused on the needs of the offender, such as the provision of stable housing, employment, education, and sustaining strong familial bonds. While the literature supported these areas as being effective in reducing recidivism, there was no consensus that they were effective for offenders with mental illness (OMI). The purpose of this qualitative study was to analyze the impact of prerelease services for the OMI population from the perspective of former correctional mental health professionals who provided these services. The research questions were focused on understanding the needs of OMIs in a correctional setting, and in the community and how the ability or inability to meet these needs impacted their successful reentry. The conceptual framework for this qualitative phenomenological study was based on social construction of reality framework and the risk, needs, responsivity theory. Based on thematic analysis of data collected from interviews with former correctional mental health professionals, qualitative findings showed that reentry programming is offered at the same rate for non-OMI and was not specific to OMI risks and needs. The social change implications affect the OMI population as well as every community they reintegrate back into. The direct impact of social change for the OMI population could be a fiscal impact which affects all tax-paying citizens. An increase in the allocation of state and federal dollars to be directed to prerelease specific programming could have the potential to reduce the rate of homelessness, crime, and victimization by increasing the ability to meet the needs of the OMI population before they were released back to the community.

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Dedication

I would like to dedicate this work to my three great blessings, my wonderful children Trevon, Elivia and Cydney. You all have loved me, supported me and were patient with me through the late nights and early mornings. I want you to know that my expectation is not for you to follow in my footsteps, but to know there are now more paths of opportunity for you to take. To my parents Deneice and Ismail and to my late father—Walter "Pete" Bradley—I pray that as I continue this journey called life, that I am the woman you prayed that I would become. Thank you, for your love, support, and sacrifices that laid the foundation for opportunity and success.

"Some of us have great runways already built for us. If you have one, take off! But if you don't have one, realize it is your responsibility to grab a shovel and build one for yourself and for those who will follow after you"

-Amelia Earhart

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First and only first, I would like to thank my Lord and Savior Jesus Christ for blessing me to be a vessel to do this work. That every fiber of my being and action is pleasing in thy sight. I would like to thank my Chair, Dr. Dianne Williams. You took a panicked and unsure young woman and counseled her on not only the PhD program, but on life. I was so afraid to approach you to request you as my Chair, but it was by far one of the best leaps of faith I could have ever made. Thank you for taking a chance on me.

To my second committee member, Dr. Carolyn Dennis. I can remember the relief and excitement I had when I learned that I share the same common interest of prisoner reentry. Without a doubt, your insight and guidance have been instrumental in the success of this work.

To my "honorary" dissertation coach, Dr. Joshua L. Adams. Thank you. Thank you for your guidance, mentorship, and patience. You challenged me, and pushed me through this journey and all the way to the finish line. God, bless you and keep you.

Lastly, mental illness is a serious matter. This work is dedicated to every man, woman, and child affected by mental illness and their families. My prayer is that this research will compel others to take a stand in the battle to fight and advocate for mental health education and programs in our nation's correctional facilities, institutions and communities.

Table of Contents

Chapter 1: Introduction to the Study

Introduction

When the psychiatric hospitals in the United States began closing in the early 1950s, correctional systems around the nation found themselves being forced to accept offenders with mental illnesses (OMI) at increasing rates (Hoge, 2009). Before the 1970s, correctional systems had very little interest in mental health care for the incarcerated (Anno, 2002). Treatment was not prioritized except in response to two significant issues: suicide prevention and crisis intervention. Understaffing had traditionally been a challenge for correctional systems due to the potentially dangerous environment and low wage compensation. The added responsibility of housing and servicing OMIs only served to exacerbate an already challenging situation.

Prisoner reentry is the process by which a formerly incarcerated person (FIP), is released from incarceration back into the community. The concept of reentry became a movement in the mid-2000s with the focus on reducing the recidivism rates, which are the rate of return to incarceration by an ex-offender (Hall, 2015). The notion behind reentry programming was that an offender would receive comprehensive skills and training to better equip him or her to seamlessly reintegrate into society as a law-abiding, tax-paying citizen. This comprehensive training would be met through the provision of educational and vocational training, substance abuse programming, self-improvement programming, and work release programs. Notwithstanding the large body of knowledge on the topic of prerelease programs for offenders (Hall, Wooten, Lundgren, 2016; Nhan,

Bowen, & Polzer, 2016), little to no research had been done on the provision of prerelease services for OMIs.

This chapter includes the background of the study, the problem statement, the purpose of the study, and research questions. The chapter also includes the conceptual framework for the research and describe the study's nature and trustworthiness, as well as the proposed methodological approach of the study. I give the definitions of essential terms and address the assumptions of the research and the relevance of the study, the scope, delimitations, and limitations. I also discuss the significance of the study and conclude the chapter with a summary.

Background

Skeem, Manchak, and Peterson (2011) posited that treatment services were efficient when implemented by knowledgeable and learned staff who had specific training and skill sets. The need to explore prerelease services for OMIs was imperative because, according to O'Keefe and Schnell (2007), without proper rehabilitative treatment and an emphasis on specific reentry for OMIs, it was likely that these offenders would recidivate. Current research indicated that there was a higher rate of individuals assessed as being mentally ill amongst offenders incarcerated in jails and prisons compared to in the general population. Amongst those individuals who were incarcerated, those who have been assessed as being mentally ill were two to four times more likely to have had a psychotic or major depressive disorder (Duwe, 2015). In fact, according to a 2016 study by Abracen, Gallo, Looman, and Goodall (2016) the prevalence of mental illness among male prisoners was more than three times that of the general population.

Ward and Merlo (2016) examined the effect of the lack of proper inpatient rehabilitation and treatment during incarceration and a post incarceration continuum of care for OMIs, and noted the problematic consequences for recidivism rates. Most of these offenders went back to sometimes unwelcoming and unstructured environments in which they were unlikely to succeed without proper support systems. These studies supported the argument for prerelease services for OMIs as an integral part of their successful reintegration into their respective communities.

Problem Statement

Between 20% and 40% of persons with persistent mental illnesses come to the attention of the criminal justice system at least one time in their lives (Castillo & Alarid, 2010), and, according to Skeem, Winter, Kennealy, Louden & Tatar, (2014), the recidivism rate of OMIs was approximately 55%. My goal for this study was to analyze whether former mental health professionals who provided prerelease services in state correctional institutions and facilities in Western Florida believed that the quantity and quality of available services met the needs of prerelease OMIs and whether the ability of these programs had any impact on the likelihood that an OMI would recidivate. The recidivism rate for OMIs continued to increase as research showed that these individuals were disproportionately reincarcerated after release (Skeem, Kennealy, Winter, Louden, 2014; Hall, Wooten, & Lundgren, 2016; Skeem, Steadman, Manchak, 2015; Sabatier & Weible, 2014). I sought to elicit feedback from former correctional mental health professionals to whether they believed that OMIs who exhibited the behavioral changes mentioned above were more or less likely to recidivate.

A review of the literature showed that there was specific funding and policies for reducing recidivism through reentry. However, there were no policies or funding specifically targeted for the OMI population.

It was arguable therefore, that this problem of non-specific prerelease programs for OMIs was potentially impacting the recidivism rate of OMIs because when offenders were released from prison, their disorders complicated their ability to reintegrate back into the community, and they found themselves in the criminal justice system (Lurigio, Rollins, & Fallon, 2004). There were many studies which spoke to other contributors to recidivism such as lack of familial relationships and bonds, barriers to employment and cognitive behavioral issues. My goal for this study was to determine whether those who provided the prerelease services felt that a lack of prerelease programming or the inadequate provision of prerelease programming, specific to the needs of OMIs, had any impact on the recidivism rates of OMIs.

Not only did this issue have social implications such as victimization, and homelessness but there were also fiscal implications on the taxpayers of the state of Florida. In fiscal year 2015–2016, it cost (per diem) $59.49 a day of $19,577 per year to house an inmate in a state-run correctional institution/facility (Florida Department of Corrections, 2017). This is significant because the monies that went into housing these inmates could not be funneled into programs to benefit teachers such as pay raises, and state tuition decreases to students. As the inmate population increased general costs rose for Floridians and created public safety issues for Florida communities.

This study sought to contribute to and extend the literature by providing insight into the experiences of OMIs in the correctional setting. This was achieved by evaluating the specific prerelease programming that was available to offenders that would suggest

potential solutions to addressing their recidivism, all from the perspective of those former service providers.

Purpose

The purpose of this qualitative hermeneutic study was to analyze prerelease programming that was offered to OMIs based on the information provided by former correctional mental health professionals (CMHP) in Western Florida. I focused on CMHPs perceptions of, experiences with, and attitudes toward current prerelease services for the OMI population and the impact on recidivism amongst this population. I also examined whether prerelease programming aligned with or made provisions for the OMI population to receive the same or comparable services as non-OMI. The participants of the study were former CMHPs who worked in one of Florida's Western correctional institutions/facilities. Their insight, experiences, and opinions were critical to gain any attempt to analyze the quality and quantity of prerelease programs for OMIs.

After having conducted an extensive review of the existing literature, I formulated the following research questions to analyze the prerelease services available in Florida's state correctional institutions/facilities based on my assumption that the CMHPs would answer honestly and truthfully

Research Questions

Research Question 1 (RQ1): What are the perceptions of former CMHPs about the quality and quantity of prerelease programs available to OMIs in the state of Florida?

Research Question 2 (RQ2): What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism for OMIs?

Conceptual Framework

The social construction of reality framework (SCF) is used to examine a policy that affects specialized populations (Sabatier & Weible, 2014). In the discussion, policymakers review the current policies and allocations of funding and benefits for the issues to create a solution to those problems that have been identified (Sabatier & Weible, 2014). According to Schneider (2006),

> …providing punishment such as incarceration to groups with little to no power who are socially constructed as dangerous or deviant (such as those who break the law) also will be characterized by increasing returns and long periods of increases in the use of imprisonment (p. 221).

OMI who are socially challenged due to the limitations on their cognitive behavioral thinking, or the ability to make rational choices, are more likely to be viewed as deviant in their behaviors and thus, become involved in the criminal justice system. The research conducted to show there could be a balance of incarceration (confinement for criminal behaviors) and rehabilitation (prerelease programs) that would hopefully produce a decrease in the recidivism rate of OMIs.

Developed by Schneider and Ingram (1977), the theory of social construction argues that policy systems and designs would always disproportionately benefit those who socially constructed as "advantaged" than those groups who are socially constructed as "deviants" (Al-Kohlani & Campbell, 2016). The cause of air pollution had been widely casted as an argument that showcases the theory of social construction universally. In environmental policy literature, there were disproportionate impacts of

costs and benefits of pollution in all areas. The system of social construction places those areas into four quadrants: *advantaged, contenders, dependents, and deviants*. Advantaged were both politically and strong and deserving. Contenders were politically strong but constructed as undeserving. Dependents were constructed as weak but deserving, while Deviants were weak and undeserving (Al-Kohlani & Campbell, 2016).

Policy makers tended to draft policy that met the interests of the advantaged or place policies on deviant groups that burdened them such as criminals (Al-Kohlani & Campbell, 2016). Policies that disproportionately affected groups of people such as criminals, did not carry the interest of the advantaged thus funding for programs to deter or allocate into the criminal justice system did not take a priority. Also, little emphasis was placed on issues that concerned the dependent and deviant groups. Minimizing of the issues that concerned these groups had very little advocacy until it came to light.

The case of Darren Rainey, an inmate incarcerated in the Florida Department of Corrections (FDC) who had schizophrenia garnered media attention when he died in the custody of the FDC, and the manner of his death became publicly scrutinized. Disability Rights of Florida launched its own internal investigation into the treatment of Rainey and the FDC's policies on the treatment of OMI. The outcome of the Rainey case opened the door for discussions on policies concerning the mental health population as well as allocations of funding for their care.

