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Effects of Psychiatric Hospital Closures on Local Jail Administrators, Correctional Staff, and Inmates

Mark Christian Lasko
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Mark C. Lasko, Sr.

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

Review Committee
Dr. Henry Cellini, Committee Chairperson, Psychology Faculty
Dr. Bethany Walters, Committee Member, Psychology Faculty
Dr. Victoria Latifses, University Reviewer, Psychology Faculty

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Abstract

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by

Mark C. Lasko Sr.

MA, Liberty University, 2006

BS, Liberty University, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

A series of psychiatric hospital closures has led to a movement of care for individuals with mental illness from state-run facilities to managed care centers. Many of the individuals who no longer reside in psychiatric hospitals have become ensnared in the criminal justice system. Correctional facilities have an increased burden to care for the needs of the mentally ill, but lack the training and facilities to do so adequately. In this study, the lived experiences of correctional staff who have experienced the process of a hospital closure were examined. Psychiatric rehabilitation and gatekeeper theories served as the theoretical framework for the study. Data were collected using focus group interviews with 17 correctional officers and individual interviews with 3 administrative staffers at a jail in a southern U.S. state. Data were recorded and transcribed and then analyzed for themes. Six themes emerged: (a) open the psychiatric hospital back up, (b) training, (c) they don't need to be here, (d) mental health housing/they can't function in general population, (e) public awareness, and (f) they didn't think it through. Analysis of study data resulted in the identification of several gaps in community supports that can improve the lives of mentally ill individuals. These include avoiding future hospital closures, improving correctional mental health bed space, and providing correctional-specific training for staff at the jail. The study has positive social change implications for both correctional staff and mentally ill inmates in that the study can inform the improvement of officer training and the development of new community supports, which can reduce negative outcomes for mentally ill individuals.

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Dedication

This work is dedicated to my Savior, Jesus; to my family, who have inspired me to help others; to Christian and Jeremy, who reminded me to work daily; and especially to my wife, Carina, who has supported me in every way imaginable.

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Chapter 1: Introduction to the Study

Introduction

Psychiatric hospital closures are a significant social issue in the United States and have effects in different areas, including recidivism (Mulvey & Schubert, 2016; Sylvestre, Nelson, & Aubry, 2017). Deinstitutionalization of mental health in the United States began in earnest in 1955 (Sylvestre et al., 2017). A second wave of deinstitutionalization occurred more recently, with closures throughout the 2000s (Mulvey & Schubert, 2016). This deinstitutionalization of mental health has been studied significantly, with the bulk of recent research focused on where displaced populations have gone (Lamb & Weinberger, 2016) and on where those displaced individuals receive treatment (Mulvey & Schubert, 2016; Sylvestre et al., 2017).

Researchers who have studied transinstitutionalization (TI), a term referring to the movement of psychiatric patients after psychiatric hospital closures to other institutional settings (Lamb & Weinberger, 2016), have discerned that displaced former patients are now becoming incarcerated in significant numbers (Fisher, Geller, & McMannus, 2016; Lamb & Weinberger, 2016). However, more research is needed to understand the implications of TI, especially focusing on the lived experiences of correctional officers who encounter greater numbers of displaced patients with mental illness, especially after the closure of a psychiatric hospital. There is a gap in the literature on the effects of psychiatric hospital closures (Lofstrom & Raphael, 2016). The research that has been conducted indicates that some who have been displaced by a psychiatric hospital closure may end up incarcerated (Fisher et al., 2016; Lamb & Weinberger, 2016). As Lamb and

Weinberger (2016) noted, there has been an increase in the number of mentally ill inmates (Lamb & Weinberger, 2016). Yet, a scarcity of data exists related to the experiences of officers within a correctional facility (Lofstrom & Raphael, 2016; Mulvey & Schubert, 2016). I conducted this qualitative study to address this gap in the literature. A focus on the experiences of correctional officers, who now must also address issues of mental illness in correctional facilities, can allow for greater understanding of the challenges posed by mental health hospital closures.

In the first part of Chapter 1, I provide information on the lived experiences of correctional officers who have experienced a psychiatric hospital closure. I review TI and its relationship with incarceration and present previous research on this issue. The chapter also includes the problem statement, purpose statement, research questions, and theoretical framework for the study. I used gatekeeper theory (Soderberg, Stahl, & Emillsson, 2015) and psychiatric rehabilitation theory (PRT; Farkas, Anthony, Montenegro, & Gayvoronskaya, 2017) to examine the impact of limited rehabilitation for the mentally ill who are incarcerated due to hospital closings. After reviewing the theoretical framework, I provide an overview of the nature of the study; define key terms; discuss the scope and delimitations and limitations of the research; and consider the study's implications for positive social change. The chapter concludes with a summary of key points and a transition to Chapter 2.

Background

Researchers have uncovered a relationship between being discharged from a psychiatric hospital and recidivism, which can then lead to rehospitalization (De Vries, de

Vogel, Douglas, & Nijman, 2015). Perpetrators of violent crimes continue to decompensate back to a hospital upon a discharge from a psychiatric hospital (De Vries et al., 2015). Those who are discharged from hospitals and require future hospitalizations are sometimes placed where their quality of life (QOL) is compromised. There is a negative relationship between being discharged and QOL when incarceration is considered (Sylvestre et al., 2017).

Furthermore, there is a positive correlation between homelessness, discontinuing treatment, and closing a psychiatric facility (Sylvestre et al., 2017). Several states have closed psychiatric rehabilitation services at psychiatric hospitals, and incidents of homelessness have risen in the aftermath (Lofstrom & Raphael, 2016). Mental health services were evaluated by researchers in these states to identify the barriers to QOL among those who have been discharged from a mental health facility. Researchers have long pointed a spotlight on the deinstitutionalization among psychiatric hospitals during the managed care era (Lofstrom & Raphael, 2016).

Research covering deinstitutionalization showed a correlating increase in prison population (Dae-Young, 2016). The type of housing is one variable that has been examined. Types of housing include independent living, homelessness, and residential treatment centers. In a recent study by Lamb and Weinberger (2016), the authors noted that the homeless were more likely to end up incarcerated. A percentage (estimated at 16%) of those released from psychiatric institutions ended up in penal institutions (Lamb & Weinberger, 2016). No quantitative data were presented regarding the effect a closed

hospital has on those previously incarcerated. As hospitals were closed, some of the mentally ill were incarcerated or ended up homeless.

TI is an established area of study when examining communities where psychiatric hospitals have closed (Prins, 2016). Prins (2016) has called for future research to be conducted addressing TI. The severity of mental illness behind bars has increased since deinstitutionalization occurred (Lamb & Weinberger, 2014), which places urgency on research concerning TI and how correctional officers experience this phenomenon (Mulvey & Schubert, 2016). An explanation for the lack of quality research on TI may be due to the general tendency to overlook the incarcerated.

Prison officials previously offered a form of therapy known as psychiatric rehabilitation on an inpatient basis to those facing incarceration in the state of Georgia. The therapy lost funding due to a move towards community-based care (McGurk, Mueser, Watkins, Dalton, & Deutsch, 2017). The recidivism rate increased after the therapy ended; in other words, those individuals who were no longer offered therapy showed a greater propensity to become incarcerated again (McGurk et al., 2017).

Researchers are beginning to focus significant attention on psychiatric hospitals that are closing, as well as on mentally ill patients who end up in correctional facilities (De Vries et al., 2015; Lofstrom & Raphael, 2016; Mulvey & Schubert, 2016). The authors of one specific study focused on the correlation between incarceration and deinstitutionalization and called for future research to study the effect of closing a psychiatric hospital upon incarceration (Lofstrom & Raphael, 2016). The mentally ill are disproportionately represented within the correctional system (Mulvey & Schubert,

2016). There are numerous contributing factors involved in an individual's incarceration, but the closing of a psychiatric hospital has been found to have a positive correlation with incarceration (Lofstrom & Raphael, 2016). The authors did not note whether the incarcerations were initial or if the patients had recidivated, but noted future research should be focused on individual outcomes following psychiatric hospital closures to determine the specific effects on individual populations (Lofstrom & Raphael, 2016). Correctional staff is one population whose experiences after a hospital closure warrant research.

Problem Statement

Many who are incarcerated suffer with mental illness and are negatively affected by psychiatric hospital closures (Dae-Young, 2016; Kennedy-Hendricks et al., 2016; Prins, 2016). The closing of psychiatric hospitals has led to TI (Prins, 2016). Psychiatric hospital closures have been heralded by many in the forensic psychology field as a positive move in the field of mental health (Fisher et al, 2016). Others have asserted that the shift from inpatient hospitals to outpatient community centers has not properly provided support for those who have been displaced (Fisher et al., 2016).

A stated goal for those who proposed hospital closures was to provide adequate safeguards to those in the community (Kennedy-Hendricks et al., 2016). However, there has been little supervision of individuals who have been released following a hospital closing (Lamb & Weinberger, 2016). In this context, researchers such as Kennedy-Hendricks et al. (2016) have called for new data to help influence policies, practice, and ideology. A qualitative study can provide insight into the impact of Searcy Psychiatric

Hospital's closure on the correctional staff at a local Alabama jail. Searcy Hospital has been closed since 2012. Study findings may allow additional safeguards to be identified to improve community care of mentally ill inmates, which can lead to positive social change.

Purpose of the Study

In the present study I examined the specific experiences of correctional staff in a local jail following the closing of a proximate psychiatric hospital. Analysis of correctional officers' experiences allows for a more nuanced understanding of the outcomes associated with the closure. Based on previous research, an increase in the recidivism rates for inmates with mental illness following a psychiatric hospital closure is expected (Lamb & Weinberger, 2016). However, while there have been numerous studies highlighting the experiences of patients displaced from psychiatric hospitals (Lamb & Weinberger, 2016), there have been few studies focused on correctional staff experiences amid greater numbers of mentally ill inmates (Dae-Young, 2016). In this phenomenological study I identified themes described by the correctional staff using PRT as a theoretical framework. Analysis of qualitative data can spotlight the gaps within community support for individuals who have mental illness and have been displaced due to a hospital closing.

Research Questions

The main research questions for the study were

RQ1. What are the lived experiences of correctional officers at a jail regarding the increase of mentally ill offenders after the closure of Searcy Psychiatric Hospital?

RQ2. What are the lived experiences of administrators at a jail regarding the increase of mentally ill offenders after the closure of Searcy Psychiatric Hospital?

Theoretical Framework for the Study

I used PRT (Farkas et al., 2017) and gatekeeper theory (Soderberg et al., 2015) as the theoretical framework for my study. PRT offers a theoretical tool to frame the change in experience of patients after a psychiatric hospital has closed (Farkas et al., 2017). Researchers studying deinstitutionalization since Farkas et al. (2017) released their seminal work on the theory have typically used the PRT framework (Farkas et al, 2017). A shift in focus from examining the closing of hospitals to focusing on what to do with the patients once a hospital has been closed has been a goal of researchers (Farkas et al., 2017). PRT practitioners seek to determine what QOL levels has been achieved for previously hospitalized mentally ill individuals, and which areas of QOL may need to be further addressed (Farkas et al., 2017). Farkas et al. developed PRT after the closing of many psychiatric hospitals left some psychiatric patients without treatment options.

One key PRT component is the focus on multiple variables in order to assess rehabilitation (Farkas et al., 2017). Social standing, independence, freedom of choice, and environment are all variables that help to paint a fuller picture of the life a patient achieves outside a psychiatric inpatient setting (Farkas et al., 2017). PRT theorists rely

on input from the patients themselves, or caretakers of the patients (McGurk et al, 2017). This aspect made PRT a suitable lens for examining data in this phenomenological study. Interviews with correctional officers, who serve multiple roles for inmates, gave me insight into the housing issues that inmates with mental illness face. The examination of one particular type of residence, incarceration, allows for an in-depth look at how deinstitutionalization has impacted mental health resources for those who become inmates after previously being hospitalized. An emphasis on rehabilitation, rather than reinstitutionalization, allows for researchers who adhere to PRT to provide direction for future research (McGurk et al., 2017).

I used gatekeeper theory to assess how information regarding transinstitutionalism is controlled. The gatekeeper theorist focuses on how limited information can be disseminated when a gatekeeper has a vested interest in limiting or increasing the flow (Soderberg et al., 2015). Gatekeeper theory can be used when examining the amount of information released to the public related to deinstitutionalization or TI. When a state-run psychiatric hospital is closed, the state still retains oversight or control of community-based mental health care (Soderberg et al., 2015). Community-based providers treat patients in an outpatient setting. In such a setting, the gatekeeper dilemma could occur. A single power, such as a State, could determine to highlight only positive aspects of a hospital closure. The exclusion of negative experiences would compromise data (Soderberg et al., 2015). Greater attention to both theories (PRT and gatekeeper theory) is given in Chapter 2.

Nature of the Study

Current research regarding mentally ill inmates has been minimal (Prins, 2016). In this study I used qualitative methodology to determine the effect a psychiatric hospital closure has on the mental health population of a jail, as experienced by correctional staff. A qualitative research approach was the most appropriate method for this study as a detailed, contextual understanding of correctional staff's experience with the impact of a psychiatric hospital closure was the goal of the study. Qualitative research allows for detailed information to be gathered on a specific phenomenon, according to Creswell and Creswell (2018), who noted that researchers conducting such studies are able to explore, describe, interpret, and analyze data to gain an understanding of a problem. The intention of this study was to fill the gap in knowledge regarding the TI occurring at a local jail upon the closure of a psychiatric hospital.

The specific qualitative approach that I used was phenomenology. Phenomenological research is a design in which the researcher conducts interviews with participants in regard to a specific event (Creswell & Creswell, 2018). The goal of using this qualitative method is to explore the lived experiences among the participants in an effort to understand the essence of the phenomenon. This design is strengthened when multiple participants are able to share contemporaneous experiences regarding the same event (Creswell & Creswell, 2018).

Researchers have estimated the prevalence of TI and examined the phenomenon on a nationwide basis (De Vries et al., 2015). Prins (2016) has called for individual studies to be used to examine specific effects of TI on local communities. Examining the

lived experiences of correctional officers who have experienced the closure of a local psychiatric hospital and witnessed the impact on mentally ill inmates answers this request for additional research.

Definitions

I present the following definitions as a means of providing clarification for terminology used within the research:

Deinstitutionalization: The removal of psychiatric patients from inpatient facilities, which began in earnest in 1955 (Lamb & Weinberger, 2016).

Incarceration: The state of being held, postconviction, in a correctional facility for the benefit of society (Sylvestre et al., 2017).

Psychiatric hospital: A hospital providing psychiatric care for those with mental illness for a period of 90 days or more (Lofstrom & Raphael, 2016).

*Psychiatric rehabilitation theory (*PRT*)*: A theory that has a central focus on finding out the level of rehabilitation a discharged psychiatric patient achieves (Farkas et al., 2017).

Quality of life (QOL): A measurement of the level of independence experienced by an individual with mental illness as compared to a non-mentally ill individual (Sylvestre et al., 2017).

Recidivism: A return to incarceration upon a new arrest after previously being released from a correctional facility (Lofstrom & Raphael, 2016).

*Transinstitutionalization (*TI*)*: The process whereby displaced psychiatric patients have moved to alternative treatment centers upon a psychiatric hospital closure (Lamb & Weinberger, 2016).

Assumptions

The first assumption for this study was that all or most correctional officers have some contact with mentally ill persons. The literature review, presented in the next chapter, supports this assumption. During the interview officers who has previously worked at other facilities stated a strong mental health population. While interviewing, if I had become aware of a participant who did not have interactions with the mentally ill population I could withhold the information from the data. This did not occur during the study.

A second assumption was that correctional officers did not have adequate knowledge regarding mental illness and accompanying symptoms. This assumption was based on the literature review, which will be explored in the next chapter. During the course of the research it became apparent to me that while the officers had undergone training regarding recognizing symptoms of mental illness a specific training, targeting only correctional officers, would benefit the participants.

Scope and Delimitations

The research scope includes only correctional staff that has interacted with the mentally ill population at the jail. The scope was designed due to the gap in research, which has been previously described. Some of the correctional staff may not have daily

contact with mentally ill inmates, which allows for a broader understanding of the impact felt by the jail.

A key delimitation is the lack of inmate interviews. These interviews would allow for insight into the specific needs and barriers facing inmates, but would also open the study to greater possibility for damage to a protected population within a system. Inmates may not have the best insight into their own needs, and this study provides a voice through the collected data. The use of correctional staff interviews has allowed for the least potential risk to the participants, research body, and researcher.

The jail was chosen due to its proximity to a closed psychiatric hospital. It is the largest jail in the state of Alabama and regularly sent inmates to the Searcy Psychiatric Hospital through court orders, which were sought on behalf of the jail (Kazek, 2016). The relationship between the jail and the hospital allows a unique opportunity to examine recidivism of mentally ill inmates after a psychiatric hospital closure.

Limitations

The research study is limited to the experiences of correctional staff within a specific, targeted jail in the state of Alabama. The experiences of the correctional staff may or may not be similar to the experiences of other correctional staff, even within the same state. Each jail is independent, and though there are federal, state, and local guidelines in place, each jail has unique aspects that can create differing experiences for correctional staff.

Some jails are in a large enough metropolitan area to be able to utilize several state-run psychiatric facilities; this is not the case in this study. The lack of other state-

run psychiatric facilities may lead to a greater experienced effect upon the closure of a psychiatric hospital. There are numerous factors that can contribute to the experience of the recidivism of mentally ill inmates, but in this research the phenomenon of a psychiatric hospital closure is examined.

The study is limited in not examining the specific causes leading to a re-arrest. It would be very useful to know the causal factors leading to recidivism of the inmates, but this would expose the inmates to further risk of harm. The limitation placed on the research by not assessing causation is not sufficient enough to warrant the risk to a protected population.

Certain steps may be taken in order to address these limitations. An example is using open-ended questions to allow the participants to guide the interviews. Another measure to address bias is to utilize committee members who oversee the research (Campbell & Stanley, 2015).

Significance

Future researchers need to address TI, especially providing new data (Lamb & Weinberger, 2016). Researchers will be able to direct attention to a problem many believe exists, but which currently lacks data from which to draw conclusions (Lamb & Weinberger, 2016). Qualitative data and accompanying analyses can help researchers to identify obstacles related to the psychiatric hospital closures. It may also help communities prepare adequate support to minimize the negative effects upon the incarcerated (Kennedy-Hendricks et al., 2016).

The incarceration of individuals with mental illnesses increases the need for larger correctional structures, and increases the need for treatment within these structures (Lamb & Weinberger, 2016). Individuals who have a recidivism history may serve time in psychiatric hospitals during incarceration (Lamb & Weinberger, 2016). These individuals must be provided for, even as resources become limited or disappear. The gathering of qualitative data, especially from a correctional staff within the jail, provides the ability to illustrate how social change must be examined at the local level.

The data produced by the research may be used as a baseline for future quantitative studies in regions where a psychiatric hospital closure has occurred. Society can achieve positive social change only after obtaining a realistic view of the problem. Individuals who suffer with mental illness have additional needs when they become entangled with the law, and determining the lived experiences in recidivism after a psychiatric hospital closure can allow for a clearer understanding of outcomes associated with closing a psychiatric hospital (Lofstrom & Raphael, 2016). Once outcomes are realized, resources can be developed to assist individuals with mental illness from being unduly treated within a correctional facility.

There is a need for increased support to be provided for mentally ill individuals who become entangled with the law (Kennedy-Hendricks et al., 2016). Inmates with mental illness who are incarcerated are currently often overlooked (Dae-Young, 2016). Elevating the visibility for such a forgotten demographic is warranted. When society recognizes the need to assist these individuals, greater attention can be directed towards improving the care for individuals who have a need for inpatient care. Individuals with

mental illness who need an intermediate level of care, less than inpatient yet greater than outpatient treatment, would also benefit from additional support (Lofstrom & Raphael, 2016).

Summary

Transinstitutionalism impacts thousands of individuals in the United States (Lamb & Weinberger, 2016). The mentally ill who have been incarcerated have been negatively impacted (Lamb & Weinberger, 2016). An understanding of the experiences of correctional staff that have witnessed recidivism after a psychiatric hospital closure, may serve to focus lawmakers on this protected population. A richer, deeper understanding of this issue must be examined in order to steer safeguards preventing repetitive incarceration.

The need for research to discover safeguards for the mentally ill is evident by the focus placed upon mental illness by the Affordable Care Act (Kennedy-Hendricks et al., 2016). Even with many safeguards currently in place there are still individuals who need further assistance to prevent entanglement with the justice system (Lamb & Weinberger, 2016). Research is required in order to uncover where a community needs to improve mental health care. It is within the scope of the present research project to identify whether additional safeguards are required.

Chapter 2 contains a more detailed review regarding the research over the last five years for recidivism and psychiatric hospital closures. An exploration of the PRT and the Gatekeeping theory is further developed in Chapter 2. The connection between the theories and the plight of those who are incarcerated with mental illness is established.

The gap in literature regarding TI and the recidivism for those with mental illness is examined to establish the need for research.

Chapter 2: Literature Review

Introduction

Social scientists have conducted a significant amount of research on the closure of psychiatric hospitals, but few studies have been conducted regarding the impact of TI on incarceration following the closure of psychiatric hospitals (Lamb & Weinberger, 2016). The majority of psychiatric hospital closures in the United States occurred during the second half of the 20th century and the first decade of the 21st century (Mulvey & Schubert, 2016). There is extensive research available on psychiatric hospital closures (Mulvey & Schubert, 2016). Yet, despite the significance of this change in care for the mentally ill, there is a gap in the literature regarding the impact of such closures on communities, according to my research. In addition, researchers have not addressed the effect on correctional officers who witness an increase in recidivism among the mentally ill inmate population (Lamb, 2015).

Effective support can, and should, be developed for those who recidivate following a psychiatric hospital closure. When public officials understand the impact a closure may have on mentally ill inmates, they can make more informed decisions regarding psychiatric hospital closures (Lamb, 2015). The scope of transinstitutional research includes recidivism, which allows for a more complete understanding regarding how hospital closures affect correctional institutions (Carabellese & Felthous, 2016). The purpose of this study was to examine the lived experiences of correctional officers at a local jail regarding the increase of mentally ill inmates after the closure of a psychiatric hospital in the area.

One catalyst in the closing of U.S. psychiatric hospitals was criticism of the treatment of the mentally ill who were housed, often with limited oversight (Perry, 2016). Criticisms included limited contact with patients, abuse by staff, and a tendency for the state to commit individuals to psychiatric hospitals without any hope of release (Lamb, 2015). The effects of such closures may have been overlooked (Fisher et al., 2016; Mechanic & Olfson, 2016; Perry, 2016). As closures occurred, the field of TI developed to help determine where individuals would reside (Fisher et al., 2016).

Researchers have used TI to identify where individuals find mental health treatment after a psychiatric hospital has closed (Fisher et al., 2016). Many researchers have focused on areas commonly seen as positive outcomes after a hospital closing (Fisher et al., 2016). Some treatment is provided by private physicians, psychologists, and community mental health centers (Fisher et al., 2016). There are also locations where mentally ill patients receive care that are considered a negative outcome of psychiatric hospital closures. One chief negative outcome is when a mentally ill person receives treatment in a correctional facility (Fisher et al., 2016). The motivation for the present research was to understand how the closure of a psychiatric hospital affects correctional staff.

The focus of PRT is on finding out the level of rehabilitation a discharged psychiatric patient achieves (Farkas et al., 2017). Researchers use benchmarks to determine if a patient has achieved a better QOL after the discharge from a psychiatric hospital has occurred (Farkas et al., 2017). One QOL aspect is the ability to remain free from incarceration. TI theorists focus their research on inmates' treatment, rather than

the incarceration (Ferrazzi & Krupa, 2016). I drew heavily from PRT theory in studying this aspect. A secondary theory, gatekeeping theory (Deluliis, 2015), was also used to gain insight about the reasons for the psychiatric hospital closures.

In the chapter, I first address my search strategy. Then, I explore PRT and gatekeeping theory in depth. Research related to recidivism among the mentally ill, TI, deinstitutionalization, and psychiatric hospital closures are presented in the chapter's literature review. I reviewed the current literature on psychiatric hospital closures, including the impact on hospital closures and the experiences of correctional staff. In doing so, I found few studies related to TI and psychiatric hospital closures. As I note, this gap in research provided a rationale for this study.

Literature Search Strategy

Limited research is available on the relationship between psychiatric hospital closures and TI for mentally ill inmates. I searched multiple psychological databases to gather relevant research. I used peer-reviewed articles as the main source for the literature review. The databases I searched were Psyc INFO, SAGE Premier, and Psyc ARTICLES. Google Scholar was also used as a search engine to supplement these scholarly databases. The search terms used to develop the literature review were *recidivism*, *transinstitutionalism*, *transintitutionalized*, *incarcerated*, *psychiatric hospital(s)*, *psychiatric hospital(s) closure*, *correctional staff*, *correctional mental health*, *psychiatric treatment center(s)*, *psychiatric rehabilitation theory*, *gatekeeping theory*, *displaced psychiatric patient(s)*, *deinstitutionalized*, *mentally ill inmate(s)*, *mentally ill incarcerated*, *incarcerated treatment*, *jail mental illness treatment*, *mental illness*

incarcerated, *community based treatment*, *Searcy Hospital*, *Alabama incarcerated mental illness*, *psychology incarcerated*, *psychiatry incarcerated*, *psychiatric hospital discharge*, and *mentally ill discharged.*

The majority of the research considered for this literature review was published between 2013 and 2018. I included several articles predating this range due to their seminal nature. I found limited qualitative research regarding the experiences of jail correctional staff after a psychiatric hospital closure. The lack of available research regarding this specific focus was balanced by examining research related to psychiatric hospital closures and to TI, independently.

Theoretical Foundation

The theoretical foundation for this research consisted of PRT and the gatekeeper theory. Researchers have used these two theories in different types of studies, and for separate desired outcomes, although they complement each other. I used both theories to allow for a fuller picture of the effects that closing a psychiatric hospital has on recidivism, and the impact this has on correctional staff. In this section, I provide my rationale for using the theories and then define and explain each theory in depth.

Use of PRT as a foundational theory allows focus to be placed on the importance of the community's role in the care of mentally ill inmates (Perry, 2016). The majority of researchers using PRT have focused on the closure of hospitals and the need for support in communities (Perry, 2016). For my research, I focused on the effects that are experienced after a psychiatric hospital closure occurs. A unique aspect of this study was the focus on how a closure affects the correctional officers who are tasked with the care

of inmates with mental illness. Understanding TI of the mentally ill to correctional facilities can be highlighted by the use of the PRT theory.

I focused on the needed areas of change for those who would benefit from community reintegration. Community supports that are currently available may be overwhelmed in some areas, and may require additional programs to add support. Use of PRT theory showcases the need for future research on the population of mentally ill inmates. One possible follow-up study could be a quantitative study of the recidivism patterns for inmates who suffer with mental illness.

The use of the gatekeeper theory addresses the motives behind the successes and failures of deinstitutionalization and TI (Adamson, Donaldson, & Whitley, 2016). Gatekeeper theorists note the existence of organizations with the ability to provide or withhold information to the public (Deiuliis, 2015). There is a certain amount of power residing with those who allow information to pass through the gate, and at times the power has provided skewed results (Deiuliis, 2015). Research on the gatekeeper theory, and the impact it may have on future research, is also examined in this chapter.

Psychiatric Rehabilitation Theory

PRT began in the 1970s with deinstitutionalization of psychiatric hospitals (Bennet & Watts, 1983). Initially created as a response to understand how the displacement of mentally ill individuals from psychiatric hospitals impacted the individuals, the theory continues to be used. The theory has become an accepted and even preferred practice by many psychology researchers, although it has changed since its inception (Farkas et al., 2017).