Kulig and Cullen (2017) explored the unseen social construction of Black victims in the naming of laws. From 1990 to 2016, laws that were named for specific victims of heinous and notorious acts such as crimes against children, women, and the elderly were

often (86.3%) named for White victims. The purpose of the naming of laws was to bring attention and to memorialize the victim's memory; however, in doing so, it only shows victimization of one prototypical face: the White face. Black victimization was thought to be the collateral damage of living in areas where violent crime and gang related activity were prevalent (Kulig & Cullen, 2017, p. 982), so it became just a story on the evening news.

Political discussions then turned to focus on the victim's rights and rehabilitating the offender. Mainly, elected officials took to the agenda of the victim and passed legislation to enact harsher penalties on the offenders and what are known as "get-tough" laws. As the SC theory shows, there is meant for a distinguishing method between those who are advantaged and those who are deviants.

Pollution was a social problem and so is offender reentry. Typically, policy was constructed when people demanded change. It would take urging upon the legislature to see that the OMI population's needs required attention toward their reentry needs. This study was intended to extend the body of knowledge on this topic to Florida with the purpose of enhancing offender reentry program effectiveness.

I also used the risks, needs, responsivity theory (RNR) for this study. According to Andrews and Bonta (2003), the core principles of the RNR were risk principle, need principle, and responsivity principle. The risk principle was used to match services based on the offender's needs. The need principle evaluated the criminogenic need and developed the treatment plan for the offender. The responsivity principle was the

offender's ability to maximize the optimal benefits of treatment based on the offender's willingness, strengths, and motivation.

According to Newsome and Cullen (2017), the risk, needs and responsivity (RNR) model was a leading and respected model in understanding offender programming to reduce recidivism. However, while it was used in nearly every correctional system in North America (Newsome & Cullen, 2017), more research was needed to refine the model. Through progressive movement, programs for offender reentry had to evolve. What was once groundbreaking may not have been sufficient in meeting the needs of the OMI population of today due to age, social issues, values, and ethics.

The RNR model, was as it pertained to offender prerelease services, not a homogenous model but heterogeneous. The need principle indicated treatment was to be targeted toward the criminogenic needs to reduce recidivism for the individual offender (Nassen & Olucha, 2017). In theory, this meant that each individual participating in the same program may have had different assignments based on their specific criminogenic needs. As this model related to the OMI population, the later showed that although they were offenders, their needs varied because of their mental illness; however, the programs were the same for the non-OMI population.

The responsivity principle was the design of the treatment plan and interventions that were designed to meet the offender’s needs, learning styles and abilities (Nassen & Olucha, 2017). This portion of the model was the most difficult to apply because of the need for the model to have had the interest and support of those outside of the clinical treatment professionals. Separation of offenders based on intellectual capabilities was

also a note to consider. This proved difficult in the correctional setting due to staff shortage/turnover, regimen of schedules and movement, availability of resources, and buy-in from administration and non-clinical staff.

Skeem, Steadman, and Manchak (2015) questioned the generalizability of risks and needs tools and instruments designed for the general correctional population, and if they were accurately reliable and valid for meeting the needs of the OMI population. Mental illness was a non-criminogenic need, meaning it was not a targeted area for treatment. For this to change and be accepted as a criminogenic need, it would have had to take a shift in policy. In a study conducted by Sacks, Sacks, and McKendrick (2004) it was noted that reentry programs with a focus on criminal thinking had been shown to reduce recidivism.

Looman and Abracen (2013) argued that the RNR based its approach to treatment on reducing the shortages of the individual rather than the goals that the offender wanted to address. The RNR only focused on the criminogenic needs of the offender and did not address other underlying issues of the offender.

In a study conducted by Guebert and Oliver (2014), the authors looked at a sample of 186 Canadian youth charged with serious/violent offenses on measures of psychopathology, substance abuse, risk and recidivism. They found that youth with disruptive behavior disorders, co-occurring disorders (dual diagnosis) evidenced more serious criminogenic need profiles.

McCormick, Peterson-Badali, and Skilling (2015) noted in a study by Fazel, Doll, and Langstrom (2008) that concluded that due to a lack of access to use of healthcare

while in the community, opportunities within the juvenile justice system offered the potential to make an impact on their health. Like the researchers before, all points of success were in the direction of the RNR model as it related to offender risk and needs assessment. Gannon and Ward (2014) stated that not only was the RNR a successful form of offender reentry assessment but that the need for psychotherapy was not to be replaced or omitted. The use of mental health case management was of equal importance as the RNR model.

Nature of the Study

I used a phenomenological approach to qualitative research for this study., Phenomenology is appropriate when the goal of a study is determining the essence of phenomena (Creswell, 2013). This study sought to analyze prerelease programming and its efficacy in reducing recidivism among OMI. This study consisted of semistructured face-to-face and telephonic interviews with former CMHPs. The qualitative approach was appropriate in that the former CMHPs could provide useful insight into analyzing the prerelease services that the OMI received or lack of prerelease services. Using hermeneutic phenomenology allowed me to provide insight into this analysis. NVivo software, which is a qualitative data analysis computer software was used to analyze the spoken data of the participants of the study.

Definition of Terms

This section provided key terms that were utilized through the course of the study. Definitions came from the literature.

Conviction: “Classification of a person as a recidivist if the court determines the individual committed a new crime" (BJS, 2014, p. 14).

Mental illness: Used interchangeably with mental disorder. “A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities” American Psychiatric Association. (2013).

Offenders: Used interchangeably with *inmate*. A person incarcerated in a correctional setting such as a jail or prison (Skeem, Kennealy, Winter, & Louden, 2014).

Pre-release services: Services that are offered/provided to an offender prior to their release from incarceration (Duwe, 2015).

Recidivism: The act of returning to prison within 3 years of the last release from incarceration (Duwe, 2015).

Assumptions

I assumed that the CMHPs would give truthful and honest answers to their accounts and opinions about the prerelease services that were available at the correctional institutions/facilities where they formerly worked. This assumption is critical to note because it was assumed that the information they provided as the subject matter experts in the field of treating the OMI population would be useful, relevant, and accurate.

Scope and Delimitations

Due to limitations on mental illness diagnosis, a net was developed to define mental illness to include identified mental illness and no documented mental illness. The scope of the study was offenders who were incarcerated in a correctional institution or facility in the state of Florida. Due to offenders transferring for various reasons throughout their incarceration, and to any of the four regions in Florida, this limited the study to covering just one region.

Only former correctional mental health professions (CMHP) were used and not those in the community as the focus is solely on prerelease services and activities within the correctional setting. Case managers and unit managers or any other staff that served in a civilian position were not used either due to not having the scope of knowledge or experiences as a mental health professional.

Limitations

There were limitations within this study. The DSM-5 was not utilized but only a measure of offenders with a documented history of mental illness or self-reported mental illness. Also, another limitation was that participants might not be truthful in their responses.

Another limitation was that, due to offenders transferring at various times during their incarceration to institutions/facilities in any of the four regions, their experiences may have varied where one institution was better than another. The former CMHPs were from the Western region of Florida, in which the results cannot be assumed for other

regions in Florida. Lastly, another identified limitation was that I was not able to secure consent to interview currently CMHPs for the study.

Transferability

Transferability was also another form of internal validity. This included information gained from research that could be applied to a broad population. To see if this was true, the same tests had to be used with the same population, but in a different environment (Shenton, 2004). As noted by Ravitch and Carl (2016), rich descriptions and details of the environment and setting would supplement the phenomenological study.

Dependability

To add to the dependability of the study, I conducted a mock or pilot interview with the first participant to test the interview questions, and ensure they aligned with the purpose of the research and research questions. All interview questions and processes were evaluated by the research committee members before the start of any data collection.

Significance

According to some estimates, as much as 50% of the U.S. prison population suffer from some form of mental illness (Long, 2014). For this study, mentally ill prisoners were classified as those prisoners who were on medications or had a psychotic disorder or both (S3), and were receiving treatment from a correctional mental health professional. Of the over 96,000 inmates incarcerated in the FDC, over 18,000 had some mental illness. These offenders were housed in facilities that were not equipped or specialized to handle their mental health illnesses. These offenders presented problems for staff and

were subject to disciplinary action including segregated housing, loss of gain time, and privileges such as the use of the telephone, television, and access to educational programming. Moreover, corrections had not invested in the rehabilitation programs necessary to reduce the recidivism rate of OMIs. Most inmates received their mental health treatment while incarcerated for a myriad of reasons. Prisons saw more mental health patients than any mental health facility in the community (Skeem, Steadman and Manchak, 2014). Therefore, it is vital that the legislature ensure that these OMIs can successfully adjust to their communities upon release. Currently, there are no specific allocation of funding in the Florida Department of Corrections' budget to address OMI in these areas.

Summary

The steady increase in the inmate population was staggering and of concern. Particularly, the offenders with mental illness population. Research showed that the OMI were challenged with increased risk factors for reoffending. Obstacles that were present for all inmates as they returned to the community were: re-housing, employment, substance abuse, and social support, whereas OMI were faced with those challenges that were exacerbated by their mental health conditions (Adams et al., 2011; APA, 2013; Baillargeon, 2009a; Castillo & Alarid, 2010; Council of State Government Justice Center, 2012; Derry, & Batson, 2008; Elbogen & Johnson, 2009; Wood, 2011).

The migration of OMIs from psychiatric hospitals to prisons crossed a dilapidated bridge in which prisons were not only ill-equipped to house the population, but were not appropriately staffed to meet the cognitive needs of the population. With little to no

discussion being had, the population continued not only to increase, but many of the offenders were returning within the three-year recidivism mark.

In so much as discussed, Chapter 2 encompassed a review of the literature as it relates to offender mental illness, prerelease programs, and the risks of recidivism for this population. Details of the framework used will also be discussed to describe the lens through which to understand the phenomenon. The use of a hermeneutic phenomenological approach to interview CMHPs was utilized, Prerelease services as outlined in their policies and procedures, and their opinions and experiences in implementing these said services was the focus.

Chapter 2: Literature Review

Introduction

Treatment for persons diagnosed with a mental health disorder was first initiated in the United States in the late 1700s. However, legislative shifts and judicial rulings over the years haphazardly spawned an influx of mentally-ill persons to move from inpatient hospitals and outpatient/community mental health facilities to the criminal justice system (Soderstrom, 2007). As the mentally-ill prison population increased, so did an increase become apparent in their recidivism rates. Trends focusing on rehabilitative services for this population were related to successful reentry into the community.

According to the Florida Department of Corrections (2010), 1 in 3 offenders reoffended within 3 years (with an overall recidivism rate of approximately 33%). Moreover, mentally-ill prisoners had an approximately 34 percent recidivism rate. The literature illustrated that offenders diagnosed with a mental health impairment had a higher propensity to return to prison than their non-mentally ill counterparts (Trimboli, 2010). As a result, this literature reviewed introduced the historical underpinnings of mental health for incarcerated persons, prior chronicle investigations into the phenomena of reentry and recidivism of mentally-ill inmates, as well as current psychological health trends within the Department of Corrections.