One change in PRT is a move from specific practices to a defined outlook on patient care. PRT is no longer simply a group of coping skills or interventions, but is more broadly seen as specific values shaping how those with mental illness are treated and accepted (Farkas et al., 2017). It is this broader PRT perspective which is used to lay the groundwork for this research.

Individuals who benefit from PRT are those who have mental illness and are seeking to improve social interactions (Farkas et al., 2017). Those with mental illness are usually assumed to have diagnosable conditions. PRT theorists, however, focus on those who present as mentally ill but do not have a diagnosis. PRT is utilized by focusing on shared common experiences for individuals as opposed to specific labels (Farkas et al., 2017). The mental illness umbrella term covers numerous subgroups, of which incarcerated inmates is a member. PRT has been used to examine the QOL individuals possess after the close of a psychiatric hospital.

One important PRT tenet is the belief in a right for all mentally ill patients to achieve as fulfilling a life as possible (Farkas et al., 2017). There are many individuals with mental illness who share the same goals and dreams others hold who do not have a mental illness. There is a conviction that all individuals will achieve meaningful lives if society can provide support (Farkas et al., 2017). The researcher has focused interview questions to help assess if additional community supports may be needed to assist inmates who have mental illness.

PRT is not a single technique or intervention, but is a theory. PRT studies use a variety of variables. One variable often measured is housing type. A shared belief by

many advocates for PRT is that mentally ill individuals are rehabilitated at a higher level when they are housed as independently as possible (Farkas et al., 2017). The goal for deinstitutionalization was to treat individuals in a community based setting, although it has been determined there are individuals who require a level of care not suited for independent living (Farkas et al., 2017).

The goal for PRT is not specific regarding housing (Farkas, et al., 2017). Rather than giving an advised housing recommendation, PRT practitioners simply view each individual as needing to gain the maximum possible independence in order to achieve what is deemed a meaningful life. Many individuals with mental illness are able to live completely free from dependent living conditions (Farkas & Anthony, 2010). Other individuals need assistance regarding basic living skills, such as the paying bills and managing funds. Still others require constant supervision in order to function in safety. Constant supervision is considered an acceptable form of housing for those who cannot function at a lower level of care (Farkas, et al., 2017).

Incarceration is often seen as the most restrictive housing option and represents a failure to rehabilitate (Farkas, et al., 2017). An individual could view incarceration as similar to constant supervision, but there is a key distinction negating this comparison. Those who are incarcerated are being held regardless of the individuals will. Individuals with mental illness who are housed in a group home to provide daily support and supervision are being housed on a voluntary basis. An exception to this distinction would be an individual who is being housed at a group home after a legislative body has granted the individual's right to refuse treatment to another individual (Watts,

1983). The law views the individual as being housed at a group home at the direction of the duly empowered guardian (Watts, 1983).

Those who are mentally ill and incarcerated have no freedom to leave, regardless of any empowered guardians wishes. It is for this reason incarceration is viewed as a failure to rehabilitate. One tenet of PRT is achieving as fulfilling a life as possible. It is incumbent upon society to prevent as many mentally ill patients from incarceration as possible (Farkas & Anthony, 2010). Freedom from incarceration is a minimal goal for those with mental illness, and this is widely accepted among those who espouse PRT (Farkas et al., 2017).

Those who have mental illness often receive treatment by an uncoordinated series of visits to emergency rooms, short-term hospitalizations, incarceration, and sporadic outpatient care (Mechanic, 2015). One goal of PRT is enabling an individual to navigate through a web of payment sources, as housing, financial aid, vocational training, medical and psychiatric care are often provided by different agencies with varying payment sources and restrictions. Correctional institutions seek to prevent inmates from recidivating, but many agencies that provide support to those who have been freed have a stated goal of retention of the consumer (Mechanic, 2015). A shared goal between community-based mental health care and correctional facilities may benefit the target population of this research.

The cornerstone for PRT advocates is a relationship between mental health care providers and the community (Farkas, et al., 2017). This standard is difficult to achieve when treatment is not provided for those who are incarcerated. There may be small

counties where a community provider sees patients both when incarcerated and when free, but this is not common. It is more common for incarcerated individuals with mental illness to be denied treatment due to the difficulty a facility may have in providing these services (Primeau et al., 2013).

An additional PRT tenet for researchers is the expectation for the participants to be active participants in determining where, and in what role, they will live and receive treatment (Farkas & Anthony, 2010). Research data suggests involving an individual in the planning for mental health services increases the likelihood for rehabilitation (Farkas & Anthony, 2010). This places limitations on those who are incarcerated with a mental illness. Those who receive treatment for mental illness while incarcerated are generally provided treatment within the institution without their input, if at all.

Rehabilitation, as defined by PRT, is seen as the interaction between an individual with mental illness and society (Watts, 1983). Rehabilitation is measured by an improvement in the individual's role among society (Farkas et al., 2017). PRT has been used as a theoretical foundation in research focused on the closing of institutions providing mental health care (Lamb & Weinberger, 2016). The use of PRT regarding deinstitutionalization has been a standard practice as it allows for researchers to focus on the QOL individuals achieve (Wachtler & Bagala, 2016).

A critical PRT element is the readiness for an individual to engage in treatment leading to change (Farkas & Anthony, 2010). The development of readiness to change happens at different times for individuals, although some events seem to predispose an individual to change. One event is incarceration, which can be described as a rock

bottom scenario (Farkas et al., 2016). A rock bottom scenario is one in which an individual is faced with either changing a course of action or a resignation to continue negative consequences (Farkas et al., 2016).

Support interventions are necessary in the community to allow mentally ill individuals to achieve a fulfilling life (Farkas et al., 2016; Wachtler & Bagala, 2016). The psychiatric hospital closure qualifies as a removal of community support and this creates a support gap (Farkas et al., 2016). When a gap in support is identified it becomes incumbent for the community to provide a new resource or to restore the former resource(s).

The replacement of psychiatric hospitals with other support systems has produced a fragmented mental health system (Perry, 2016). The mental health system has created barriers to gaining care, due to the increased specialization by those who provide services (Mechanic & Olfson, 2016). Those who provide services in psychological outpatient settings often have a separate funding source than those who provide inpatient care. A provider of substance abuse treatment may have a much different source, and likely a unique vision and goal (Perry, 2016). The use of PRT models has allowed researchers to demonstrate the unintended negative consequences this system has on the most disadvantaged population (Farkas et al., 2016).

PRT advocates have identified a fragmented mental health support network as a factor in the increased number of mentally ill individuals without treatment (Lamb & Weinberger, 2016). Poverty, unemployment, lack of housing, and other unmet needs can prevent an individual from becoming major contributors to society (Perry, 2016). When

a released individual transitions from a correctional facility to society and is unable to engage with community support, it prevents rehabilitation from occurring (Farkas et al., 2017).

Successful reintegration depends largely on two key areas, according to PRT advocates. Treatment must be provided when the patient expresses a readiness to change (Farkas et al., 2017). There is a correlation between inpatient treatment, including treatment while incarcerated, and a readiness to change (Farkas et al., 2017). When an individual is being provided treatment while incarcerated it is necessary to assess their readiness to change.

Another key target for patients who are being treated through the PRT foundation is successful reintegration into the community (Perry, 2016). Providers who focus treatments solely on psychiatric medications will miss the macro-level view of necessary support needed in community reintegration (Mechanic & Olfson, 2016). The successful solution must include tools needed for reintegration. PRT can be used as a foundational theory as there is a use of support skills by many practitioners (Farkas et al., 2017).

Researchers have used PRT, although it is still seen as a theory in the early stages for ongoing quantitative research (Farkas et al., 2017). One reason for limited qualitative studies is the difficulty in gathering data from correctional facilities. The use of PRT as a theoretical foundation has helped to guide the research, allowing the researcher to focus on the QOL the inmates currently experience, as related by correctional officers through interviews.

Gatekeeper Theory

A secondary theoretical foundation is the gatekeeper theory (Soderberg et al., 2015). This theory is used when examining the control of information as it passes through a gate (Deluliis, 2015). Gatekeepers make decisions about which information should be released and which should be retained (Deluliis, 2015). Great power is given to those who are gatekeepers, as they can inform or conceal information.

Lewin's field theory provides an accurate template for arranging information when the lines between the gatekeepers and the gated have begun to blur (Deluliis, 2015). Gatekeeping is not only a model of information flow; it can also be seen as a template to understand the workings of society as a whole, which is important for the purposes of the present study (Deluliis, 2015). The Gatekeeper theorist looks at field theory as a basis for examining how the age of the Internet allows power to those who control information (Adamson et al., 2016).

Gatekeeper theorists state the possibility of a gatekeeper dilemma and note the unintended consequences, which could follow (Adamson et al., 2016). When a single source is responsible for both the administration of treatment centers and as gatekeepers to information regarding treatment centers, a gatekeeper dilemma can follow. One of the first applications of the gatekeeper theory was in regard to the release of information by a newspaper (White, 1950). When a newspaper editor controlled all the stories and editorials, they effectively controlled all the information flowing into the general public sphere. This has dire consequences for the implementation of a just and fair social order (Adamson et al., 2016). When a single party controls all the information available within

the public at any given time, the social contract between citizens begins to falter and difficulties may arise for the implementation of any new order.

This relates to the present study as it offers a model for the kind of situation occurring when a hospital closes. When the State has a monopoly on the distribution of information, such gatekeeper paradoxes can easily arise. The monopoly can create an atmosphere in which the public sphere does not have access to the correct information on which to base future legislative decisions. A psychiatric hospital closure gives the state incentive to share only data casting a good light upon the State (Adamson et al., 2016). This creates a dilemma; as the State may retain data showing less than ideal outcomes regarding the displaced patients, yet choose not to share these examples. Despite the freedom of press, there is a deafening silence regarding most United States psychiatric closures (Adamson et al., 2016).

Researchers focusing on the media reports regarding mental illness have focused increasingly on recovery and successful interventions (Adamson et al., 2016). Recovery is obviously the sought after goal for those with mental illness. It is misleading, however, to researchers, practitioners, and the public at large to avoid the truth regarding unsuccessful outcomes. Accurate data is necessary in order to devise successful interventions (Adamson et al., 2016).

The problem with the dominant media coverage of recovery and successful psychiatric interventions is the contortion of the public discourse on hospitals and public policy regarding psychiatric treatment (Adamson et al., 2016). This is an example of how the gatekeeping paradox can lead to more than just disinformation within the public

sphere. Gatekeepers can also lead to harmful public policy outcomes impacting the mentally ill (Adamson et al., 2016).

The public narrative is often dependent upon access to information, which can determine the quality of numerous citizens' lives. This illustrates why the gatekeeping theory is integral for understanding the paradigm of this study. It is useful to utilize gatekeeper theory as a foundation for the present study because it provides a framework for understanding how public opinion is formed and how recidivism has been removed from the conversation regarding psychiatric care.

The use of the gatekeeper theory in relation to psychiatric hospital closures would showcase an argument for the releasing all data, including less than ideal outcomes. The release of all data to the community can allow for proper support and resources to be identified. The resulting new supports could assist the individuals who are unable to achieve a fulfilling life (Farkas et al., 2016). The gatekeeper theory may have limited an accurate understanding regarding the effects resulting from a psychiatric hospital closure in a community. The gatekeeper theory is thus a useful additional theoretical foundation.

Literature Review Related to Key Concepts

The available research regarding TI and recidivism has deinstitutionalization as a historical marker. Deinstitutionalization is used to describe psychiatric hospital closures, and many studies have been completed regarding this process (Dae-Young, 2017). One researcher also reviewed research related to deinstitutionalization and summarized the results by noting psychiatric hospital closure was correlated with a higher percentage of inmates with mental illness (Torrey, 1995). A call was made as early as 1995 to examine

individual variables leading to this increase. There has been research regarding the deinstitutionalization effect, yet there are remaining variables to be researched (Kalapos, 2016).

Using qualitative interviews allows researchers to examine multiple variables, but data is not easily generalized. Qualitative researchers seek to explore a phenomenon by examining the lived experiences as related by participants (Creswell & Creswell, 2018). The connection between socio-economic variables such as housing and psychiatric deinstitutionalization has been established (De Vries et al., 2015). The researcher can use the qualitative method to dig in deeper and gain rich data regarding the reality of a psychiatric hospital closure as experienced in a county jail.

Researchers examined the long-term outcomes after a local psychiatric hospital was closed (Frankfort-Nachmias & Nachmias, 2015). Researchers included individuals who had been hospitalized at said psychiatric hospital, but did not account for the well-being or mental health for those in the community who had not previously been a residential patient. Recidivism demographics are crucial to the present study, and former researchers did not adequately illustrate how the recidivist population suffered from the absence of the institutions that once would have supported them (Kalapos, 2016). An individual who has been previously incarcerated and who would benefit from a psychiatric hospital remaining open is a new population worthy of examination. A jail is likely to have a higher percentage of its population suffering from mental illness, and thus may have inmates who need psychiatric hospitalization (Lamb & Weinberger, 2016).

It is important to distinguish between TI and deinstitutionalization. TI refers to the transferring of patients into different institutions for reasons both fiscal and institutional, and while many of the root causes of TI are similar to the causes of deinstitutionalization, it is important to draw a clear line between the two practices and make clear that the present study is specifically concerned with TI. The concept of TI is quite similar to deinstitutionalization but differs in the focus TI researchers aim at treatment locales. TI researchers focus more heavily on ascertaining continued treatment in as independent a setting as possible (Prins, 2016). TI has previously accepted the fait accompli for psychiatric hospital closures (Prins, 2016). Recent TI research has begun questioning whether psychiatric hospital closures must be accepted (Lamb & Weinberger, 2016). TI is ripe for future qualitative research as it examines what may be done to provide support for the mentally ill as psychiatric hospitals are being closed.