Literature Search Strategy

The literature review for this study was composed of qualitative peer-reviewed literature on prerelease programs for offenders with mental illness. Included literature that was reviewed and utilized included the Prison Discipline Society,

deinstitutionalization, and the incarceration revolution. The sources utilized for my research review included the Walden University online library and Grand Canyon University's online library database. Several databases were utilized including ERIC, SAGE Premier, EBSCOhost, ProQuest Criminal Justice, and Lexis/Nexis and Thoreau. The keywords that were used in the search engines for peer reviewed articles between the years 2013-2018 included: *mental illness, prerelease programs, reentry, offender, prison reentry, transition,* and *services.*

Historical Overview

The prison discipline society. Founded in 1825 by Reverend Louis Dwight, The Boston Prison Discipline Society was composed of statistics collected on prisons through visits Reverend Dwight made at various prisons from 1826-1854 (Torrey, 1997). Reverend Dwight would deliver his Bibles to inmates and noticed how mentally-ill prisoners were restricted to inhumane conditions. His writings and advocacy for this population captured the attention of the Massachusetts Legislature, who appointed a team to investigate the circumstances of state prisons. The group's investigation was reported to the state's General Court. Consequently, the courts recommended protective laws for the mentally ill (Torrey, 1997). Before the development of The Prison Discipline Society, some of the mentally-ill individuals were placed in prisons due to the overcrowding of state mental health hospitals and their inability to pay for their mental health treatment. Activists such as Dorothea Lynde Dix (1802-1887) recognized the work of Reverend Dwight and lobbied the United States Congress to remove the housing of the mentally-ill from prisons and to create the first mental asylum.

The Asylum Movement

Dorothea Dix was employed as an instructor to teach inmates at a prison in East Cambridge, Massachusetts when she discovered the horrid conditions and the deplorable treatment of its prisoners. She also recognized that violent criminals were housed in the same area as the mentally impaired. The prisoners were physically and sexually abused, left unclothed, without heat, and unhygienic (Smark, 2008). As a result, Dix began to travel to all public and private prisons (for 2 years) to observe and report her findings to the Massachusetts Legislature. In 1841, Dix's efforts compelled the legislature to allocate funds toward public hospitals to remove the mentally-ill from a correctional setting, and by the 1880s, 75 psychiatric hospitals were built in the United States (Smark, 2008).

Now that the efforts of Dwight and Dix have improved the conditions of the mentally-ill from a prison to a psychiatric setting, new challenges have emerged to include recovery and discharge planning. According to Lamb and Bachrach (2001), these new psychiatric, inpatient facilities, have become more of a warehouse for the mentally ill instead of symptom amelioration and discharge into the community. This discovery, in turn, catalyzed a more therapeutic regimen via community-based care. Thousands of mentally-impaired persons were released into the city, but resources via community mental health programs were few, and the needs of the masses were not met. Consequently, the resurgence of mentally-impaired individuals entering prisons increased and led to the rise of a social movement known as Deinstitutionalization (Griffin, 2007).

Deinstitutionalization

The Deinstitutionalization Movement of the 1950s has been recognized as the significant component regarding the resurgence of the mentally ill entering correctional facilities (Griffin, 2007). This movement was launched as a way to reduce expenditures because the maintenance of state-run psychiatric hospitals would exceed financial limits. In 1954, the development of the antipsychotic drug, Thorazine, was approved for the treatment of schizophrenia in a community-based setting. Shadish (1984) stated that deinstitutionalization forced the mentally impaired into the community, and their abnormal behavior (due to chronic, persistent mental illness) garnered the attention of law enforcement. This, in turn, suggests that this leads to a higher probability of arrests among the mentally ill. Further, the United States Department Justice conducted a study in 2006, that stated that more than 50% of incarcerated persons in jails or prisons have a mental health disorder. This number is sequentially higher than the 11% of those with mental impairment in the general population (Daniel, 2007).

Gilligan (2001) postulated that the Joint Commission on Mental Illness and Health created the Community Mental Health Centers Act (CMHCA) of 1963. President Kennedy's administration passed laws to create federal programs (such as Social Security Disability and Medicaid) to provide financial care and insurance coverage for the mentally ill. Coupled with the use of psychotropic medications, the weight of the financial burden of psychiatric institutions on the American economy had been lifted; the mentally ill could now be appropriately cared for in an outpatient setting. Preparations, however, for accommodating these individuals in community outpatient settings were

underestimated. For example, the massive number of patients released from psychiatric hospitals resulted in the mentally-ill becoming homeless (Litschge & Vaughn, 2009). These homeless individuals fell through the proverbial cracks, and, coupled with the inadequacy of the community mental health centers, lead to the second reason for these individuals ending up in the prison setting and the emergence of the Incarceration Revolution.

The Incarceration Revolution

Deinstitutionalization policies of the 1960s significantly impacted the transference of the mentally ill from asylums to prisons. According to Litschge and Vaughn (2009), by the 1970s, evidence was substantial that the closing of state mental facilities caused an increase in the imprisonment of Persons with mental illness. Metzner and Fellner (2010) posited that there is a tremendous shortage of credentialed psychological health staff and programs. Further, the noninterest in stakeholders regarding the treatment of prisoners forced political figures to be hesitant in allocating appropriate funding for mental health care. Griffin (2007) noted that the Council of State Governments endorsed improved assessments and treatment planning for psychological illness during incarceration because the care received during imprisonment posed essential problems for individuals' reentry and recidivism.

Mental Health Treatment in Correctional Institutions

The Eighth Amendment to the United States Constitution stipulated that prisoners had the right to medical and mental health treatment under the clause of cruel and unusual punishment. In the 1977 United States Court of Appeals, Fourth Circuit, the

case of Bowring v. Godwin, inmate Larry Bowring petitioned the Courts due to the deprivation of his constitutional rights that were protected by the Eighth Amendment. Mr. Bowring complained that the Virginia state prison system denied him parole because his psychological evaluation indicated that he would not be capable of completing the terms of his probation. Mr. Bowring's request was to receive psychological assessment, diagnosis, and treatment so that he could qualify for parole. The U.S. Court of Appeals ruled in Mr. Bowring's favor and agreed that the withholding of mental health treatment was the same as withholding medical treatment. This ruling laid the foundation for the establishment of psychiatric treatment within correctional facilities.

The National Commission on Correctional Health Care (NCCHC) provides guidelines on how prisons are to ensure proper psychiatric treatment to mentally ill inmates. However, scant research has been conducted on prisoner service utilization regarding actual services offered in prison setting (Morgan, Steffan, Shaw, and Wilson, 2007). As a consequence, there is a revolving door of mentally ill persons moving between homelessness and incarceration.

Mental Health within the Florida Department of Corrections (FDC)

Torrey (2010) stated that in 2007, the Polk County, Florida Sheriff's Department exclaimed that prisons and jails had become asylums to thousands of prisoners with mental health needs that could not be met while incarcerated. Moreover, Aufderheide and Brown (2005) explained that Florida's prison system's psychological health epidemic was a microcosm of society, with the rates of inmates receiving mental health treatment increasing over the past few decades. The Florida Recidivism Study of 2009 listed

approximately 24,000 inmates diagnosed with a mental health impairment and a 33.7% recidivism rate (FDC, 2010). This report strongly endorses further research into reentry programs for the mentally impaired so that ex-offenders do not recidivate.

According to Corrections Digest (2006), the Florida Department of Corrections (FDC) created 160 additional beds available for mental health treatment although the beds made available did not meet the housing needs of the mentally ill inmates. Also, the FDC extended the time offenders would receive support upon release to from prison. Third, the FDC ensured continuity of care from the prisons to the community by continuing the supply of psychotropic medications from 7 days to 30 days (Corrections Digest, 2006).

In 2013, The Florida Department of Corrections (FDC), hired two private healthcare organizations to provide oversight for prison health services, including medical, mental health, and dental services. Eighty-two percent of the prison health services in Florida were awarded to Corizon Health with a 5 year, $1.2 billion contract for approximately 44 prisons (Regions 1-3) Corizon health's headquarters is located in Brentwood, Tennessee. The remaining 18% (or nine prisons) were awarded to Wexford Health Services for the southernmost region of Florida (Region 4). On May 30, 2016, Corizon Health canceled its contract with the FDC (approximately 2 years before the contract was supposed to end). The Correctional Medical Authority (CMA) provided oversight for these two private organizations, and upon their most recent site visit, audits revealed that Wexford Health Services failed to provide adequate mental health services and the FDC canceled their contract in 2017. Trend analyses were also conducted to recognize that prisoner deaths increased more during the three-year period of privatized

prisoner health care than it did in the past decade under the oversight of the FDC. With the two-privatized healthcare organizations no longer servicing Florida prisons, a new organization, Centurion, was awarded the remaining 18-month contract that Corizon canceled until a permanent replacement was available. This time, Florida created the Statewide Mental Health Ombudsman with four Regional Mental Health Ombudsmen to investigate grievances made by mental health inmates and their families within the Florida Department of Corrections. This new office within FDC was created to ensure that mental health-related abuse and death do not surface during the prior administration.

Although the FDC has made improvements in the care of the mentally ill, areas targeting recidivism of mentally impaired prisoners are unaccounted for. Gaps in the current literature lend to further investigation of this phenomenon.

Prisoner Recidivism Rates

The Florida Department of Corrections (FDC) administered a recidivism study in 2009, which produced a list of the risk factors associated with inmates returning to prison (FDC, 2010). Of the 19 indicators identified for recidivism among men, a mental health diagnosis was not included. Instead, predictors such as race, number of offenses, time served, and supervision upon release made the top four. However, risk factors for incarcerated women did include mental health diagnosis, along with substance abuse severity, the number of offenses, and supervision upon release. This study went on to explore the stigma associated with male inmates seeking mental health treatment while incarcerated.

According to the U.S. Census Bureau, there were a total of 44,000 inmates in the state of Florida in 1990 with an exponential increased of prisoners to 102,000 in 2008 (U.S. Census Bureau, 2009). Cloyes (2010) posited that recidivism rates among the mentally ill are at an increased risk of reoffending.

Prevalence of Mental Health Treatment in Corrections

Kinsler and Saxman (2007) discovered that inmates received 10 times more mental health care than state hospitals. These numbers illustrate the significance of mental health treatment within a prison setting. Mental health services are among the least researched, but one of the most significant facets of correctional interventions. Harvey and Smedley (2010) posited that therapists must be cognizant of the uniqueness of the inmates in their prison environments for therapeutic interventions to impact wellness. In doing so, correctional therapists must recognize that mental health problems may be exacerbated during incarceration, the imbalance of power that exists within a correctional setting, the barriers to treatment in the prison environment, tensions between therapeutic and non-therapeutic staff, and the dominance of security over providing mental health services. The correctional setting itself challenges the deliverance of mental health services. Untreated mental health impairments run parallel with maladjustment to prison life. Overcrowding, lack of privacy, and the risks for victimization and isolation actively contribute to inmate self-harm. In short, all of these factors play a role in the success or failure of delivering mental health care to inmates.

Gonzalez and Connell (2014) identified one of the barriers to mental health treatment in a correctional setting to include medication continuity. These researchers'

extrapolated data from approximately 18, 200 prisoners in the Survey of Inmates in State and Federal Correctional Facilities. The results of the survey concluded that 26% of the prisoners were diagnosed with a mental health impairment at some point in their lifetime. Of the 26%, only 18% were prescribed psychotropic medications upon admission to prison. However, 50% did not receive psychiatric medications. In sum, this subpopulation of inmates is not receiving treatment for their mental illnesses. This reality has the propensity to impact recidivism upon release from prison. Correctional facilities in North America are recognized as the largest provider of mental health services. Psychiatric disorders among inmates have exceeded rates of that in the general population. Gonzalez and Connell (2014) further opined that despite rulings for access to mental health care in corrections, these mandates are usually delineated to persistent, chronic mental illnesses such as schizophrenia and other psychotic disorders. Moreover, individuals with non-psychotic psychological health disorders may pose a higher risk for treatment failure and future recidivism upon release from prison.

Current Conversation in the Literature

The reentry process for any offender can be difficult and painfully arduous. For an offender with a mental illness, the process can prove to be compounded exponentially due to their limited abilities to advocate for themselves. The transition from prison to the community poses a great risk to offender health and safety. Lacking family support and their own financial means, causes many of offenders to look for housing in shelters, which are not equipped or staffed to handle their unique needs. Worse, when shelters are at capacity, formerly incarcerated persons will congregate in inadequate places such as

woods, bridges, and unsanitary conditions. These then, compound their mental illness and can result in reoffending behaviors (Angell, Matthews, Barrenger, Watson and Draine, 2014).