Recidivism has long been an area where researchers have focused attention (Abracen, Gallo, Looman, & Goodwill, 2015). Communities often have a goal to reduce the times an individual returns to incarceration, although there are many means to accomplish this. Some communities seek longer and harsher sentences in an effort to prevent an individual from having another opportunity to reoffend (Aracen et al., 2015). Other communities seek to provide support resources to allow an incarcerated individual to experience rehabilitation towards becoming a productive member of society. Many communities continue to struggle with recidivism.

Mentally ill inmates who recidivate within the criminal justice system are an especially concerning trend (Matejkowski, Conrad, & Ostermann, 2017). Recidivism of

mentally ill inmates has been examined to determine if there is a correlation between mental illness and criminal behavior. Researchers examined whether the correlation was related to mental illness and early arrests during juvenile years, finding criminal risk was increased in those with a serious mental illness (Matejkowski et al., 2017). A call was made for future research to be conducted focusing on the experiences of mentally ill inmates (Matejkowski et al., 2017).

Few studies have examined the impact of deinstitutionalization on recidivism. Previous studies provided data about the relationship between mental illness and the criminal justice system, but they leave the question of psychiatric care and institutions to the side (Matejkowski et al., 2017). Whereas policy regarding institutions and cutbacks is bound to have an effect on the nature of recidivism within communities housing lots of mentally ill patients, the studies cited previously have treated institutional or public policy issues as tangential to their concerns.

The prevalent belief regarding the correlation between TI and recidivism has been noted, but qualitative, rich data are not present in current research (Kalapos, 2016). There are significant cultural beliefs about the relationship between deinstitutionalization and the increase in mentally ill portions of the population; there has been little to no research conducted on the subject (Kalapos, 2016). The belief that closing a psychiatric hospital will directly lead to mentally ill inmates has been colloquially termed Penrose's Law. This theory began in a 1939 study examining a connection between hospital beds and imprisonment for murder (Kalapos, 2016). A request for qualitative data to be researched in order to prove or disprove Penrose's Law

was made, but no research has been done on the subject, especially as it relates to policies enacted by the state. The State determines either to fund or de-fund state psychiatric institutions.

The call for data continues to be heard after 79 years have elapsed (Kalapos, 2016). The cultural knowledge about the correlation between psychiatric institution's demise and the increase in mentally ill citizens within the population has been reduced to a form of common sense written off by legislators. There is significant justification for using a phenomenological qualitative method to study the effect closing a psychiatric hospital has upon recidivism for the mentally ill inmate. Recidivism, deinstitutionalization, TI, and the criminal-justice system have all been studied during recent years, though the connection between deinstitutionalization and recidivism has gone unnoted by researchers within the field. The studies presented in this section are justification for researching TI, recidivism, and psychiatric hospital closures.

Psychiatric Hospital Closures

Understanding the effects of deinstitutionalization requires an examination of the main factors resulting in psychiatric hospital closures. The closure of psychiatric hospitals has not been a neutral practice, and the relationship between institutions and the citizens they are supposed to treat can be tied together by the phenomenon of psychiatric hospital closures. Psychiatric hospital closures occurred in the 1950s and continued throughout the 1960s (Torrey, 1995).

The reasons for such closures were multifarious, and in many cases such closures were justified by the increasingly difficult and punitive treatment inmates and patients

came to experience (Kalapos, 2016). Many closures occurred largely due to the media, which undertook numerous stories highlighting the poor conditions under which many patients were confined, often against the patient's will (Kalapos, 2016). The media became gatekeepers, allowing access to the more lurid scenes witnessed in hospitals and psychiatric clinics across the country. A form of cultural knowledge, casting the institutions of mental health in a wholly negative light, came into existence.

A second cause for the hospital closures may be due to the operating expense (Tillotson & Colanese, 2016). During the 1970s America experienced an economic recession and a decrease in financial commitments to state institutions. Many psychiatric hospitals were among the first casualties. Many public services faced steep cutbacks from the public sector in the United States and even in Europe during the late 1960s and 1970s (Tillotson & Colanese, 2016). The reason for such closures was cast in purely economic terms, leaving the human element and the costs to patients an afterthought for legislators (Tillotson & Colanese, 2016). The next three decades saw many psychiatric hospitals cease to exist.

The existence and purpose for the psychiatric hospital predate America. As early as 1697 English Common Law made provisions for houses of correction for those with mental illness (Tillotson & Colanese, 2015). The purpose in 1697 was to provide a place where individuals with undesirable behaviors could be housed, and the purpose had not changed significantly through the 1950s.

As late as the 1950s there was no expectation for residents in psychiatric homes to be returned to the community, but rather for each resident to remain hospitalized

throughout their lives. Deinstitutionalization placed a greater emphasis on closing psychiatric hospitals. This led to mentally ill individuals being placed within a community where adequate care could not be provided (Mulvey & Schubert, 2016).

A key change occurring along with deinstitutionalization was the goal to restore the individual to independence. A method to achieve this was eliminating long-term psychiatric hospitals, which led to 90% of the existing psychiatric hospitals being closed (Wachtler & Bagala, 2014). As the number of long-term beds decreased there developed a population that was unable to gain independence and who ended up entangled with the criminal justice system (Zdanowicz, 2015).

A move to provide care within the community in which the individual resided began across the country. The creation of community based short-term psychiatric beds provided for many displaced individuals with mental illness (Abracen, Gallo, Looman, & Goodwill, 2016). Jails and prisons now treat more mentally ill individuals than hospitals (Sisti, Segal, & Emanuel, 2015). The higher percentage of mentally ill individuals in correctional facilities has led a minority to a call for a return to establishing long-term psychiatric hospitals (Lamb & Weinberger, 2016; Sisti et al., 2015).

Scottish hospitals saw a decrease in the provision of psychiatric care in the 1960s and 1970s, which resulted in the gradual disappearance of psychiatric institutions (Long, 2016). Scottish psychiatric centers attempted to develop new approaches to assist patients who faced immanent discharge due to the closure of such hospitals (Long, 2016). Glasgow, for instance, offered no community based services and instead relied heavily on over-burdened hospitals, which were facing severe cutbacks from the Scottish

government due to the recession of the 1970s (Long, 2016). Ultimately, there was a stretching of human resources within the hospital system in Scotland, which staved off the negative effects of hospital deinstitutionalization until the 1980s (Long, 2016). This is relevant to the present study as it offers a potential solution to the problems being examined in this research.

Transinstitutionalism

When examining the effect psychiatric hospital closures play on recidivism among the mentally ill, one consideration is whether there is treatment being received after the closure occurs. Once a psychiatric hospital closes many individuals are forced to seek treatment at unfamiliar locations (Raphael & Stoll, 2013). It is necessary for an individual who was receiving treatment at a hospital to seek an alternative treatment center, either individually or with assistance from a support network. It must be noted change is often not welcome among those who are suffering with mental illness (Farkas et al., 2016). Some mentally ill individuals are forced to seek mental health treatment while at correctional facilities.

TI patients must be treated in community-based centers with increasing support in order to maintain their independence and, by extension, freedom (Prins, 2016). Bereft of proper community supports in place, there is difficulty in treating patients outside of in-patient treatment centers (Prins, 2016). Many who have been displaced from psychiatric hospitals have ended up incarcerated where they have less than adequate access to mental health care (Farkas et al., 2016). Others who have been displaced became homeless, with

approximately ⅓ to ¼ of the homeless population having a mental illness (Lamb & Weinberger, 2014).

Recidivism

Researchers have explored the relationship between recidivism and treatment of the mentally ill and note the targeted population is protected under both the groupings of mentally ill and inmate (Abracen et al., 2016). The protected population label is granted to protect the participants from abuse (Abracen et al., 2016). Due to considerations regarding the protected populations the researcher has focused the research on the lived experiences of the correctional officers who have witnessed the effects of a psychiatric hospital closure (Abracen et al., 2016).

Utilization of Psychiatric Hospitals

The utilization of psychiatric hospitals depends upon how those hospitals function, which is often measurable by the number of beds available for those with mental illness. Limited access to inpatient treatment can lead to higher suicide risk, homelessness, and a disposition to violent crime (Allision, Bastiampillai, Cino, Fuller, Bidargaddi, & Sharfstein, 2017). The limitation of hospital beds is not dependent upon the hospitals alone, but a consequence of the crisis precipitated by policies, which has led to decreased numbers of functioning psychiatric facilities. Such policies have lead to an increase in recidivism to hospitalization by patients, which in turn has lead to a decrease in the number of hospital beds available to patients (Allison et al., 2017).

Many correctional facilities have specific policies related to the circumstances under which a psychiatric hospital can be utilized (Pomerantz, 2016). Each correctional

facility is unique in their population, location, and leadership, although many have similar standards that must be met to send an inmate off site. Many facilities allow for petitions to be filed through the court systems (MacKillop & Chaimowitz, 2016). These can be filed by the court, by an attorney, by correctional staff, or by family members, and each circumstance has unique aspects highlighting a need for an off site visit to a psychiatric hospital.

The issue of discharging patients from a psychiatric institution is never neutral (Loch, 2014). Despite more than a century passing since the widespread utilization of psychiatric services, many negative outcomes exist for discharged patients, even after supposedly successful treatment. Patients who have been released from treatment into the general population often suffer from a remaining social stigma for those who have been treated for psychiatric conditions or are seen as socially or intellectually deficient (Loch, 2014). This stigma has a circular effect for patients who leave psychiatric treatment centers in negative circumstances, such as when the patient is discharged or when the treatment center closes. This instance of recidivism is relevant to the present study because it offers an example of the social effects of deinstitutionalization.

The individual who petitions the court may affect the likelihood of success, but other variables may dictate utilizing psychiatric hospitals for inmates (Kennedy-Hendricks et al., 2016). One primary concern dictating using off site facilities is whether the correctional facility can treat the individual adequately onsite. This causes many populations, such as geriatric, to spend more time utilizing off site hospitals than the general population (MacKillop & Chaimowitz, 2016). Older populations utilize hospitals

more than younger populations; due to physical breakdowns, an increase in psychiatric hospitalizations among the geriatric forensic population has occurred (MacKillop & Chaimowitz, 2016).

The introduction of antipsychotic medications in the mid 1950s changed the nature of psychiatric institutions in the United States (Pow, Baumeister, Hawkins, Cohen, & Garand, 2015). According to data gathered on discharge and readmission rates of United States mental hospitals between the years 1935 and 1964, discharged rates significantly increased in the period before antipsychotics. The result was a hidden deinstitutionalization beginning long before 1954, despite readmissions during the same period increasing at the same rate as discharges (Pow et al., 2015). What appeared to be a reduction in the population of mental hospitals was correlated with the introduction of antipsychotic medications (Pow et al., 2015). Deinstitutionalization before and after psychiatric drugs has resulted in increased, though inadequate, community care (Pow et al., 2015).

Correctional facilities have become a treating ground for the mentally ill (Hutchison, 2017). Some facilities may have onsite hospitalization able to handle most psychiatric events and may have minimal need to utilize an off site community psychiatric hospital. Most facilities have limited resources to address psychotic outbursts (Hutchison, 2017; Kennedy-Hendricks et al., 2016). The implementation of cost-benefit structures into the public policy domain regarding mental health policies has made the polity implementation less rational and less evenly distributed than it was in the 1960s. Thus, the capabilities for each correctional facility may dictate the use of off site

psychiatric hospitals. One facility may have a dire need for a community-based psychiatric hospital while another may function without a hospital nearby and not see any negative consequence to the inmate population. A goal of the current research is to show that recidivism is a symptom of such public policies rather than a failure of modes of psychiatric care.

Crucial to this discussion is the location of hospitals, and especially the difference between correctional facilities and psychiatric hospitals, which differ greatly in terms of function. One chief concern when considering an off site move from a correctional facility to a psychiatric hospital is the imminent danger threat to the inmate or staff (Mulvey & Schubert, 2016). This often correlates with the illness from which the individual is suffering. The standard correctional practice is to have a medical or psychological professional authorize the transportation to a prearranged facility once the professional provides a clinical rationale for the need (Kennedy-Hendricks, 2016; Tillotson & Colanese, 2016). The clinical need can range from not being able to provide a certain type or dose of medication or therapy to a need to have the inmate restrained to prevent harm to the inmate or others.

Combined with the decrease in available hospital bed space across the United States there now exists many mentally ill persons who are involved with the criminal-justice system (Kennedy-Hendricks et al., 2016; Lamb & Weinberger, 2016; Mulvey & Schubert, 2016). Fewer available beds has led correctional facilities to attempt to provide greater treatment levels, some of which the facility is not equipped to undertake (Mulvey & Schubert, 2016). Some facilities have seen dramatic decreases in off site psychiatric

hospital utilization. The State of Iowa noted a decrease in the percentage of mentally ill inmates who had utilized an off site psychiatric hospital from 40% to 28%, which leaves 12% who must now receive treatment within a correctional facility (Pomerantz, 2016).

Homelessness has increased across the United States in the wake of psychiatric hospital closures, though this conclusion is disputed by some researchers (Winkler, Barrett, McCrone, Csémy, Janouskova & Hoschl, 2016). The professional literature in the matter often linked the increase in imprisonment with the deinstitutionalization of psychiatric care across the United States and the United Kingdom (Winkler et al., 2016). Long-term assessments of psychiatric hospital residents who have been discharged showed a lack of long-term care had increased homelessness and imprisonment in the majority or urban populations (Winkler et al., 2016). This is often due to a methodological error, as a number of studies purporting to show the correlation between deinstitutionalization and an increase in imprisonment made the mistake of focusing on patients with short-term psychiatric disorders rather than on the more stable section of the population, which relied on long-term hospital care (Winkler et al., 2016).

Public policies create ideological imprints, which take a significant amount of time to be felt within the lived experiences of real communities (Shen & Snowden, 2014). The question of concern is whether mental health policy adoption induced transformation in the structure of mental health systems across the globe between 2001 and 2011. It is imperative to ask how many psychiatric beds will be available depending on the particular policies adopted. Ultimately, late adoptees of mental health policy are more likely to reduce psychiatric beds in mental hospitals and psychiatric wards than those

who adopt more innovative policies (Shen & Snowden, 2014). Deinstitutionalization is more a matter technical efficiency for late adopters of mental health policies; such policies are not implemented to improve the services offered but to decrease the amount of public funds spent on such services (Shen & Snowden, 2014).