The concept of engagement or service engagement is incorporated to remove barriers and build motivation to participate in treatment. Engagement invokes the attitude and behavior of the individual as it relates to their involvement in their mental health services. Positive engagement is meeting obligations, for example, attending treatment, consistency in taking prescribed medications, and meeting other obligations as outlined in their treatment plan. Likewise, disengagement is the lack of participating in treatment, for example, not attending treatment or not attending treatment, and not taking medication. Engaging OMI In the process *prior* to release does one of several things; builds motivation. Angell et. al. (2014) studied the engagement process in two programs designed for the OMI population; Critical Time Intervention (CTI) and Forensic Assertive Community Treatment (FACT). Both programs were evidenced-based treatment protocols for OMI and are widely used in correctional facilities in the nation. CIT was developed as intervention method or soft hand-off to smooth the transition from the prison/institution to the community. Case management consists of a 9-month period of services to connect linkages to the community. The main focus is to get the offender connected to more sustainable and permanent options for housing, treatment, employment, and counseling. FACT is much like CTI but there is no stipulation on time limits for services. This means there is a continuation of on-going support.

Conclusion

Prisoners with a mental health diagnosis are more significant in number than individuals in the community with similar mental health diagnoses. Young (2003) recognized three mental health diagnoses associated with increased recidivism rates three years after reentry: schizophrenia, Major Depressive Disorder, and Bipolar Disorder. However, the literature does not provide the reason why the recidivism rates are highest among this subpopulation. Further, the Florida Department of Corrections is the 3rd largest state housing incarcerated individuals. However, no studies have been done to target the mental health needs of this particular population. As a consequence, this study aims to illuminate those psychological health tendencies that contribute to recidivism versus successful reentry into the community. The need to explore the identified problem and research question is because other states—besides Florida— have realized the need for better OMI reentry programs, but there is no discussion on possible solutions as evidenced by the lack of scholarly articles on the topic.

Chapter 3: Research Method

Introduction

The purpose of this qualitative hermeneutic study was to analyze the prerelease programming that is offered to OMI based on the information provided by correctional mental health professionals (CMHP) in the state of Florida. In Chapter 3, I will describe hermeneutic phenomenology, the research design and rationale, the role of the researcher, methodology, trustworthiness, and close with a summary.

Research Design and Rationale

Creswell (2013) asserted that qualitative research is used to address the need for a problem or phenomenon to be explored. The following research question was designed to examine the perceptions of CMHPs who manage the caseloads of the OMI population who have been sentenced to serve a specified term in the custody of the Florida Department of Corrections (FDC). The primary focus will be on collecting information on how the CMHPs perceive the impact of current prerelease programming on the recidivism of OMIs. The Risk, Needs, Responsivity Theory (RNR) and Social Construction of Reality Framework (SCR) conceptual framework were used during the construction of the research question.

Research Question

RQ1: What are the perceptions of CMHPs about the quality and quantity of prerelease programs available to OMIs in the State of Florida? Impact of prerelease programming on the recidivism of OMIs?

RQ2: What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism for OMIs?

Phenomenology

Known for his expertise in the areas of mathematics and psychology, Edmund Husserl developed the philosophy of phenomenology between 1900 and 1901 (Ungvarsky, 2017). In phenomenology, the idea surrounds the notion of finding out what are the "lived experiences" from the individual that is directly entranced in the phenomenon. Phenomenology invites the researcher to observe the individual(s) in their environment as well as the commonalities that are shared among those individuals (Creswell, 2013). An epistemological view is how we gain knowledge and understanding of how we develop our reality (Maxwell, 2013; Reiners, 2012). "Phenomenological study describes the meaning for several individuals of their lived experiences of a concept or phenomenon" (Creswell, 2007, p. 57). Because I examined the perceptions CMHPs, a phenomenological approach was the best research method for my study.

Patton (2002) described phenomenology as an approach to qualitative inquiry that is used to capture and explain how an individual experiences a phenomenon thoroughly, including their perception of it, description, memory, feelings, judgments, how they make sense of it, and how they discuss it with others. Further, Patton (2002) posited that the data is gathered by conducting in-depth interviews.

Hermeneutic Phenomenology

Hermeneutics has its early roots in methods to interpret the Bible. Today, hermeneutics is used as a method of analysis of theory or texts and significance of

understanding (Forster, 2001). Hermeneutic phenomenology engages the researcher in the research by being an active participant in the interpretation of the meaning of the human experience or phenomenon (Sloane & Bowe, 2014). The value of using a hermeneutic phenomenological approach in my research study is that I work as a classification supervisor in administration in a correctional facility and hold a master's degree in professional counseling. Much of my bias comes from the fact that I work face-to-face and come into daily contact with the offender population as well as the CMHPS. I also have readily available access to data both statistical and in the environment. Coupled with these experiences, I can, in turn, provide interpretation of the meaning of this research.

The ability of the researcher to utilize reflexivity/self-reflection in the interpretation of processes and meaning challenges the researcher to identify personal bias, yet allows for acknowledgment of professional experience engagement (Creswell, 2009).

Role of the Researcher

I was the chief data collector and orchestrator of this study. The importance of each participant's insight is invaluable to understanding and solving the research question. To gauge the climate of the current prerelease programs in the Department based on the CMHPs perspectives will shed light on other factors such as the recidivism rate of the OMI population.

I began my career with the Florida Department of Corrections (FDC) in June 2004, as a records clerk. Having to fulfill an internship component for my bachelor's

degree in social work, I reached out to then-Deputy Secretary, Dr. Laura Bedard and was blessed with the opportunity to not only complete my internship but to experience both the correctional setting and community corrections (probation and parole). It was through these experiences and contact with the offenders that I was able to increase my awareness of working with marginalized populations and the barriers (both social and interpersonal) that they faced. My mother is a retired detention officer who spent 23 years working 12-hour shifts with both male and female offenders. Weekly, I would listen to the stories about her day and the encounters she had with the offenders, mostly women with mental health disorders. My educational experiences led me to pursue my master's degree in professional counseling with an emphasis on mental health counseling.

My role as the researcher will be to ask the participants to explain their position as mental health professionals in a correctional setting, and how they assess the prerelease services that are available to the offenders they manage on their caseloads.

Bias

As previously stated, I am an employee of the FDC, which has the potential to present itself as a potential bias in my research study due to my daily contact with the OMI population as well as the CMHPs. As I engage in the interview process, the potential of leading during questioning is an area that I must remain cognizant and aware of. The use of reflective journaling will be critical in documenting my self-awareness for bias.

Ethical Issues

Careful consideration of potential ethical scenarios is essential to recognize, diagnose, and have a plan of action. This is done by purposefully taking note of potential issues. A possible moral problem that could arise is if a participant were to disclose a violation of the Health Insurance Portability and Accountability Act (HIPPA) of an inmate's information. To prevent this from happening, participants will be advised before the commencement of the interview to not use any offender's names or Department of Corrections (DC) numbers to identify any offenders. The only use of categories, (psychiatric level) or scenarios will be used.

Another potential ethical issue that could arise is that I work in the environment of my advanced research group. Having daily interactions which are both social and professional, with proposed participants could potentially raise an ethical issue. To address this, I would again state the purpose of my research, how their information and insight is relevant to the phenomena and that there is no pressure for accepting or declining to participate. Should they elect to participate, their information will be kept strictly confidential, anonymous and the interview will be conducted offsite and not on any institutional grounds. This will also be important to disclose on my Institutional Review Board (IRB) application. The initial consent will be obtained from each participant and via electronic or ink signature before scheduling an interview.

Methodology

There are three separate stages of the hermeneutic approach: naïve interpretation, structural analysis, and comprehensive understanding (Ricoeur, 1973; Singsuria, 2017).

In the naïve stage, the researcher attempts to speculate what the meaning is behind the data, while structural analysis will identify themes through grouping and generalization of phrases. Comprehensive understanding will encompass information gathered from naïve interpretation and fundamental review along with my educational background in counseling and my professional lived experiences of working in a correctional facility with offenders and CMHPs.

Population/Participants

The participants of my research study were former correctional mental health professionals in Western Florida who worked in one of the state's correctional facilities and or institutions. Each participant will be screened for eligibility in that they must be working or have worked for at least one year as a correctional mental health professional in one of FDCs facilities (private institutions are not included as their prerelease programs differ from state facilities). There will be no limitations as far as race, age, or educational background; however, this demographic information will be included in the research.

Sampling Strategy

The proposed sampling method for this research study will be that of the purposeful sampling method. Patton (2002) noted that in purposeful sampling, participants are strategically selected by the researcher to obtain in-depth information. I will also use snowball sampling to access participants. Snowball sampling is the method of using current participants to refer other participants of the population or research study to participate in the study (Patton, 2002). I have worked at two institutions (one of which

was private) and have come to know several current and former CMHPs. To deflect potential bias and to gain access to CMHPs who I have yet to meet, or will have difficulty in accessing I will invoke snowball sampling to supplement my participant base further.

The correctional mental health professionals were chosen as the target population because they are the subject matter experts on the services of the OMI population. More so, they have direct access and information to identifying the needs of the OMI population and can assess in their professional opinion the prerelease services that are available to the OMI population.

Site

The site location that was utilized was a state-operated correctional institutions/facilities in Western Florida. In thinking about which place would be most appropriate for my research, I immediately ruled out county jails, municipalities or townships to keep the focus on state prison institutions and facilities. County jails, cities, and towns are not suitable for my research study because offenders are either there for short sentences (one year or less), or are awaiting sentencing. Typically, prerelease services are going to differ for those offenders sentenced to less than a year in that their immediate needs are the focus of their services. It is uncertain how long those who are awaiting sentencing are going to stay, thus assessing their needs can be either premature if the outcome of their charges is unknown. To assist the CMHPs in feeling comfortable about speaking with me, I conducted interviews in locations other than correctional facilities.

Participant Size

According to Creswell (2007), a phenomenological inquiry is primarily composed of in-depth interviews, with one to 10 participants. Ten participants was the ideal size to gain an understanding for this research study to gain an understanding of a phenomenon from a smaller sample size with similar experiences. There are 21 state-operated correctional institutions/facilities in Western Florida. I will utilize snowball sampling in which I will ask CMHP participants to provide names of possible CMHPs to participate. According to Jeong and Otham (2016), data saturation can occur with a small participant pool of three to five. Being that the prerelease programs that are offered at the state-operated institutions are the same, it is assumed that many of the CMHPs will generate commonalities and similarities.

Instrumentation. For my proposed research study, I plan to utilize standardized, open-ended questions that will be recorded. Interviews will either be conducted telephonically or face-to-face utilizing an interview guide created by myself. Open-ended questions will allow for participants to give responses based on their experiences. In this method, I asked follow-up questions and the participant had the opportunity to ask for clarification or continues to elaborate on the subject.

According to Patton (2002), the exact wording and order of the standardized, open-ended questions are developed in advance to ensure that all participants in the study are asked the same basic items in the same sequence. Patton (2002) illustrated that standardized, open-ended interviews increases comparability of responses. Because the participants answer the same questions, the data are completed for each participant.

Standardized items allow the researcher to evaluate and interpret the data based on the same issues that were asked of each participant.

Procedure for Recruitment, Participation, and Data Collection

Once approval was granted from the Walden University's Institutional Review Board (IRB) (approval number 07-11-18-0595941), I began making contact with prospective participants. This was achieved by communication via electronic mail to schedule interview dates and times. When a face-to-face interview could not be recorded, arrangements were made to conduct a telephonic interview. For interviews conducted face-to-face, the location was held in a place that was comfortable for the participant with little to no distractions. In both interview methods, I reiterated appreciation for their time and willingness to participate in the research study, the informed consent procedures, and addressed questions and/or concerns before obtaining their signature.