Policy factors, which have shaped the current institutional landscape, are determined by recovery and community integration, cost containment and commodification, and increasing control over those with psychiatric disorders (Scheid, 2016). This creates a paradigm allowing deinstitutionalization to seem the most rational response to a struggling public sector overburdened due to an increased demand on services. An increasing number of advocates have noted the hollowing out of psychiatric institutions is antithetical to the healthy functioning of society. A concentration for future research on the hidden logics behind the current privatization paradigm within the public sphere has been advocated (Scheid, 2016). The researcher focused the study on determining the effects felt by correctional staff upon the closure of a psychiatric hospital, which meets the call made by Scheid (2016).

The logic behind hospital closures is easily reducible to an entrenched neo liberal ideology placing cost-benefit analysis ahead of the healthy functioning of public institutions (Scheid, 2016). When cost is factored ahead of public health, there are consequences to be considered. The research examines the lived experiences of correctional officers who have witnessed these consequences.

Summary and Conclusions

A major theme appearing in the limited research between the psychiatric hospital closures and mentally ill inmates is the need for additional research in local communities. The impact psychiatric hospital closures have, at times, shown limited negative outcomes (Fisher et al., 2016). An understanding about the risks associated with psychiatric hospital closures and possible negative outcomes may lead to a more effective way to provide community support.

Another theme within the research regards the potential usefulness in long-term psychiatric hospitals. An increased presence in mentally ill inmates is correlated with the deinstitutionalization of long-term psychiatric hospitals (Ferrazzi and Krupa, 2016). Additional research on the lived experiences of those who are employed within a correctional facility allows for a deeper understanding of the phenomenon experienced upon a hospital closure.

One goal suggested by current research is to limit mentally ill recidivism among inmates (Lamb, 2016). This may be accomplished through collecting qualitative data focused on psychiatric hospital closures. The lack of qualitative data available on mentally ill individuals who have been negatively affected by psychiatric hospital closures should be noted (Kalapos, 2016). This supports the need for researchers to understand the holistic effect closing a psychiatric hospital can have on community resources. A qualitative methodology allows the researcher to gain a holistic understanding of the multifaceted impacts a psychiatric hospital closure can instigate.

The research may not only allow new social supports to reduce recidivism among the mentally ill, it also serves to provide better guidance to those who provide mental health care to those who are incarcerated (Lamb & Weinberger, 2016). Research focused on those who provide care for the mentally ill population can allow for improvements to be made by future correctional staff. This research has the potential to create positive social change, with the goal to reduce recidivism and provide data to guide social supports in the community.

Chapter 2 focused on an exhaustive literature review regarding what is current among research in TI, deinstitutionalization, PRT, Gatekeeper theory, psychiatric hospital closures, psychiatric hospital utilization recidivism, and how this study addresses a gap in existing research. The research design chosen to address the gap is described in Chapter 3. The qualitative research design was chosen to allow for rich, meaningful data to be gathered. The theories addressed previously are examined again within the methodology to validate its use. The choice in methodology and the population chosen for this study is presented in Chapter 3.

Chapter 3: Research Method

Introduction

Closing a psychiatric hospital has a ripple effect on a community. The local jail is one community institution impacted by a closure. The purpose of this qualitative, phenomenological research was to examine the experiences of correctional officers who have witnessed the effects of a hospital closure on the mentally ill within a jail. Analysis of the data provides greater understanding of some outcomes associated with hospital closures. In this chapter, I discuss the research methods, beginning with the research design used in the study. After factoring in the ethical and logistical constraints presented in the study of mentally ill inmates selected a qualitative methodology with correctional officers constituting the sample population.

Searcy Psychiatric Hospital was located in Mount Vernon, Alabama, and provided mental health services for Mobile and the surrounding metro areas. Searcy was a state-owned and -operated hospital with a history of providing mental health services dating to 1902. The hospital was closed by the state of Alabama on October 31, 2012. At the time of the closure there was no state-owned hospital in the counties Searcy had previously served. I examined the experiences of the correctional staff working at the jail who were employed at the time of the hospital's closing.

The facility chosen for the research is a jail located in Southern Alabama and serves two counties. The population of these two counties is over 430,000 individuals (U.S. Department of Justice, 2010). The jail has an average daily population of 1,500 inmates and books over 42,000 unique individuals each year (U.S. Department of Justice,

2010). Approximately 18% of the population receives psychotropic medications, which is equivalent to 270 inmates (U.S. Department of Justice, 2010). There is limited housing for the mentally ill at this jail. Due to this constraint, approximately 120 inmates are housed daily in the mental health unit (U.S. Department of Justice, 2010).

For this study, I conducted interviews with correctional staff working at the selected site. Correctional staff included those who provide security to inmates with mental illness, as well as members of the jail leadership team. I conducted the interviews using individual appointments and focus groups. In Chapter 3, I present specific aspects of the research design and the rationale for this design. I examine the steps taken to address ethical considerations and discuss the manner in which these steps altered the research. After reviewing the handling of all data and the ethical precautions taken, I provide a detailed review of the role of the researcher, research tools, and analysis.

Research Design and Rationale

TI refers to the relocation of patients from an inpatient hospital setting to any other setting (Lamb & Weinberger, 2016). Research regarding TI, mental illness, and hospital closures is lacking (Kalapos, 2016). Fewer studies exist when introducing the population of mentally ill inmates who have recidivated back to detention (Kalapos, 2016). The goal of this research was to examine the personal experiences of correctional officers and staff who have witnessed the effects of a psychiatric hospital closure and the impact it perpetrates on the mentally ill who are incarcerated.

The phenomenological approach is underutilized in forensic psychology (Miner-Romanoff, 2012). In reviewing the literature, I found a lack of available qualitative

studies regarding the effects experienced by jail staff when a psychiatric hospital closes. The theoretical framework that I used to guide the research was PRT and gatekeeper theory. One area of focus for those who study PRT is the housing of individuals with mental illness (Farkas et al., 2017). The research questions were

RQ1. What are the lived experiences of correctional officers at a jail regarding the increase of mentally ill offenders after the closure of Searcy Psychiatric Hospital?

RQ2. What are the lived experiences of administrators at a jail regarding the increase of mentally ill offenders after the closure of Searcy Psychiatric Hospital?

This study had several constraints. One resource constraint was the protected nature of the sample population (see Kennedy-Hendricks et al., 2016). Mentally ill individuals are susceptible to risk, as are incarcerated individuals (Kennedy-Hendricks et al., 2016). The use of interviews with correctional officers, rather than with mentally ill inmates, allowed for the problem to be explored without risking harm to this protected population (Kennedy-Hendricks et al., 2016). Data handling is explored in further detail later in Chapter 3. I also address the risk factor to each participant. Time is often a constraint in research studies and sometimes prevents data saturation (Hennink, Kaiser, & Marconi, 2017). In the study I planned to interview 21–24 participants to meet saturation. My actual sample size was 20.

Despite the constraints due to the protected population, the qualitative design allows for future analysis. This is consistent with the need in scientific fields to produce

new knowledge (Creswell & Creswell, 2018). Qualitative data regarding TI are lacking, according to my research. The relocation of inmates from a psychiatric hospital to a jail is one common form of TI (Prins, 2016). The research results may lead to a deeper understanding of the experiences of correctional officers who witness this type of TI. This deeper understanding can allow researchers to target gaps in community support systems. As I discuss in the chapter, the qualitative methodology was the most practical means of gathering and analyzing data to achieve this goal.

Role of the Researcher

There are numerous roles a researcher must adopt for a study. The first role is as a researcher, which is evidenced by the steps taken to gather data. The researcher inquires into observed problems, listens, and evaluates gathered data (Merriam, 2002). A researcher must be the primary handler of data, yet must also remain self-aware in order to decrease bias in the study (Merriam, 2002).

A researcher must examine not only the collected data, but also the location of the participants, personal preconceived beliefs of the researcher and the participant, and both of their understanding of the interview (Creswell & Creswell, 2018). Understanding the background of participants assists in developing rapport. Building rapport allows for an exchange of information to take place between the interviewer and the participants, which allows for data to be gathered (Creswell & Creswell, 2018).

Interpersonal process recall is one tool used to decrease researcher bias (Creswell & Creswell, 2018). This process allows the researcher to reflect on personal thoughts, feelings, and beliefs arising during the course of an interview (Creswell & Creswell,

2018). Acknowledging the presence of these personal feelings can make a researcher aware of potential bias. Following the procedures required when working with a dissertation committee can also mitigate bias (Creswell & Creswell, 2018). I undertook these steps to reduce bias in this qualitative research study.

The researcher is considered a data collection instrument in qualitative studies (Creswell & Creswell, 2018). Multicultural awareness is a tool that can allow the researcher to establish a connection with participants to facilitate data collection. The researcher must be aware of the cultural beliefs and perspectives of the participants. In doing so, the researcher can frame questions that generate memories for the participants. In addition, an ability to reflect on new data presented by the participants allows the researcher to establish and maintain rapport (Creswell & Creswell, 2018). The use of reflective listening can result in rich data for the researcher. The participants are the experts in regard to their experiences and focusing on their individual experiences provides quality data (Creswell & Creswell, 2018).

I believe my personal experience as a forensic mental health professional may have helped me in establishing rapport with the participants. I have worked in correctional facilities over a 9-year period. I have had professional interactions with both the mentally ill population and with correctional officers who work with this population. My experience increased my level of understanding of study participants' daily job duties. However, my experience did not provide me with knowledge of the participants' lived experiences with TI as I have not previously researched this topic.

As I have previously worked with both mentally ill individuals and correctional officers, I engaged in regular discussions with committee members to avoid bias. In addition, interpersonal-process recall was practiced to reduce the presence of bias in this study. Any conflicts of interest were examined within the confines of University protocol, and I took steps to minimize their effects.

It is vital for qualitative researchers to acknowledge biases throughout the course of a study. In the field of counseling, it is equally vital to avoid letting bias impact working with a patient (Nachmias & Nachmias, 2015). My prior work in counseling, combined with my education in forensic psychology and multiculturalism, translated well to qualitative research and served as a guide to communicate effectively, build rapport with interviewees, actively listen, and remain aware of biases.

Methodology

Participant Selection Logic

The target population for this research consisted of correctional staff working in a facility that was serviced by Searcy Psychiatric Hospital. The sample population was 21–24 individuals, a number which meets saturation requirements (Hennink et al., 2017). An examination of the transcripts from these interviews allowed me to analyze the lived experiences of officers who participated in the study. For this study, my target population was correctional officers with experience working with the mentally ill population.

The goal of this research was to determine the experiences of correctional officers after the closure of a psychiatric hospital, so the participants were purposefully sampled.

Purposeful sampling allowed me to target those individuals who have had contact with the mentally ill population in the jail. Future research may be focused on all correctional officers to gain a deeper understanding of the impact of a closure upon the average correctional officer.

I sought those correctional officers who have worked directly with the individuals, as well as administrators who have oversight of the mental health units. The officers selected have worked at least seven years, which has provided them experience working prior to the closure of Searcy. A total of 21–24 participants allows for code saturation to be achieved, which allowed for all identifiable codes to be examined. The intent of this research was to interview correctional officers who worked at the jail when the hospital was open. If the turnover rate had made it difficult to locate 20-24 jail staff that had seven years of experience, this researcher would have been forced to interview some staff hired within the last seven years.

Semistructured interviews were used for this study, as this method allows for the participants to guide the researcher. Letters requesting participation were distributed to correctional officers. The letters included the purpose of the study, assurance of anonymity, the length of time needed, and my contact information. Snowball sampling may have been used if additional participants were needed. Since 20 participants were obtained, no additional sampling was required. Additional precautions for participants are discussed in the following sections.

Instrumentation

Interviews are the most often used method for collecting qualitative data (Creswell & Creswell, 2018). Interviews are an effective method of collecting data as they allow the researcher to seek rich data through saturation. In this research I conducted semistructured interviews. To conduct the interviews, a list of questions was compiled for both the individual and focus group sessions. Interviews took place individually as well as in focus groups.

Prior to the interview, participants were asked to answer several basic questions. A short demographic form queried the length of experience at the jail, the length of experience in the profession, the average number weekly of contacts with mentally ill inmates, the location of contacts with mentally ill inmates, and a description of how happy they are with their line of work. I also requested e-mail addresses, cell phone numbers, and preferred method of contact. The use of the questionnaire allowed the limited interview time to be focused on gaining rich data regarding the lived experiences of the officers.

Questions for the officers were constructed to gain insight about their lived experiences with mental illness. One question asked during the focus group was, "How do inmates with mental illness impact your job at the jail?" Collecting data regarding the impact of mental illness allowed for greater insight into the duties and conduct of correctional officers.

The comfort level of officers with the mentally ill population was also gauged by asking, "How equipped are you to provide for the needs of mentally ill inmates?"

Questions such as this allow greater insight into the positive and negative aspects of the lived experiences of correctional officers. A question was also used to extract rich data regarding the differences between the facility both prior to the closing of Searcy Hospital and after the closure.

Separate questions were constructed for the administrators of the facility, as the experience of administrators can be quite different than that of an officer. Questions were kept as similar as possible, with several exceptions. A question such as "How comfortable are you with the level of mental health training of your officers?" provided rich data from the administrators. Questions regarding the budgetary strains, available bed space, and additional man-hours have provided useful data. I also sought information on the changes seen by administrators after the closure of Searcy Hospital.

My goal through this research is to create a positive social change by allowing a community to recognize the impact closing a psychiatric hospital has on a local county jail. The use of an effective instrument to gather data is vital to achieving this goal. Through gathering data, providing analysis, and offering suggestions for social change, I hope to help a community more fully understand the experiences of officers in the wake of a psychiatric hospital closure. Accomplishing this goal required steps to validate data accuracy.

Each interview was audio recorded to verify accurate data collection. In addition, contemporaneous notes were taken by myself to allow for clarification and follow-up questions to be formulated. Establishing rapport with the participants was of utmost importance, as semistructured interviews place an emphasis on this aspect of qualitative

interviewing. The participant can be empowered to direct the conversation, offer new information, and share personal information when rapport is established. Notes taken during these sessions will be stored for five years in a locked storage at a local state college campus, and then will be shredded by the college.

I have formulated interview questions after considering the target population. Previous experience working with correctional officers, as well as the experiences of the committee, allowed the questions to be tailored with specificity. Participants were asked numerous questions regarding specific interactions with mentally ill inmates. Follow up questions were aimed to gather rich contextual information regarding the officer's individual experiences. Participants were encouraged to answer questions thoroughly, and questions could be revisited at a later time if the participants desire. The use of semistructured interviews allows the participant to feel as if they are steering the interview rather than simply participating (Creswell & Creswell, 2018).

Aspects of the gatekeeping theory influenced the questions asked during the interview. The questions reflected gatekeeping theorists' belief in limiting the negative news when the subject is the gatekeeper. In the current study, the gatekeeper is the state/county and the gatekeeper dilemma is whether or not to publicize the impact closing a hospital may have (Adamson, Donaldson, & Whitley, 2016). I have undertaken the research in order to uncover a gatekeeper dilemma, if one exists.

Procedures for Recruitment, Participation, and Data Collection

PRT theorists have noted the importance housing plays in the rehabilitation of psychiatric patients (Farkas et al., 2017). The lowest level of housing is against-will, or

whenever a patient has no freedom to choose another housing option (Farkas et al., 2017). The inmate with mental illness qualifies for this lowest housing level. I paid particular attention when questioning the officers regarding housing options.

Interviews were constructed based upon a one-hour time frame. Individual, as well as focus groups, were scheduled for one-hour intervals. Interviews were conducted in-person and at the jail. The setting was used to provide a convenience to the facility, which allowed the officers to participate during breaks in their scheduled shifts. Each interview was semistructured and contained open-ended questions. Appendix A contains a list of all focus group and individual questions that were used during the interviews.

I asked the Warden of the jail to suggest a location convenient to the officers for the scheduled interviews and focus groups. The Warden noted the training room at the facility could be used to provide the greatest ease for the officers and administrators. Alternative locations could present an obstacle to participation, as well as add additional burdens to the staff. The use of the training room also provided me greater access to the participants.

The focus groups were advertised by initial contact via email. Each participant was given the opportunity to opt in or out of the research. The goal of understanding the lived experiences of correctional officers after a hospital closure was explained. The participants who opted to participate were given instructions regarding a date, time, and location for the upcoming focus group.

Administrators who opted in were asked to provide a date, time, and location convenient to their schedule. As often as possible, I sought to accommodate the

participants' schedules. Individual interviews were held with the administrators to accommodate a busier schedule.

Each interview and focus group opened with a brief word of thanks for their voluntary participation and a review of the purpose of the research. A disclaimer noting the recording of the sessions was made both before and after the recording began. Those participants who did not wish to be recorded may have opt out of the research at any point. The session ended at the conclusion of the hour, and follow up questions from the participants were answered.

The session concluded with a word of thanks and an explanation of the gains realized by each participant. A comment regarding the upcoming summary was made to alert participants of the coming email. I left the facility premises once the training room had been turned back over to the officers, which occurred in the late afternoon.

Data Analysis Plan

The retention of all data is important to this study. To assist with gathering and retaining data, each interview was recorded and then transcribed. This allowed all data to be captured, which allowed for appropriate identification of all themes. I have also taken contemporaneous notes to provide reference points throughout the interviews and focus groups.

Desowing data is an important step in data analysis (Creswell & Creswell, 2018). Because the data collected in phenomenological studies is often dense and rich there is a need to determine which portions of the data best assist in describing the lived

experiences among the participants. A total of between five and seven themes was sought to highlight these lived experiences.

The use of a computer program to assist in identifying themes into categories was used, as hand coding is time consuming and prone to error. NVivo is a qualitative software package that allows for categorization of data sets into themes. A benefit of Nvivo is the ability to search and sort data sets, which allows for accurate identification of themes to emerge.

Nvivo is a software program used by qualitative researchers to analyze collected data. The use of non-numeric data is unique to qualitative studies. Nvivo allows researchers to organize the data from focus groups and interviews by categorizing the data and identifying trends.

In this study, I have used the program as an easy forum to store and organize all data collected during the research. The best opportunity to retain all useful data is to utilize software, such as Nvivo, which can store all data sets. An additional benefit is the savings in time and energy when locating the data and sorting through the themes. Nvivo allows the use of charts, spreadsheets, emails, audio files, and graphs to help visualize the results of the research.

Content validity is important to all qualitative studies. One method to improve the accuracy of collected data is to communicate with the participants after the interviews have been analyzed. A summary of each interview or focus group was sent by myself via encrypted email to each participant to verify the data collected was interpreted correctly. The summary included the identified major themes. The benefit to the study can be seen

when the participants verify the accuracy, offer new insights, or expand upon their answers.

All replies to the summary remained private. Emails were saved electronically to allow additional insights to be added to the data, as well as to preserve the communication between the researcher and the participants. The data is stored on an electronic device kept in a locked office. The device will be kept for five years before being wiped clean.

Issues of Trustworthiness

My personal history in the field of forensic mental health is a benefit to conducting the research. Experience in the workplace of a correctional facility has allowed me to become more familiar during interviews. The history of work in corrections lends credibility, which increases the credibility of the data received through interviews.

It is vital for me to note a lack of any professional role in the correctional facility during the interviews. A disclosure was made noting my role and the goal of the qualitative research. I have previously worked in the field of corrections, but this history does not change the role of an outside researcher.

Research questions were developed with a goal of removing bias. Leading questions have been removed from the question list, as the goal is to compile an accurate description of the lived experiences as stated by the interviewees. Thus, using open-ended questions is optimal. This can allow authentic knowledge to be gained from the

interviews. Allowing the participants to guide their sharing of information has provided for validity in the data collection process.

The officers participated in the research of their own volition. This reduces bias in the participant process, as the use of coercion into the study is decreased in likelihood. Voluntary participation is especially critical in this study as the current climate towards mental health is gaining a wider audience.

Having prior knowledge of the working conditions of correctional officers assisted in the formulation of questions for the interviews. The hierarchy, structure, and related systems in corrections are somewhat unique, and prior knowledge of them allows me to phrase questions knowledgeably. Rapport was sought through phrasing during the interview. Having a personal desire to see each officer succeed in their work with the mentally ill provided additional areas for rapport building during the interviews.

Interview questions were structured to provide the participant with many opportunities to provide their personal lived experiences. Clarification was sought throughout the interview in an effort to have the participants expound on their statements. The goal was to gather complete, accurate, and clear data. The ability to share personal, lived experiences with clarification adds to the validity of the research while accomplishing these goals.

Taping and transcribing the interviews allowed for increased internal validity to the research. Data that was typed can be clear and easily sorted using a computer program. Typed data is also less open to misinterpretation, as the written word is less

subjective. Transcribing data has taken additional effort, but was well worth the additional credibility lent to the research.

Ethical Procedures

The researcher is responsible for ensuring ethical research (Creswell & Creswell, 2018). Truthfulness, privacy, responsibility, and uncoerced participation are all areas of consideration when designing ethical research. The data collection follows guidance provided by the University, the committee, and the administration of the Mobile County Sheriff's Department. The use of a dissertation committee provided additional guidance towards achieving these goals.

Privacy is an important aspect of ethical research. Making sure no identifying information was included in the results of this study ensures participant confidentiality. Assigning a number to participants and referring to them by a randomly assigned number in the research achieves this. Officers were able to have their anonymity preserved throughout the research.

The officers were asked to participate at times convenient to the jail, and most interviews were anticipated to take place directly after a shift has ended or at a break during the shift. Conducting interviews with participants during or after they have completed a shift achieved two purposes. First, the participants were likely to provide accurate data, as limited time had expired after their shift. Additionally, the participants were able to speak freely and share feelings, as their work shift has ended. Sensitivity to the participants is important to the research, as their personal experiences are the basis for this research.

Once the participants were selected, I asked that they sign a consent form prior to any interview. The consent form was written at an eight grade reading level to assure ease of understanding. The Smog Index was used to verify the readability. Voluntary participation was acknowledged to verify the participant's desire to take part. Confidentiality was explained, and limitations were noted. Among the limitations to confidentiality are specific to those whose titles will allow those familiar with the institution to determine who is being discussed. An example may be the warden of the jail, whose position in the community may prevent anonymity. The absence of specific titles was utilized to protect anonymity for each of the participants. Voluntary termination from participation was also discussed to empower participants.

Scope and Delimitations

All researchers have aspects that limit the scope in which they can begin a study (Creswell & Creswell, 2018). The scope of the study covers the lived experiences of correctional officers when a psychiatric hospital closes. The specific factors leading to the closure of the psychiatric hospital are not explored. The particular cases of inmates with mental illness fall outside of the scope of this research, although future case studies could be undertaken.

Limitations

I face several limitations in this study. Among these are the available participants, the location and time restraints imposed by the officers, the training each officer has undergone, and the personal backgrounds of each participant. The participant pool is located exclusively in the Southern portion of Alabama. The closure of a

psychiatric hospital has occurred in many other states, but the time required to survey each one argues for this limitation.

Summary

In summary, this qualitative phenomenological study was completed using semistructured interviews in both individual and focus group settings. A qualitative phenomenological study is suitable, as the closure of a psychiatric facility has created a phenomenon in the correctional world (Sylvestre et al., 2017). A gap exists in the literature for such a study to provide data regarding the personal, lived experiences of correctional officers. There is a need for qualitative data to provide an understanding of the holistic issues faced by a community when a psychiatric hospital closure occurs.

The use of semistructured interviews allowed for the best method of capturing all data in a phenomenological study. Open-ended questions allowed for the greatest amount of rich data to be gathered, which allowed for the identification of themes. This follows the therapeutic interview process, upon which the interviews were based. The use of interviews allows for credible data to be gathered from the source. The interviews allowed each participant to explore their personal experiences while gathering data allowed for themes to be identified.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to explore the experiences of jail staff in the wake of a psychiatric hospital closure. I examined the beliefs, culture, training, and education of the staff at a jail to gain insight about their specific experiences and the possible unintended consequences of the closure. Information from the reviewed literature suggests that the inmate population will experience negative consequences from closures (Lamb & Weinberger, 2016), but prior researchers have not focused on the impacts on correctional staff following a psychiatric hospital closure, according to my review of the literature. In conducting this study, I sought to fill this gap in knowledge. The research yielded insight into the perspectives of the correctional staff. Using the findings from this study, future researchers and policy makers can begin to explore possible solutions to prevent the unintended consequences of a psychiatric hospital closure.

This chapter begins with a presentation of descriptive information regarding the demographics of those correctional officers who were sampled. I provide details on the data collection methodology and describe the analysis of gathered data. In addition, I provide evidence of the trustworthiness and credibility of the methodology. The results of the data collection and analysis are presented, with a summary of the findings serving as a conclusion to the chapter.

Demographics

The study included 20 participants from a single jail in Southern Alabama. Of these participants, 17 were correctional officers, and three were administrative staff. I interviewed the correctional officers in a focus group setting in a training room of the jail. I conducted three separate focus group interviews on a single day and asked each group identical semistructured questions. The officers completed a focus group consent form and provided contact information before the focus group. For the administrative staff, I conducted three individual interviews in the administrative wing of the facility. Each of the administrative staff was asked identical semistructured questions, with several questions used from the focus group and additional questions added that focused on their administrative duties. The administrators were each provided a copy of the administrative consent form before the interview. I provided separate consent forms noting the differing format, length of expected time, and questions for both the administrative officers and the correctional staff.

Within the sample ($N = 20$), there were nine men ($n = 45\%$) and 11 women ($n = 55\%$). I chose the sample participants based upon their length of service; eligibility criteria included a minimum of 5 years length of service to ensure that participants had work experience at the jail when the local state psychiatric hospital was operating. The range of experience within the sample population ranged from 5 years to 30 years (see Figure 1). The average length of service was 8 years. Nine officers reported 5-10 years of service ($n = 45\%$), seven reported 11-15 years of service ($n = 35\%$), one reported 16-20 years of service ($n = 5\%$), and three reported 21-30 years of service ($n = 15\%$).

Participants also related their level of education. There were 16 participating officers who reported a high school diploma as their highest completed level of education (*n* = 80%). Three participants reported having earned a bachelor's degree (*n* = 15%), while one officer reported a master's degree as the highest completed level of education (*n* = 5%). The average completed level of education among the sampled correctional staff was a high school diploma. Figure 2 offers a graphic presentation of participants' educational level.

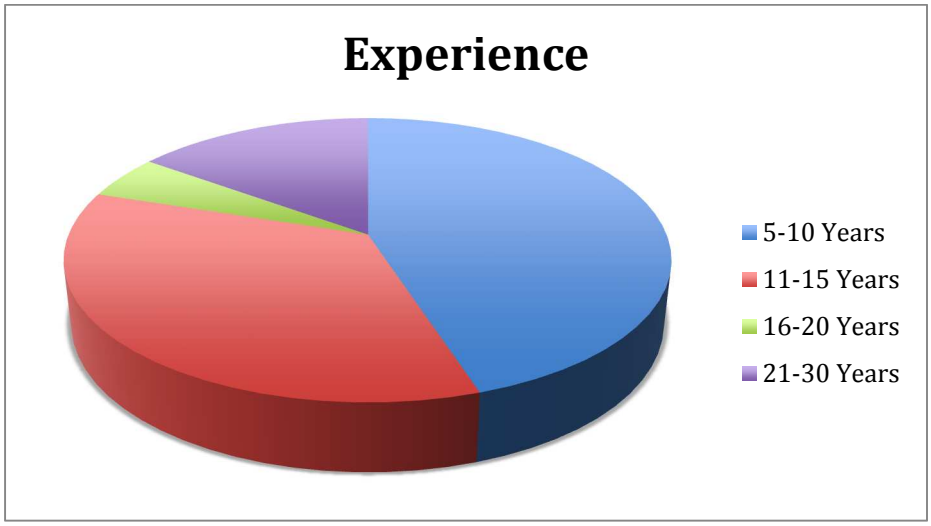

Figure 1. Demographics: Years of experience of participants.