The standardized interview questions were open-ended and recorded via audio as previously consented to by the interviewee. Each interview was anywhere between 30-60 minutes. At the end of each interview, each participant was thanked again for their time and was given written instructions and a courtesy follow-up email on how to obtain results from the research.

Recruitment

My research study utilized the process of snowball sampling in which I met with one potential participant and asked that they provide names and contact information for other former CMHPs who may be interested in participating in the study. Access to this

participant was not an issue, as they were a former CMHP whom I had worked with before.

Reciprocity and Gifts

Pandya & Desai (2013) proclaimed that when there is a limited skill required to act as a participant, gifts were appropriate to disseminate at the conclusion of the interview. In my debriefing with each participant, I thanked them for their time and cooperation in my research study and provided them an e-gift card to Target. The monetary amount was $15.00. To be fair and consistent, the store and amount were the same for each participant.

Participation

Participation in my research study was strictly voluntary. I used snowballing to recruit former CMHPs for participation in the research. I began with my first participant and once s/he agreed to participate I then followed up by asking if they could provide information of former CMHPs who I could invite to join in the study. Informed consent forms were signed before conducting the interviews. Digital signatures were accepted from participants to secure the interview and scheduled time.

Data Analysis

In-depth interviews were conducted to understand "common experiences to develop practices or policies or a deeper understanding about the features of the phenomenon" (Creswell, 2007, p. 60). For the proposed research study, I conducted in-depth recorded telephonic qualitative interviews as well as face-to-face interviews of participants who could meet in a central location within Leon County, Florida. In either

instance, the conversations were recorded utilizing a digital recording device that had features to record, play, stop, pause, and rewind and fast forward. The use of a digital audio recording device allowed me to record interviews while taking free-hand notes.

Transcription

Each interview was transcribed by a professional transcriptionist and re-reviewed for accuracy. I located an online transcribing company that reproduced the conversations. I reviewed those transcripts against the audio recordings to ensure the accuracy of the interviews as were recorded. After careful review of the transcribed material, I then proceeded with the analyzing of the rick context data provided by the participants.

Bracketing

To adequately and succinctly analyze the data provided from the transcripts, I utilized the method of bracketing to discern biases as the researcher that could have potentially impacted the richness of the responses generated from the participants. To accomplish this, I explained in detail their experiences as it related to this phenomenon so that the focus remained on the participants.

Coding

Evaluation of poignant themes were categorized into units or themes and then formulated into clusters and categories (the researcher to combine and create text and structural data to illustrate the skills of the participants with this phenomenon and how they experienced it. Data analysis was achieved through emic coding categories which took words verbatim from the interviewees. Open coding allowed me to organize the data into themes. This made it so that I could later analyze the data that would continue to

answer the research questions. Axial coding was used as the comparison of emerging themes and causal relationships from the open coding. The final stage was selective coding in which a common theme was combined with the themes from the axial coding phase (Hennick, Hunter, & Bailey (2011).

Issues of Trustworthiness

Credibility

The outcome of the research was only as good as how the information was accurately produced. When the researcher can explain the components of the research and any challenges that arise, s/he has met credibility (Ravitch & Carl, 2016). Among several processes that I planned to implement as the researcher, the process of member checking was used by giving participants copies of the transcripts (verbatim) to ensure the accuracy of the replication of the participant's information so that it would contribute to the study.

Transferability

Examining the prerelease services for the OMI population was viewed from the experiences of former CMHPs in state correctional institutions/facilities. This could be applied to federal and state prison systems as well. Transferability could be achieved when the study has content-rich data that could be used in broader and more significant contexts or those in the same scale. To ensure transferability, I used very descriptive data that was "context-rich" (Ravitch & Carl, 2016, p. 88).

Dependability

Dependability is achieved when the data is stable over time, and the researcher can back the research with proven testable procedures that can be repeated and yield the same outcomes (Ravitch & Carl, 2016). Important to note was the method of how the research was conducted and the manner in which it was artfully done. The key to achieving this was to ensure that the research question was answered.

Confirmability

Reflective journaling is a process that allows the researcher to address the personal biases that are experienced while being immersed in the research study. To remain objective and not impose any bias, I used reflexive journaling throughout the process to be able to look back at varying stages of the process to ensure there was no imposition of the researcher's experiences and thoughts.

Ethical Procedures

The Walden University Code of Conduct as well as the Walden IRB webpage and application was reviewed to ensure compliance with all institutional, state and federal applicable laws that governed the use of participants for research studies. All participants in the study acknowledged that they understood their participation in the study was voluntary as outlined in the consent form. All participants were treated with respect and dignity by the researcher.

Data Storage

All data that was collected in this study was locked safely and is password protected with a digital password. All information was stored on a universal serial bus

(USB), informed consent forms, paper notes, digital audio recorded interviews, and questionnaires also being kept and secured in this same locked safe.

Data Maintenance

All data collected during the research study was kept anonymous and confidential. All information has been kept and will be retained for the five-year retention period and subsequently destroyed after that.

Summary

Chapter 3 provided the history and background of phenomenology in qualitative research. Each section within detailed the role of the researcher, the research design and rationale, methodology, and trustworthiness.

Chapter 4: Results

Introduction

The purpose of this qualitative hermeneutic phenomenological study was to analyze the impact of prerelease programming that was offered to OMIs based on the information provided by former correctional mental health professionals (CMHP) in Western Florida. I focused on CMHPs' perceptions of, experiences with, and attitudes toward current prerelease services for the OMI population, and the programmatic impact on recidivism amongst this population. This study also examined whether prerelease programming aligned with or made provisions for the OMI population to receive the same or comparable services as non-OMI. This qualitative study utilized interview questions that were open-ended and served as the principle mechanism in understanding meaning and common assumptions.

In Chapter 1, I covered the background, problem statement, purpose of the study and introduced the research questions. The nature of the study, definitions assumptions and scope and delineations were also covered. Chapter 1 concluded with limitations, significance and a summary. Chapter 2 illuminated the strategy of the literature review, databases and sources for query. The theoretical lens and conceptual framework that aligned this study were also incorporated in Chapter 2 as well as an exhaustive review of the literature. In Chapter 3, I reviewed the methodology by restating the purpose of the study that encompassed the alignment of the study, research and design and procedures for the qualitative study, recruitment and number of participants. In Chapter 4, I will describe the research settings, participant demographics data collection methods, and data

analysis. The emergent themes and concepts as shared by the participants and credibility will also be discussed along with the closing remarks and conclusion.

Research Questions

The following research questions were framed to explore if the prerelease programs that were available to the OMI population worked through the experiences of former correctional mental health professionals:

RQ1 - What are the perceptions of former CMHPs about the quality and quantity of prerelease programs available to OMIs in the state of Florida?

RQ2 - What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism for OMIs?

Pilot of Interview Guide

I conducted a pilot test of my interview guide (Appendix A) with the first interview participant to see if there were any issues or concerns with wording or clarity. The participant noted that the questions were understandable and clearly stated. The participant also noted that the letter of consent and invitation to the study were also clear and precise and had no questions in regard to either. The pilot test participant was also from the same setting of the main study. This pilot test helped me become familiar with the recording device and cellular telephone to detect any technical issues that could arise and to see which recording settings produced the best quality of sound.

Upon completion of the pilot test interview I referred to the notes that were taken during the interview and began coding them while it was still on my mind. The interview was transcribed and received within 48 hours. I then compared notes to the transcript to

ensure the contexts of the interviews could be understood as this is a critical component of this hermeneutic phenomenological study (Sloane and Bowe, 2014). I also conducted the member check/debriefing process with the participant to establish credibility of the study which allowed the interview participant to read the transcript for themselves and provide any feedback or clarification on their experiences. Since this pilot test interview revealed no issues, there was no need to propose any changes to the study to the Walden University IRB.

Setting

The setting for this study consisted of one face-to-face interview which took place in participant's home and the other six were telephonic interviews that took place at the participant's home or work. Each of the former correctional mental health professionals worked in various correctional institutions in Western Florida. The correctional mental health professionals were chosen as the target population because they are the subject matter experts on the services of the OMI population. They have direct access and information to identify the needs of the OMI population and can assess, using their skills and training, the prerelease services that are available to the OMI population. The Walden University Institutional Review Board (IRB) approved the study (07-11-18-0595941). Letters of consent were obtained from each participant in the study. My initial plan was to have both former and current CMHPs participate in the study, however a letter of cooperation from the contracting agency that employs the current CMHPs could not be obtained. Participation in the study was voluntary and participants had the option

to stop or opt out of the interview at any time. Each participant received a $15.00 Target e-gift card upon completion of the interview.

Demographics

The participants in this study were two adult men and five adult women. All seven participants identified as African American and of non-Hispanic ethnicity. All seven participants were former CMHPs who had not been employed at a Florida state correctional institution for 2 years or more. Initially, I proposed that there would be an interview pool of 10 participants; however, saturation was met at seven. To safeguard each participant's identity, I assigned pseudonyms that only I knew. Interviewee names, affiliations, and other identifying factors were altered to respect each participant's privacy. The interviewees represented a wide age-range from 31 to 66 years. The highest level of educational achievements of the participants ranged from possession of a bachelor's degree to doctoral degrees in psychology, while years of experience ranged from 2 years to 19.5 years. Three of the participants were licensed clinical social workers (LCSW). As seen in Table 1, the total years of correctional mental health professional experience of all participants combined was 50.5 years.

Table 1

Participant Demographics

Participant	Age	Gender	Highest Level of Education	Years of CMHP Experience
PP1	43	F	PsychD	5
PP2	41	F	MA	4
PP3	42	F	BA	12
PP4	31	F	PsychD	3
PP5	30	M	MA	2
PP6	49	M	MA	19.5
PP7	66	F	MA	5

Note. M=Male F=Female, BA=Bachelor's degree, MA=Master's degree PsychD=Doctorate of Psychology degree.

Data Collection

Two men and five women participated in this qualitative research study. I utilized snowball sampling in which an identified participant for the study is identified who then in turn was asked to encourage other potential participants to come forward to participate if interested. Snowball sampling is a non-probability sampling method which is a technique where the odds of any member being selected for a sample cannot be calculated, thus random sampling (Cohen, Nissim, Arieli, 2011). Each participant identified was emailed an invitation to participate in the study as well as a letter of consent. Once the consent was obtained via electronic signature with the words "I consent" from each participant, I began scheduling and interviewing until data saturation was reached.

The interview occurred with PP1 at their home office. It was a quiet setting with just the two of us present. The interviews conducted with PP2, PP3, PP4, PP6 and PP7

were telephonic while they were at their homes. The interview with PP5 occurred while they were at work on their lunch break and I was on break. Prior to each interview beginning, each participant was polled as to if s/he were in a quiet environment, with adequate cellular phone reception and at least 60 minutes to complete the interviews. Once this formality was completed, each participant was thanked for their time, explained the nature of the study and reiterated their information would be kept confidential and that they could end the interview at any time. I collected data using a series of open-ended questions that were designed to gauge a description of the prerelease programs available to the OMI population and the impact of those programs on the recidivism of OMI. The initial interview was recorded with an Olympus VN-541PC Digital Voice Recorder, however, subsequently an Olympus WS-853 Digital Voice Recorder (which used MP3 files) was purchased after the interview with PP2 resulted in poor transcription quality feedback. All interviews lasted between 28 and 40 minutes.

Each interview began with asking the participant about her/his demographic information such as age, race, and highest level of education and years of CMHP experience. Subsequently, each participant was provided with information about the study. The participants were asked if they had any questions, comments or concerns before proceeding with the interview. I reiterated to all participants that I wanted to hear and learn about their experiences as it related to this study and to not feel compelled to not disclose any information that they believe is pertinent to this study due to my current employment position. All participants were administered the same open-ended questions,

and were asked follow-up questions accordingly to the responses provided to gauge more insight and understanding into their experience.