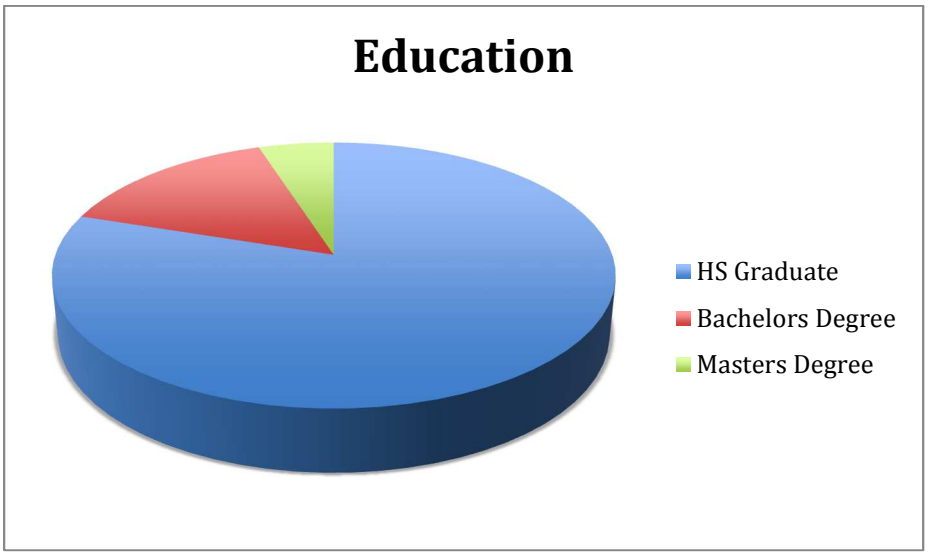

Figure 2. Demographics: Level of education of participants.

Data Collection

I collected data from 20 participants via in-person interviews on March 19, 2019. There were 17 participants in three separate focus groups. I chose a focus group format to meet several goals. First, I sought to obtain a consensus on the impact that closing a psychiatric hospital has on a local jail. I believed that using a group format would further the willingness of the staff to share their experiences. Second, I thought that the shared experiences of correctional officers might serve to stimulate the memories of other focus group participants and allow me to obtain richer and fuller contextual information. Finally, the facility requested as little disruption as possible to their general operations; use of a focus group format accommodated this request.

The number of groups had not yet been determined until I arrived at the facility. A scheduling officer determined the participants of each focus group, although all participation was voluntary. The scheduling officer selected each group to cause the least

amount of disruption to the workplace environment. The scheduler drew from a list of officers who had been identified by the administration of the jail. The targeted population were those officers who were working when the phenomenon, the hospital closure, occurred. Each of the participants met this criterion.

There were three separate focus groups, with each group containing unique participants. The first focus group had seven participants and lasted for 72 minutes. The second focus group contained five participants and lasted for 62 minutes. The third focus group contained five participants and lasted for 70 minutes. There were approximately 15 minutes in between each focus group.

The focus groups lasted for an average of 68 minutes. This was longer than anticipated due to the groups' engaging in vigorous discussion of certain questions, which allowed for the development of themes. One week before the focus group, I e-mailed each participant a copy of the consent form, which was signed upon entrance to the training room on the date of the focus group meeting. Prior to the focus group, I reviewed the consent form and provided all participants an opportunity to withdraw from the study. The consent form included the Walden Institutional Review Board (IRB) approval number for this study, 02-12-19-0321606, which expires on October 20, 2020.

I informed each participant at the beginning of the focus group that, while I would maintain confidentiality, I could not force other participants to retain the disclosed information as confidential. The group discussed the importance of confidentiality in the ground rules, and I encouraged all the participants to keep confidentiality. Participants were encouraged to be open and honest during the focus group but were also cautioned to

share only information that they were comfortable sharing. One member of the focus group withdrew before the start of the interview.

I recorded the focus group with a password-protected digital recorder. The participants were informed of the recording in the consent form and at the start and conclusion of the focus group. Each participant was given an opportunity to answer every question, if desired, before I moved to the next question.

The administrators were unable to attend a separate focus group due to timing and the necessity of their positions requiring them to remain in a certain location. Each of the three administrators was interviewed in their office at a time they provided. The interviews took 34, 26, and 33 minutes each. I provided a separate consent form to each of them for review at the start of the interviews. The specific job titles for each administrator are not included to help preserve anonymity of the participants. Each participating administrator provided a signed copy of the administrator consent form. The consent form included the Walden IRB approval number.

I informed each administrator about the confidentiality measures I would provide. At no point during the recording did I refer to the participants by name; I refrained from doing so to protect confidentiality. Each of the participants was asked all 12 of the semistructured questions designed for administrators, and each participant provided answers to all of the questions. Before the interview, each administrator was informed that a recording device would be used. At the conclusion of the interview, I noted the stoppage of the recording device.

I transcribed each audio recording. The data were entered and evaluated using Nvivo 12 for Mac. There were no deviations in the collection of data from what was anticipated, and there were no unusual or unexpected circumstances taking place during the data collection.

Data Analysis

All the interviews occurred on a single day at a single location. I conducted the interviews using semi-open-ended questions to allow an opportunity for participants to explain the phenomenon. The open-ended questions allowed the participants to share their personal knowledge and experiences regarding the closure of the local psychiatric hospital and the impact they witnessed on their job.

There were three separate, individual interviews with administrators and three focus groups conducted with correctional officers. Each of the sessions was taped for accuracy and reference. Upon completing the gathering of data, I reviewed each session, making notes to aid my memory.

Once the interviews were transcribed, a software package, Nvivo 12, was used to identify and locate themes, subthemes, and recurrences in the data. Repetitive phrases were coded together, and opposing phrases served as subthemes, allowing a contrast of themes to emerge. Each participant was emailed a password-protected summary of their transcription to allow changes. None of the participants elected to make any changes to the document. The themes and patterns that were identified are presented in the following sections of Chapter 4.

Evidence of Trustworthiness

Preparations to ensure trustworthiness began prior to the research. The faculty and staff at Walden University, the University Research Reviewer, and the IRB all contributed to the credibility and trustworthiness of this study. I also completed the Collaborative Institutional Training Initiative's course on protecting participants in research. The course was customized to my specific research, with a section dedicated to researching within a correctional environment. These steps helped ensure that ethical measures were in place to protect those who participated in this research.

Each interview question was structured to provide the participants with the opportunity to present their specific and unique experiences, as well as to expand on each topic. Questions were designed at the eighth grade level to ensure comprehension for participants with varying degrees of education. This adds to the internal validity by allowing for clear, complete and accurate responses to be gathered.

My personal background as a therapist allowed me to ask questions without leading the participants. I spent several years as a correctional therapist, and this background allowed me to have credibility to ask questions, as the officers noted several times during the focus groups and individual interviews. I was able to build rapport and trust with the officers during the focus groups, which promotes honesty among the responses. In qualitative research, the researcher is the data collection tool, and my prior experience as an interviewer impacts the validity of the research.

Throughout the interview process, additional clarifying questions were asked to improve my understanding of the answers. Often, this would lead to an expansion on the

original statement. Throughout the interviews and focus groups, I strove to show no bias and provide zero leading questions. Keeping an open mind and recognizing that each participant had a unique perspective accomplished this. A focus was placed upon obtaining an accurate and thorough understanding of each focus group and interview. No value judgment was relayed to any participant as each answer was given.

Once the data were collected and transcribed verbatim, each participant was assigned a case in the Nvivo. The creation of unique cases allowed an email summary of each participant's answers to be emailed to the participant as a form of member checking. Member checking adds reliability to the data collection process (Edmonds & Kennedy, 2017). The emails were sent with a password protection, and participants were asked to reply if any changes needed to be made. No participant replied to the member checking email seeking any change.

All data was analyzed in writing using Nvivo data software. This analysis provided concrete data regarding what each participant said. Using software allows the data to be less vulnerable to varying degrees of interpretation. The fact that repeated themes and patterns occurred in both the focus groups and individual interviews contributes to the credibility of this study.

Credibility

The participant selection process adds to the validity and credibility of the study. All participants were working at the facility prior to the closure of the local state psychiatric hospital, which allowed each participant to experience the change that occurred at the time of the closure. The participants were selected by seeking to obtain

20-23 participants who met the criteria of working at the facility for at least five years or more. There were 21 who met these criteria, and one of those elected not to participate in the research. The participants who elected to be a part of this study have a variety of ranks and work at various stations and units throughout the jail, including intake, transportation, female units, male units, and the special populations unit. Using a varied sample population helps illustrate a decreased risk of bias in recruitment of participants.

The consistent themes that occurred from this variety of participants add to the credibility of this study. The participants are the experts of their experiences, and the consistent themes add to the likelihood that others may perceive the study as credible. Utilizing triangulation of data sources increases the credibility of the study, and finding consistent themes illustrated their importance.

Transferability

The selected population for this study is representative of a single jail in Southern Alabama. The results of this study may not be generalizable to other jails, whether close in proximity or distant from Southern Alabama. Each correctional facility has unique rules, laws, and policies, which may make the results of this data unique. This limitation of a qualitative study is both obvious and necessary.

The design of this study, phenomenology, could be transferrable to other correctional facilities. This phenomenological study examined a specific phenomenon, the impact of a psychiatric hospital closure on the correctional officers of a local correctional facility. The method, data collection interview questions, and data analysis

methods are transferable to study the impact of hospital closures in other facilities and states. Results may vary, especially when rules, laws, and policies are considered.

Dependability

I collected the data that was recorded and transcribed verbatim. This allowed the identification of themes and sub-themes during the transcription and analysis. The study examined the experiences of 20 correctional officers and administrators, and it must be remembered that their experiences may differ even from those who experienced the same event, a hospital closure. It is expected that other officers may have different experiences of the same event though the consistent themes presented by the participants support the results.

The research suggests that those who have experienced training in mental health have a greater appreciation for additional training, which will be discussed later in Chapter 5. Those who did not receive mental health training did not place a high emphasis on the training. Thus, those participants who received additional mental health training since the research occurred may have a different experience today than they had shared initially.

Conformability

There are several aspects of the methods and procedures in this study that aid in promoting conformability. Using a standardized list of interview questions was a deliberate move to minimize bias and distortion. The use of a recorder to capture everything that was said also assisted in this goal, as did the transcription process, which allowed me to not rely solely upon memory recall.

Involving the participants in member checking occurred when the summary of each participant's transcript was provided via a password-protected email document. The participants were invited to verify that the document was correct and accurately reflected their particular point of view. Each participant was also informed that a summary of the dissertation would be provided upon completion and approval and would be emailed in a similar manner. These steps assist with allowing the results of this study to be corroborated and confirmed by the participants.

Quotations were utilized to maximize conformability. Providing direct quotes supporting the themes from the participants helped to safeguard against bias in presentation. These quotes support the themes free of my personal point of view and bias.

Results

The research questions were designed to gather information regarding the lived experiences of correctional officers following the closure of a state psychiatric hospital. Upon review of the gathered data, several themes emerged. Each theme listed is ranked by the number of occurrences.

1. Open the psychiatric hospital back up
2. Training
3. They don't need to be here
4. Mental health housing / they can't function in general population
5. Public awareness
6. They didn't think it through

Examples of the related interview question and data results are discussed thematically below. All quotations are written as they were captured, and grammatical changes were not made in an effort to preserve both the intent and the tone of the participants.

Theme 1: Open the Psychiatric Hospital Back Up

All 20 participants voiced their desire to see the state psychiatric hospital reopen. Many of the participants noted reasons the hospital should still be open. Three subthemes emerged. The concern of the family members of mentally ill inmates, their treatment, and the benefit to both the jail and the inmate if the state psychiatric hospital were reopened are discussed below.

Subtheme 1.1: Family concerns. Officer E stated, "We need another hospital. Many times the families have cut ties with the inmate and it's either a hospital or a jail." Several officers noted that when the hospital was open, it was the first place a mentally ill individual would be taken. Officer D noted, "When a family member calls the police on a mentally ill person, they wish they would take them to a place to get help, but since no hospital is open, they dump them in jail." Several officers shared their experiences with inmates who have mental illness and their knowledge of specific family concerns. One officer, who was not a participant in the study, is known to have a family member with mental illness who has been arrested at this facility. Many of the participants shared the concern for their fellow officer's family.

Subtheme 1.2: Treatment of mental illness. Participants vocalized positive viewpoints on the need for mentally ill inmates to be treated for mental illness. Officer O stated, "Until we get a hospital that can help these people, I don't think they will ever be

helped." Prior to the closure, mentally ill inmates could be sent from the jail to the hospital, but Admin A stated, "Now, we have become the new asylum." The jail becoming a replacement for the closed psychiatric hospital was repeated throughout the interviews, with 31% coverage.

Admin B noted, "I wish they would open Searcy backup, but I think that with the current political and economic climate, it seems very unlikely it could ever happen." The dichotomy of needing a hospital and yet believing the State would not provide this need was prevalent throughout the administrative interviews. In contrast, the officers' focus group held a belief that the state psychiatric hospital could be reopened. Officer D related, "The people who closed Searcy, as soon as it's their family member who is sick, who has mental illness, and they come here…that's all it would take. Bam. Searcy reopens." Officer E added, "They might open it when they find out we (are) running out of room at the jail for mentally ill." Officer H noted, "Why don't they use one of the prisons they are getting ready to rebuild? Use the old prison as a new psychiatric hospital. That could save money and jobs."