At the end of each interview, each participant was offered the opportunity to review the transcript of his/her interview (member checking) and to ensure that the information presented was an accurate account of his/her perception and experiences. The interviews occurred over a 5-week period. At the conclusion of each interview. I enlisted the services of Rev.com for transcription of the interviews. Each transcript was done verbatim and then verified for accuracy by replaying the interview recording and making any necessary corrections.

Each recorded interview is stored on a universal serial bus (USB), and all paper forms to include notes, journals, questionnaires, consent forms, interview guide and the digital audio recording device are stored in a locked safe that is password protected for the minimum retention period of 5 years. There was no variation from what was proposed and approved and there were no adverse events that took place in the data collection process.

Data Analysis

My approach for data analysis was to use the hermeneutic phenomenological approach developed by Ricoeur (1973) and again celebrated by Singsuria (2017). The three steps in hermeneutic phenomenology include naïve reading, which is interpreting the data or context of the participant's meaning from their experiences. Structural analysis involves the shaping of themes by identifying texts and phrases that stood out from the interview. Comprehensive understanding of the lived experiences surrounding

the phenomenon entails the process of making a final composition of the themes and subthemes. In this last review, I was able to intertwine conjectures along with the naïve reading and literature review material.

The qualitative analysis began by me reading interview transcripts, notes and memos collected during the data collection process. The notes and memos were recorded during the interviews and reviewed after each interview for analytical thinking and initial reflection to preclude personal biases.

Evidence of Trustworthiness

Credibility

I used the process of member checking in which respondents who selected this option were given a copy of their transcript for review to ensure data accuracy of the transcript and make any corrections if needed. Credibility of the study is supported by Ravitch and Carl (2016). There was no variation in procedure as noted in Chapter 3 of this study.

Transferability

To achieve transferability, descriptions that were thick and rich in context of the data to increase transferability was used. There were no variations from the outline in Chapter 3.

Dependability

Dependability is achieved when the data is stable over time and the researcher can support the research with proven testable procedures that can be replicated and yield the

same outcomes (Ravitch & Carl, 2016). I did not experience any variation from Chapter 3.

Confirmability

I used reflexive journaling to note personal biases while conducting the study. This ensured that I remained objective.

Results

Codes were created into the study by the interview respondents, or what is known as emic approach. I also created a list of preliminary list of categories prior to the interviews, which assisted with the development of the interview guide. The purpose of the preliminary categories was to assist in organizing the interview responses by research question. I then began coding each transcript by listening to the digital audio recorded interview while reading the transcribed version to ensure accuracy in appropriate data review.

Themes

Reoccurring themes began to emerge during repetitive reading of the transcripts. Themes were coded and nodes developed when entered the qualitative data analysis software NVivo 12 Plus. This in turn allowed me to specifically hone in on the participant's lived experiences of their perceptions of the prerelease programs for offenders with mental illness based on their positions as correctional mental health professionals. There were three main themes and six subthemes identified that emerged from the data collected.

The qualitative exploration was guided by the two research questions: *What are the perceptions of former CMHPs about the quality and quantity of prerelease programs available to OMIs in the state of Florida and impact of prerelease programming on the recidivism of OMIs* and *What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism for OMIs?* As previously noted, three themes emerged from the participant interviews along with six subthemes. Each theme was garnered from emic coding, followed up with axial coding which was the comparison of emerging themes and causal relationships from the open coding. The final stage was to use selective coding in which a common theme was combined with the themes from the axial coding phase (Hennick, Hunter, & Bailey, (2011). Figures 2, 3, and 4 are illustrated below to support answering the two research questions.

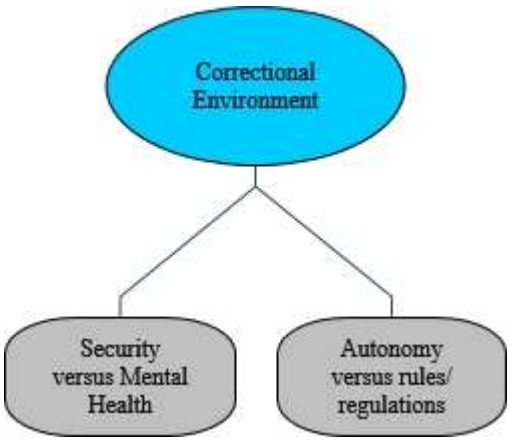

Figure 2. (Theme 1). Sturcutral analysis from the theme of the correctional environment as the main node and the subthemes of security versus mental health and autonomy versus rules/regulations.

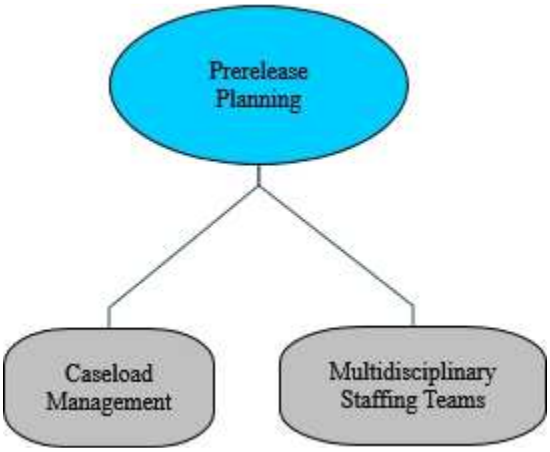

Figure 3. (Theme 2). Sturcutral analysis from the theme of prerelease planning as the main node and the subthemes of caseload management and multidisciplinarystaffing team.

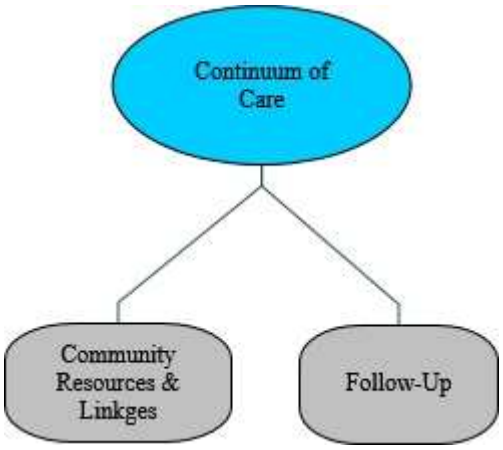

Figure 4. (Theme 3). Sturcutral analysis from the theme of continuum of care as the main node and the subthemes of community resources and linkages and follow-up.

Figure 2, illustrates the structural analysis of the correctional environment as not being conducive to a therapeutic model of rehabilitation and counseling. The notion that security is first, supersedes all operations of the facility. An OMI who may be experiencing an episode of psychosis or psychological emergency, will be seen when security informs mental health services which is not always immediate. The subthemes of

security versus mental health and autonomy versus rules and regulations developed from the main theme. Themes one and two were used to answer the first research question of the study of the perceptions of CMHPs about the quality and quantity of prerelease services for OMIs and the impact of prerelease services on the recidivism of OMIs.

Figure 3, reflects during the structural analysis experiences of prerelease programming. The subthemes that emerged were caseload management and multidisciplinary staffing teams.

Lastly, Figure 4, shows the theme of continuum of care. The subthemes that advanced from there were community resources and linkages and follow up. This theme was used to answer the second research question of the impact of prerelease programming on the likelihood of recidivism for OMIs based on the perceptions of the CMHPs.

Theme 1: Correctional Environment

The first theme that came from the data was the correctional environment. Participants of the study revealed their lived experiences in working within the correctional environment.

Security versus mental health. Security versus mental health was one of the most common featured themes shared among the participants when discussing their ability to provide care for the inmates on their caseloads. PP1, PP6 and PP7 shared experiences of having conflicts with the institutional security officers when it came to being notified that an inmate made a claim of having a psychological emergency.

PP1 stated:

For example, if a patient has, uh, declared medical emergency, and security feels that they may be malingering, then the likelihood of us addressing that mental health emergency is nil to none. Because they have the authority to, um, inform us whether or not there is an issue. So, that perpetuates either the individual either has an intentional event where they try to harm themselves.

PP6: There's something we used to say a lot, you know, is that security and mental health often had a rough, a rough marriage, because we looked at, um, the inmate's adjustment from two different perspectives, but if, if security did their job right and mental health did their job right, then the two would protect each other, even though the, the marriage would be rough. But ultimately you, you really had to push yourself to approach the situation and think from a mental health perspective doing a mental health assessment. And sometimes you got pressure from, um, security staff even, because they're like, "Oh, he's just playing" or "She's just playing" and blah-blah-blah-blah-blah, and you know, you, you, you, kind of listen to that, and you take it in, but ultimately when you do your assessment you, um, you give the best, um, clinical, you use your best clinical judgment and not let pressure from security staff effect how you, um, approach the clinical situation.

PP7: That was, that was part of the case, and the other part was, uh, even if they called a psych emergency, uh, because of the restraints of, the rules of the correctional system, and mental health, the inmate would not get the kind of care

they would get, uh, if they were not in a, in an environment where they were incarcerated. The therapeutic environment is absent from the correctional system.

Autonomy versus rules and regulations. Autonomy versus rules and regulations was the second subtheme to emerge from the correctional environment. The counseling techniques that the CMHPs administered encompassed coping techniques and mechanisms. This technique is used to help the offender find a way to acknowledge when they were in crisis and how to deal with the situation. However, the counseling techniques encompass autonomy or independence. This however, cannot always be practiced in an environment where there are restrictive rules and regulations.

PP7: We work on plans about ways to cope with stress because prison is a stressful environment, like taking a walk or journaling. This is not always, uh possible. The inmates can't just get up and go walk because movement is, is restricted. And um, security turns the lights off at a certain time at night. But if the inmate is feeling like he's in crisis and wants to write his feelings out, he can't just pick up a pen and paper and write because its light's out.

PP3: I had a client who suffered from bi-polar disorder and he had a beautiful voice and could sing very well. Singing, was um, one of his, his coping mechanisms. One of his triggers was being in closed spaces. Because security saw him as a behavioral problem, they would put him in confinement in a single-cell. To cope, he would sing, but, but security would tell him he could not sing because it was disruptive. I told the staff that, that is one of his coping mechanisms and

some staff would let him, but others would yell at him and threaten him again, with discipline for singing.

PP5: I used Cognitive Behavior Therapy (CBT). CBT is aims to change our thoughts patterns, the beliefs we may or may now know we hold, our attitudes, and our behavior in order to help us reach our goals. In my experience in using this technique I have found that as inmates become more aware of their thoughts and their belief system; their behavioral begin to change. This was always a challenge for me with working with inmates due to inmates battling between changing their thoughts and surviving in prison. There were several of times I would get statements like "I know I need to change the way I'm thinking but I can't get caught being weak".

Theme 2: Prerelease Programming

The second emerging theme was prerelease planning. The interview participants gave accounts of their perceptions of the prerelease programs and services that were available and what they think could have changed.

Caseload management. Caseload management was a reoccurring subtheme of the prerelease programming for OMI. Many of the participants noted having large caseloads and high turnover rates of CMHPs.

PP1: I felt like when I was there that I was just herding cattle. I think I was responsible for about 35 hundred patients. So, I would work 17 hour shifts. But I only got paid for 8. Because I felt that I needed to see everybody so that if

someone dies, you know, I will be able to, I would, you know, I would-I would want to be able to sleep at night.

PP4: And so for me, there was a kind of like a gamut of mental health disorders that I saw. Any…everything from, um, psychosis, schizophrenia, thought disorders, to just, you know, everyday anxiety, depression. Um so it-it ranged in-in terms of severity of the mental health diagnosis. Um, and I-I had probably over like 200 folks on my caseload, which now looking back is ridiculous.

PP6: Um, an average caseload for me was um, between uh, wow, maybe between 70 something on the low end and 120 on the high end. Somewhere in be-somewhere in between there. And, um, um, being able to serve that many, it depends on the, the level of challenges, the degree of issues.

PP7: Um, the caseloads were, uh, rather high. The number ran from about, uh, 120 or more. Time was kind of limited, and actually doing counseling was, uh, was, uh, rather difficult, because you had the restraints of, uh, the correctional system, and you had to abide within their guidelines. Um, some of the people that I dealt with as far as with depression, um, I was able to, uh, work with them. Um, some of the ones that had life sentences were, were difficult to work with, so what, um, I worked with them on is, how to, uh, survive and make the most of their time while they were incarcerated, to expand their minds.

Multidisciplinary staffing teams. Multidisciplinary staffing teams was a notion that was raised by the participants as needing comprehensive and collective collaboration of all areas of the institution in order for the OMI to have a prerelease program that would help them prepare for life outside.

PP1: I think that all-I think that reentry should be-should begin at- from the reception center until they leave to go to the community. I think that reentry should be a part of every institution. Even though they say it is, but it's not focused upon. It should be comprehensive that everyone has an individual plan.

And they have no clue as to how we can help them. Because we haven't done anything up until, up until it time for them to leave, to address it. So, this reentry must start when they first get there. And all the ... just like they have an individual education plan for kids who are not meeting grade level, and they call the guidance counselor and the principal and the parents and the teachers in, everyone needs an individual plan, um, when they first get to the institution.

PP7: Right, the classification unit was the one that basically, uh, did most of the pre-release. Uh, no. One of the things, one of the things that, that, uh, that I found was that, um, some classification officers were uh, uh, amenable to doing that. Uh, but again I think that their caseloads were so high until, uh, a lot of times, you know, they just did minimum of what they could do. You know, finding a place for that person to live.

I think it has to be a holistic approach. Uh, in order for the uh, the inmate to not return ... return to the facility. Uh, mental health can only deal with one part

of it, but there's a whole lot of other things that are going on. And one of the things that, that happened is that these inmates, which they have to remember, is that they were in need and they had issues going on prior to coming, uh, to prison. So, even as a counselor, one of the things that I try to do was, uh, to get them to, uh, recognize, um, those issues, and come up with alternative plans on how they would deal with them.

PP2: They were uh, uh, I mean there were various types of interdisciplinary teams, you know, and I don't know, I don't know if I would say that there was some official way that education interacted with, for example, mental health. I mean, I, I think so on some level, but, but I think more so it was, it, it was like having patients in common, or having, you know, clients in common or something, that, you know, I would know that, you know, this inmate went to school, I would know that he's working on his GED or whatever cause he's telling me this in his sessions and things like that, and um, and of course his teacher would be, you know aware that, okay, he probably goes to mental health or whatever, and, and sometimes if they see things that um, might be helpful for us or vice versa, I think.

PP4: There was a multi-disciplinary team, but they did not talk about pre-release or recidivism, um, issues. There was more so a focus on problematic concerns that were currently happening.

Theme 3: Continuum of Care

The third theme to emerge from the data collection was the need for improved continuum of care. The participants explained in-depth their lived experiences of their perceptions of continuum of care for the OMI after they are released from custody. The data collected from the participants provided the answer for the second research question.

Community resources and linkages. Community resources and linkages are an important aspect of the prerelease process. Life beyond incarceration can prove difficult for anyone, however the OMI prove to have more difficulty because their mental illness exacerbates their ability to adjust.

> PP3: Well, I think it's extremely likely to recidivate, because, as I mentioned earlier, if they don't have mental health resources in their communities, specialty within their communities. Eventually, their medication is going to run out and then you are going to start to see offenses. Or, they don't have the type of insurance to afford the medication, and then you're going to see symptoms where, you know, their symptoms will coincide with their criminal activities. So, there is a high likelihood of the recidivism, um, for those who are from, definitely, from rural areas, and also for those who do not have the, um, regional diagnosis, many shared resources, to be seen by, um, community-based mental health.
>
> I would have, I would have like to have a health care specialist to make themselves available, especially, um, to other agencies, um, you know, um, to network with other, um, facilities, you know, who are in Florida and provide, and help to provide options and brochures on services we're providing, it's a better

mental health community. I would have liked for, you know, individuals, rural counties, to connect with the mental health agencies in the area, just to go visit and discuss concerns, you know, because, um, there could be other avenues that may not have been up to. So, um, just more networking with the mental health community in Florida, especially now with the opium crisis that we have going on.

PP7: Okay. Well, for one thing I that, um, one of the things that needs to, uh, to be emphasized is, uh, making sure that, that upon release that they are connected to resources, uh, that they can continue in counseling. Um, I think too, that one of the things also that could happen is that maybe working with the, uh, client in, uh, pre-release to have an idea of what kinds of things that they would like to do. Um, coping mechanisms. um, let them know that the same, the same type of things, uh, that ... and people that they left and hung around with would still be there, and there would be temptations, and, uh, giving them coping skills.

PP6: I, I think that prerelease planning, um, was critical, the discharge planning. And, and once again, in, in my day it was a whole process of us, um, trying to get the inmate connected with, um, a mental health provider in the community before they even left, um, because, um, of course, without the right support and stuff when they got out, recidivism, uh, I think that had a lot to do with recidivism, because sometimes even when we go through the challenges of getting the follow-up or af- after care appointments, schedules and all of that type

stuff, um, they get out there and then they don't go. You know, they don't, they don't show up for that appointment.

Follow-up. Follow-up is a key component that tied in with community resources and linkages.

PP4: No. That ... we-we had no follow up. So there was a person that they could be referred to that would ... that would create some type of community mental health appointment, but there really was not any ... any follow up.

Um, I feel that way because, um, I just don't think that there was a lot of time and thought, um, that was put into ... at least from what I could see, the work that was being done to connect folks to services. Um, I think that the most that was done was, you know, I'm going to give you this phone number and this place that you're gonna go and you can contact them. Or, in sometimes, they would ... they would ... there was an appointment that was made, but I don't think that there was really any type of coordination, uh, between providers to really figure out if that was the best fit.

PP6: You know, and sometimes, um, a lot of times it was no follow through, no follow-up with their mental health appointments.

PP1: Follow-up is integral to the overall recidivism of the offender. When the offender is told to report to his appointment, are we making sure he understands or the person he's releasing to, understands that it is not only important to follow-up with his appointment but that he *remembers* to attend his appointment? I think it was a 30-day supply of mediation that he's released with

but after those 30 days, what happens? We have no way of knowing. Mostly we find out if we see him come back through the system again.

Summary

In this Chapter, I provided the results of the qualitative study on the perception of prerelease programming for OMI and the impact of prerelease services on their recidivism. The research exposed three themes; correctional environment, prerelease planning and continuum of care and six subthemes using hermeneutic phenomenological analysis. The two research questions were answered. For Research Question 1, *What are the perceptions of CMHPs about the quality and quantity of prerelease programs available to OMI*, I found that the correctional environment is not conducive to the therapeutic model that the CMHPs use to provide services to the OMI. The participants perceived that security supersedes all operations regardless of the importance of mental health seeing an inmate who is experiencing a psychological emergency and that their (security's) opinions dictated if/when mental health was called to see the inmate.

There were no prerelease programs specifically designed for the OMI population. Educational opportunities were based on whether he had a high school diploma (HSD) or GED and vocation programming was based on Testing of Adult Basic Education (TABE) scores. The OMI population was likely not to have neither the HSD/GED nor the TABE scores to participate in a vocation. In those situations, there was nothing available for the OMI.

I also discovered that there were no formal multidisciplinary staffing teams that centered on each department working collectively on a prerelease plan for the OMI. In other words, education/programs, classification, security and mental health did not work collaboratively to discuss the needs of the OMI and how to administer those needs to reduce the likelihood of his recidivism. Each department appeared to work in silos or informally.

For Research Question 2: *What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism on OMIs?* I found that the CMHPs believed that the lack of community resources and linkages and follow-up care were factors that contributed to the likelihood of the offender recidivating. Rural areas such as the panhandle of Florida have limited community service providers in comparisons to central and south Florida. Also, the fact that the CMHPs did not have any communication with the offenders when they released to verify if they followed through with their appointments with community providers to continue counseling and medication.

In Chapter 5, I discuss interpretation of the findings, limitations of the study, provide recommendations, and implications for possible social change of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to analyze prerelease programming that was offered to OMIs based on the information provided by former correctional mental health professionals (CMHP) in Western Florida. My approach was to focus on CMHPs perceptions of, experiences with, and attitudes toward current prerelease services for the OMI population and the impact on recidivism amongst this population. This study also examined whether prerelease programming aligned with or made provisions for the OMI population to receive the same or comparable services as non-OMI. I utilized the social construction of reality framework (SCF) and the risk, needs, responsivity (RNR) theory as the theoretical lens of my analysis. This study is significant to the existing literature on prerelease programs and reentry efforts for incarcerated persons utilizing the SCF and RNR. This study enhances understanding and further develops the need for continued research on identifying the prerelease services and programming needs specifically for the OMI population.

In Chapter 4, I reviewed the research setting, sampling strategy, the pilot study data collection methods, and participant demographics. Issues of trustworthiness were also addressed along with explanation of the emerging themes and subthemes from the participant's experiences and concluded with a summary. In Chapter 5, I will provide an interpretation of the findings utilizing the aforementioned frameworks and peer-reviewed literature. I also discussed the limitations of the study, provided recommendations for

further research, and described the possible implications for positive social change and end with the conclusion.

Research Questions

Below are the research questions that I developed to analyze the prerelease services available in Florida's state correctional institutions/facilities for the offenders with mental illness:

RQ1 - What are the perceptions of former CMHPs about the quality and quantity of prerelease programs available to OMIs in the state of Florida?

RQ2 - What are the perceptions of CMHPs about the impact of prerelease programming on the likelihood of recidivism for OMIs?

Interpretation of the Findings

Participants in the study spoke of their experiences of working with offenders with mental illness in the correctional setting and the types of prerelease services and programs that were made available specific to this population. The three major themes that emerged were: (a) the correctional environment, (b) prerelease planning, and (c) continuum of care. The theme of the correctional environment supports the existing body of knowledge that the correctional environment is not a conducive environment for cognitive therapeutic change and autonomy. It further extends the existing knowledge that offenders with mental illness did not receive adequate mental healthcare to include prerelease services.

The theme of prerelease planning supports and extends the central body of knowledge that prerelease planning through the lens of the risk, and needs, and

responsivity framework as well as the social construction framework. Prerelease planning is an integral part of effectively reducing the recidivism rate of incarcerated persons. Achievement of an education and/or vocation program certificate and work skill development can significantly reduce their chances of success (Hall, 2015). The theme of continuum of care in this study supports and extends the main body of knowledge of the risk, needs, and responsivity framework that the inmate's needs must be met not only during incarceration but afterwards. Support and linkages to the community are necessary to maintain the trajectory on the road to implantation into the community.

Interpretation of the Correctional Environment

With the closing of state-operated mental health hospitals or insane asylums, there began an increase in and rise in the mentally-ill prison population which led to the social movement of Deinstitutionalization (Griffin, 2007). The literature suggested that the correctional environment was not conducive to the mentally ill who were incarcerated. Research respondents provided support for the literature by describing their personal lived experiences of working as correctional mental health professionals in the correctional environment and the challenges they incurred working with the security officers. Moreover, the interview participants explained that despite the opinions and actions of the security staff, they had to maintain their professional degree of efficacy and complete a proper and thorough clinical assessment of the offender in crisis.

Interview participants also spoke of their lived experiences and perceptions of feeling an "us versus them" dichotomy, referring to the mental health department and the security officers. That security did not fully understand their functions and

responsibilities. Participants had the perception that security staff thought they were being manipulated by the inmate when he would request a psychological emergency (process for inmates to see a CMHP) and that the inmate was only looking to have some sort of personal gain. The Eighth Amendment to the United States Constitution stipulated that prisoners had the right to medical and mental health treatment under the clause of cruel and unusual punishment, yet inmate manipulation through the eyes of security, does not always allow that to happen. Participants shared that their experiences with security negatively impacting their abilities to do effective case management of their offenders and that the delay in assessing the offenders exacerbated their symptoms.

The findings from the study are supported by the vast consensus among the participants that there should be designated facilities and institutions for offenders with mental illness that can accommodate their mental health needs and reentry needs as well.

Interpretation of Prerelease Planning

The findings from the study support the belief that prerelease programming was nearly nonexistent for the OMI population based on the participants' lived experiences as former correctional mental health professionals. The focus was mainly on counseling on coping techniques and cognitive behavioral therapies (CBT) to aid in decision making while incarcerated. As noted in the literature review, Angell (2014) studied the engagement process of two programs designed for the OMI population; Critical Time Intervention (CTI) and Forensic Assertive Community Treatment (FAST) which were both evidenced-based programs. Case management consisted of 9-month period of services that included linkages to services in the community such as housing,

employment, and counseling. This model encompassed continuum of care in that the support was on-going. As noted by the interview participants, there was no formal process centered on these linkages in preparation for release in the community. This responsibility for finding housing solutions was placed on the classification departments and there was no collaboration from other departments within

According to Newsome and Cullen (2017), the Risk, Needs and Responsivity (RNR) model was a leading model in understanding offender programs to reduce recidivism. Identifying the offender's risks of coming back to prison and what services the offender needed to prevent returning are important; however, the responsivity, which is the offender's ability to understand and utilize those program needs is, where the juxtaposition lies. An OMI's responsivity will not be the same for a non-OMI. The OMI's ability to take education and vocation programs is limited because of the scope of their mental illness, cognitive understanding, and behavior. As noted in the findings of the research, the CMHPs were not aware of their OMI even being enrolled in programming unless the offender told them during a counseling session.

Interpretation of Continuum of Care

The findings from the study concluded that there was no continuum of care beyond incarceration. Appointments in the community were arranged prior to release but knowledge as to if the offender attended the appointment was unknown. The interview participants advised that they had limited to no knowledge of the inmates on their caseload's whereabouts after release.

The system of SCF created four quadrants: advantaged, contenders, dependents, and deviants. According to Al-Kohlani & Campbell (2016), policies that disproportionately affected groups of people such as criminals, did not carry the interest of the advantaged thus funding for programs to deter or allocate into the criminal justice system did not take priority. Not only is little interest in allocating funding for criminal justice programs, but offenders with mental illness are scant to none. Allocations of specific funding for OMI prerelease programming is integral to their ability to thrive in the community and reduce their likelihood of recidivism. Due to their unique risks and needs, a continuum of care is needed to provide case management, counseling and medication dispensing to alleviate the stresses of being formerly incarcerated. Participants viewed the collaboration of a multidisciplinary team for the OMI would significantly assist in preparing the offender for release where each department has knowledge of the offender, his needs, abilities and what resources are available.

Limitations of the Study

Transferability was a limitation of this study, as noted in the demographics of the participants. Ravitch and Carl (2016) posited that in a qualitative study, transferability should be applicable to a wider setting. Although a snowball sampling method was utilized, I could not, with intent appeal to any one or more participants based on race. Participants in this study were all Black. One White CMHP returned a letter of consent and an interview date and time was solidified; however, she had to cancel and never rescheduled. Several attempts were made to reschedule with her, but she never responded. In total, there were two male participants and five female participants.

Each former CMHP varied in educational achievements and years of work experiences, therefore a generalization could not be made to apply to all former CMHPs in the state of Florida. The participants were also former CMHPs and not current; therefore, these findings may not generalize to current CMHPs. The former CMHPs were in Western Florida, therefore these findings may not reflect other regions in the state of Florida.

Another issue of transferability was that the initial research participant pool was to include both former and or current CMHPs. Initially, a verbal request was secured to include permissions to access the current CMHPs, however, when the email for consent was sent to the Walden University Institutional Review Board (IRB), the permission was rescinded by the contracting agency of the current employees, thus the study only includes those perceptions from former CMHPs about the prerelease services that were available at the time they were employed.

Recommendations for Future Research

Current research on prerelease programs for the OMI population is very limited in availability as evidenced through an exhaustive review of the existing literature. The results of this study illuminate some recommendations for future research, based on the limitations of this study. Primary, this study took place with former CMHPs in Western Florida. Increasing the area of the study to other regions in Florida would add to more empirical data that could potentially validate or disprove my findings. Second, future research could be conducted utilizing a qualitative method that includes current CMHPs to collect data on their perceptions of the prerelease programming for the OMI

population. Lastly, a recommendation for future research would be to conduct a qualitative study that looks at the perception of prerelease programming services of a former OMI utilizing a case study from incarceration to release. This type of study could be done as a case study with a former OMI in each region of Florida.

Implications for Social Change

Offender reentry has been a topic across the United States within the last 10 years (Miller, 2014). My interest in OMI was kindled by my experiences working in the correctional institutions. Time and time again, I would see inmates come into the system, only to return. Granted, the laws are very clear, but there is not always fair for a certain group; offenders with mental illness. Offenders with mental illness are a marginalized population within a marginalized population. The gap in the literature was related to the fact that the reentry knowledge base is scant in addressing prerelease programming for offenders with mental illness.

Individual

The participants in this study were former CMHPs in Western Florida. These individuals were charged with providing assessment and counseling services to offenders within the correctional system who had prediagnoses or identified mental health or psychological impairments. Working in a correctional institution is by no means an easy feat. Working around and being near some of the state's most dangerous offenders in aging facilities with only a telephone and personal body alarm as your protection can appear daunting. In listening to the recorded interviews and reviewing transcripts, the participants of the study perceived that there was no specific prerelease programming for

offenders with mental illness. Their duties were centered around assessment and providing counseling. Positive outcomes result when offenders with mental illness can be provided with prerelease programs that address and meet their unique needs for successful reintegration back into their communities to reduce the likelihood of recidivating.

Organizational

The correctional system and the contractual agency that provides psychological services for the offenders should consider examining their current processes and policies that address specific prerelease programming for offenders with mental health impairments. If none are in place, the development of a prerelease process that every releasing offender with a mental health impairment must go through. Correctional mental health professionals perceived that there should be a collaborative effort in tailoring a prerelease plan for the OMI population.

Societal

The results of this study could lead to an effective continuum of care for OMI that makes a streamline transition process from incarceration to the community. Implications from this process can lead to a reduction of crime and victimization on our neighborhoods and communities.

Recommendations

As a result of the findings from my research it is recommended that correctional agencies evaluate their prerelease programming services that are specifically unique to their offenders with mental illness. If none are apparent or evident, that the creation of a

multidisciplinary team be developed to address the void of prerelease services for the OMI. A member from each department in the institution; classification, security, programs, education, vocation, medical and psychological services would be able to provide information and data that pertained to that inmate from their respective area and assist the inmate in tailoring a plan for while incarceration through release. This centered approach not only keeps communication open between departments but establishes a mapping plan for the inmate to follow to help them in succeeding.

Another recommendation would be for correctional officers working in institutions that house offenders with mental illness to undergo training that is specific to how to interact with offenders with mental illness. The American Correctional Association's (ACA) Correctional Behavioral Health Certification (CBHC), provides officers with training that equips them to securely supervise and aid in the treatment of these inmates (Sloan & Efeti, 2017).

Lastly, I would recommend addressing the needs of continuum of care; that community resources to include local, county, state and federal agencies work collaboratively to share information and resources with the correctional institutions in and around Florida. Specific funding that is earmarked for prerelease programs for offenders with mental illness should be budgeted to also include funding for the community providers that will accept them as clients.

Conclusions

The findings illustrated that there is a significant need for offenders with mental illness to receive prerelease programming that is unique to their needs. In sum, although

the interviewees did not cite significant concerns around the recidivism of the OMI population, they did testify to the impact and benefits that prerelease programming could have something like this had been available at the time they served as correctional mental health professionals. This study sought to explore how prerelease programming is nonspecific to offenders with mental illness and that by the very nature of their mental health illness adversely affects their ability to participate in the programs that are available.

Correctional institutions were not constructed and operated with offenders with mental illness in mind. This population was funneled through the criminal justice system due to budgetary constraints with the closing of state psychiatric hospitals. With the responsibility of corrections to provide custody of these inmates, specific training and programming should be mandated. The participants in this study validated these very concerns through the obstacles they faced with lack of support from security staff to lack of continuity of care upon release. Hence, the inmates came into the system, and were released back out to the community by the system, the very same way they came in.

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Appendix A: Semistructured Interview Guide

Semi-Structured Interview Part 1: Demographic Questionnaire

Participant ID Number: _____ Date: ____/____/_____

1. **What is your highest level of education completed?**

   GED/High School Diploma _____

   Some college/trade school _____

   Associate's degree _____

   Bachelor's degree _____

   Some graduate school _____

   Master's degree _____

   Terminal degree (PhD, etc.) _____

2. **What is your age in years? _____**

3. **What is your race? (Mark one)**

   _____ White or Caucasian (non-Hispanic)

   _____ African American or Black (non-Hispanic)

   _____ Asian-Pacific Islander

   _____ Hispanic

   _____ Native American

   _____ Bi-Racial/Multi-Racial

_____ Other: _____

4. What is your gender?
_____ Male
_____ Female

5. How many years of correctional mental health professional experience do you possess?
_____ mark here if less than one year
_____ years.

Semi-Structured Interview Guide/Protocol: Part 2 Data Gathering

This interview will be semi-structured with open-ended questions; however, additional questions may emerge as the interview progresses. I would like to begin by thanking you for volunteering and consenting to participate in this study. As stated before, this interview will be audio recorded for transcription and analysis of the data for the purpose of this study. Your information and responses will be kept confidential by assigning you with a unique assigned identification number that only I know identifies you as the participant. You may stop the interview at any time.

The purpose of this research study is to analyze the underlying causes of recidivism among mentally ill prerelease offenders from the perspective of former correctional mental health professionals. Prerelease programs, for the purposes of this study, means those services that are provided to offenders with mental illness specifically administered for the preparation of future release from incarceration back into the community.

1. **Talk about your experience(s) as a Correctional Mental Health Professional and your interaction with the offenders with mental illness that were assigned to your caseload.**
2. **Describe in-depth your experience administering counseling techniques as they related to the prerelease programs.**
3. **Please discuss and explain your feelings on the importance of effective prerelease programming specific to the OMI population.**

4. **How would you categorize the quality of prerelease services that were available to OMIs?**
    a. Exceedingly Effective
    b. Somewhat Effective
    c. Exceedingly Ineffective
    d. Somewhat Ineffective
    e. Neither Effective or Ineffective
5. **What is your perception of the impact prerelease programming has, if any, on the likelihood of recidivism of OMIs in the state of Florida?**
    a. Extremely likely to recidivate
    b. Likely to recidivate
    c. Extremely unlikely to recidivate
    d. Unlikely to recidivate
    e. Neither likely or unlikely
6. **What else do you think is important for me to know that we may not have covered about this topic?**
7. **What, if anything, would you change about current prerelease programming available to OMIs?**

In addition to the above questions, probing questions will be utilized to gain more insight, and follow-up on questions to expound on concepts that may emerge from the discussion. Examples include:

"Can you please tell me more…"

"You said…tell me why you chose that…"

"Why did you do that…"

"What makes you feel that way…"

"Can you give me an example of…"