Subtheme 1.3: Mutual benefit. The state psychiatric hospital being reopened would help the jail staff as much as the inmates. Officer I: "A (mentally ill) inmate needs to be medicated. Okay? But we can't give him the same meds and attention like a hospital. So, is the inmate better off here? If the hospital was open officers would have it better and so would they (mentally ill inmates)." The belief that both the mentally ill inmates and the jail staff would benefit was shared by both the focus groups and the administrative interviews. Admin A: "A lot of times they act out, but they are not the

enemy. They just are sick, and if the hospital was open we could focus on those who have criminal backgrounds, not mental illness."

Theme 2: Training

I asked each participant the following two questions which led to a discussion of training:

1. Describe the training that you received regarding inmates with mental illness.
2. What training would adequately prepare an officer to provide care at the level it was provided at the psychiatric hospital?

Not all participants received formal education or training although all noted that they had received real-life training from their experiences with mentally ill inmates. Officer A noted, "(I) went through crisis intervention training (CIT) and also got trained in mental health first aid. That helped a lot to understand how to respond to people in crises." Admin A reported attending a 40-hour course at the University of South Alabama leading to certification to train other officers. "The course I had was very extensive; in fact, I think that all of the officers should take the 40-hour course because it explains the types of mental illness and even what individuals may be experiencing when they are acting out. It gave me a new perspective."

Officer F noted, "I had CIT training, and that's really the main training any of us here have. If you haven't had CIT yet, you probably aren't thinking of inmates with mental disease any differently than any other inmate." Admin B stated, "CIT is the main training we try to provide, but because of staffing shortages we have some officers who

have been waiting for years to receive it. Our goal is to have every officer that works at the jail trained in CIT."

Officers B, C, D, and E noted they were all on the same waiting list for training. Officer C stated, "We all have been on the list for about six months. We got excited, but it keeps getting pushed back because of coverage. Even if they have it scheduled, if there isn't coverage on that day you just have to miss it." Several of the officers shared a similar complaint, noting that their training was also pushed off several times before they could attend. Officer I reported completing CIT training several years ago, but it was not as useful as hoped. "CIT is geared more for police officers on the street. To give them options on how to help them (get) to a hospital. But nothing like this is how you deal with them." Officer F agreed, "We need a CIT that is geared towards correctional officers, because we are not dealing with people on the street. Our people are in a jail cell filled with other inmates, and sometimes they are really provoked by them."

A CIT training course focusing on corrections would be beneficial, as all 17 participants of the focus group agreed. Officer P stated, "If you go to a CIT class for corrections it should break it down on what to look for, body language, marks on the arms for cutting and stuff like that." Those officers who have had CIT appear to find it useful, but not all the material pertained to their specific job duties and the population they work with.

Officer N reported having a degree in psychology. "I had CIT training, but overall my degree in psychology has been more useful to my work." Officer O noted, "My degree is not in psychology, but I took a few classes and I agree with (Officer N);

having college education in psychology is very useful if you work with mentally ill inmates." Only four of the participants earned a college degree, but all of them believe their education was helpful. Even with a college degree, however, it was noted by all participants that a jail could not provide training that would allow it to serve as a psychiatric hospital. This led to the following discussion regarding whether a mentally ill person should be at this jail.

Theme 3: They Don't Need to be Here

Three questions drove the discussions that led to the results under 'they don't need to be here'.

1. How has the closure of the local psychiatric hospital impacted your daily experience?
2. What areas of mental health services offered at the jail appear helpful, and which would benefit by being improved?
3. What can be done to achieve improvements in mental health services at the jail?

Officer A answered the first question stating that the closure led to more inmates. "They actually bring in more sicker people now that don't necessarily need to be here in the jail." There was an overwhelming consensus that the closure of the hospital led to an increase in acuity. Officer D stated, "They don't need to be here. They should be in a hospital, not here." Officer B: "They may have committed a crime, but most have very minor charges, like loitering or wandering abroad. They don't belong here, because they need to be in a hospital for an illness."

Officer I noted a difficulty with treatment times at the jail, noting that sometimes an officer would see an inmate that had previously been incarcerated, but the mental health staff might not be able to see them until later. "I mean, we know if somebody is crazy. If they have been in (mental health housing) 400 times, then they will need to be medicated. But for some reason, we can't medicate them the way they do in a hospital. When I took someone to (an emergency room) they shot him up and he calmed down in a hurry. But here, it could be a while before they get on meds, and it's not like they were compliant with meds in the free world." This belief that mentally ill inmates stop taking medication once they are released to the general public was shared by the focus group. Officer H stated, "It's not always bad behaviors that lead to them being here. These people need help, and when a good Samaritan sees they need help, they call the police and they bring them here."

Subtheme 3.1: More time. Officer J reported, "This isn't the right environment for them. A lot of times they want to talk to you, they probably just have a little issue." Officer F shared, "They (mentally ill inmates) are really hard to deal with. And when you know they have a history of mental illness then you have to deal with them a certain way. It's just really hard to deal with them because it takes more time." Admin B stated, "The mentally ill take up more than their fair share of (the average) inmates time with our mental health staff obviously, the medical staff. Any group here that takes more time to manage their behavior and address their needs is significant. We have to keep 2 to 4 officers at a time in their quad and that is not enough. We really need at least 4 officers due to transportation, maybe not on every single shift, but it is a drain on our resources."

Inmates with mental illness take additional time due to their circumstances. Officer A shared, "Because inmates with mental illnesses require more attention in general than just normal general population inmates. Their needs are more extreme, they require more attention." The focus group agreed, with Officer C adding, "When someone disruptive comes in, it slows down the whole process. Everyone's got to stop what they're doing, lock everyone down. We don't have the manpower to make sure the person is all right. Because we don't know why they are acting out." It takes additional time to talk to an individual to see if their behaviors are due to an illness or due to anger, and additional time is in short demand among these correctional officers.

Officer L noted that when time is provided for the mentally ill inmate, good outcomes follow. "You have to be patient with them and get on their level. If you talk to them right then most of the time you can get them to do what you want. Sometimes they'll just have a little issue." Officer F summed it up: "They are just really hard to deal with. If we had all the time in the world we still can't treat their illness, and that's what they need."

Subtheme 3.2: Poor outcomes. Several stories were shared regarding bad outcomes among the mentally ill population. Admin B noted, "We had one bad case of a mentally ill 18 year old brought here that should not have been. He remained for 30 days, had gone thru 2 different group homes. He was two to three hours away from where he needed to be. He became a ward of the state. On day 31 a $50 fine was placed on him and since he couldn't pay it he had to be held in the jail. He became noncompliant, was acting out. Got seriously injured in a confrontation with a group of

officers. Became paralyzed from the neck down. A tragic situation all around, he never should have been here." Wards of the state receive financial support to live in group homes, according to Admin B, but the group homes will not use the ward's funds to pay any fines in the jail.

Officer I noted, "If the inmates were in a hospital they would get medication and they would follow up to make sure they take it in the community. Just this year there was an inmate who came in after they made their way up to the top of (a high rise building near the jail) and attacked a lady. They had to use SWAT team to get her rescued and now this guy, who is seriously a mental patient, is in jail." Officer P added, "It wouldn't have happened if they were on their medications. They are off their medications and not in the right frame of mind when they commit crimes. It's because they did not know what they were doing."

Officer A shared an event. "We had a guy sent to us (jail) for arguing with his roommate in a mental health group home that's run by the mental health center. They sent him because they didn't want to deal with him. He was here for like a month and then was sent back. We tried to send him to a psychiatric hospital up north (8 counties away) but they were full, so he went back to a group home. About a month or two later he was back after he stabbed a different group home patient in the eye. The guy died, now this kid's charged with murder, and he should've been in a hospital to begin with. People like that don't belong here!"

Theme 4: Mental Health Housing/They Can't Function in General Population

Two questions drove the discussion regarding the housing of mentally ill inmates. They are:

1. How does the jail determine who needs mental health housing versus general population?
2. How adequate is the available bed space for inmates with mental illness?

The following section focuses on the availability of space dedicated to those with mental illness and on the need for mentally ill inmates to be housed outside of general population.

There was a distinct split in the opinions of those administrators who were interviewed separately and the officers who participated in the focus group. Officer A stated, "You have housing for 16 people and sometimes there are up to 25 people. Makes for overcrowding." The space for 16 individuals is broken up between two mental health units, each of which has eight cells. Each cell contains two bunks, although at times the need for additional beds leads to cots being placed on the floors of the unit. Officer G reported, "It is over-crowded. It is extremely over-crowded. There is less space in our units than when Searcy was open." Officer H noted that if more of the mentally ill inmates could be isolated to a unit with other mentally ill inmates, there might be improved behaviors among the jail. "Isolating them together works, but there's only a few beds to do that right now. We should add onto the jail, but it'd be better if they opened the hospital again."

Officer J shared, “Right now we are very short. We need more beds. Right now we have 4 inmates we can’t house with anyone so that takes 4 cells out automatically. That means we have to put 3 and 4 in the other cells.” Officer J explained that many mentally ill inmates who were noncompliant with medication are required to be housed in a cell alone. This would mean that one bed would be occupied and one would be empty, which resulted in a different perspective for administrators.

Admin A shared this perspective, “I think they actually take up too much space. We have five or six cells with only one inmate each. That’s a waste of space.” Admin B shared a similar thought, “Actually we have plenty of beds, some are actually empty.” This differing of opinions, with administrators feeling they had too much space, versus officers feeling that space was too limited can be explained due to perspective, which will be addressed in Chapter 5.

Officer A stated, “They can’t actually function with the rest of the population. Sometimes they do for a little bit when they get here, because they have mental health workers that have to interview them, do background and then determine who goes to GP (general population) or who goes to special housing.” Admin B agreed, “Our officers (in general population) may use more force, because they don’t recognize where a (mentally) ill inmate is coming from. Not that they would hurt an inmate, but in GP you use a lot more forceful language and behavior than in a mental health unit.”

Officer C stated, “They don’t respond to structured environment as well as, respond differently. We have to engage them a different way. Normal people respond to stimuli such as you give someone an instruction “Go over here and sit down” and they

listen to that. Those with mental illness you may have to come at them more simple "Come over here and have a seat please." They may respond poorly. You learn through trial and error. It could change day-to-day or even hour-to-hour. If a person has a mentally illness crisis they are going to act different than if it were a working crisis. They are still suffering from their mental illness." This acknowledgment of the need for different methods of communication with inmates who have mental illness is insightful. It also speaks to the earlier theme of inmates requiring additional time.

Officer I noted the difficulty of finding mentally ill inmates in general population despite efforts to keep them housed in separate units. "But that docket nurse, if he's acting out or doesn't answer the questions the right way they'll end up in mental health or if there is something in their behavior or he's not acting right, they'll notify mental health if it's day time. But come night time, they'll slide right on through general population, it takes them to start acting foolish back there to get moved to mental health." There have been times that an individual accumulates additional charges due to fighting with other inmates or officers, and Officer I notes that once they are moved to mental health housing they improve. "But they are still stuck with extra charges sometimes."

Theme 5: Public Awareness

I asked each participant if the impact on the jail was known to the members of the community. The overwhelming majority of individuals stated that the public was ill informed. Only one administrator believed the public was aware, stating, "If anyone watches the news or reads the news, they can follow along." All other participants

believe the community is largely unaware of the impact that the jail experienced upon closure of the hospital.

Officer D stated, "I don't believe they know realize the impact of the situation until something happens to one of their family members by someone with mental illness and then a light bulb goes off. It was not a good decision to shut down our last mental hospital that we had." Different officers used the phrase 'They don't have a clue what's going on' six separate times. Officer G stated, "The average member of the community doesn't not know what happens in here (jail)." Officer I shared, "Even the officers who work on the other side don't really get it." Officer I's point was to note that only those officers who work with the mentally ill regularly have an understanding of the impact the closure had on the jail.

Officer J added to the belief that the community was unaware of the impact of the closure, stating, "I have family that has no idea what we go through. I don't share it because it's depressing to think about. People who do not work with them do not have a clue." Officer M believes most people do not think about mentally ill people being incarcerated at all. "The average person is not aware of how many mentally ill are in jail. They don't understand it's a crisis in here."

Theme 6: They Didn't Think It Through

The single question that sparked the lengthiest discussion was 'Do you believe those who closed the hospital considered the impact on the jail?' The administrators were more definitive in their statements. Admin B said, "There was zero discussion or dialog between the state and the jail prior to the closing of Searcy." Admin A shared,

"They certainly did not discuss it with us. I'm appalled that they didn't prepare us for this; they seem to be in denial of the consequences of their decision." Admin C added, "I understand, that in the long run, it is not their immediate concern for the organization." The administrators could be more definitive, as they were in a position to know the apparent lack of communication that occurred.

The officers, however, were not as certain. Many officers in the focus group stated their belief that the individuals who closed the hospital did not consider the effect on the jail. Other officers were more emphatic, such as Officer D, who shared "I doubt it. It was not a good decision, so I can't imagine they spent time thinking it through." Officer I added, "I don't think so. Every (decision) is dealing with money. It was easier to get the people out of the hospital than upgrade that facility. There is always money someplace, though; they got a new VA building."

Officer J stated, "No, no. There is no way they thought about it. If they had thought about it (they would know) we as officers are not as equipped as those at Searcy. And they would have left it open. Those officers (at the hospital) that worked there worked there all the time and had the training to deal with the patients. Had I not been dealing with this kind of stuff for 10 years it would be very hard for me to come in here. There is no way."

Summary

This chapter examined all aspects related to the study and the method in which it was conducted. Information was provided for the participant population, the way the data were collected, and how the data were analyzed. The major themes were presented,

each of which was chosen based on a specific phrasing used by the participants or an overarching theme. The six themes include:

1. Open the psychiatric hospital back up
2. Training
3. They don't need to be here
4. Mental health housing / they can't function in general population
5. Public awareness
6. They didn't think it through

The use of quotes directly from the interview participants was used to support the themes as encountered in the data. Factors and precautions were taken to improve the trustworthiness of the data. In Chapter 5, the interpretations of the findings are presented. The limitations of the study as well as future recommendations for additional research are addressed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I conducted this study to close the gap in the literature regarding the impact of closing a psychiatric hospital on a local correctional facility. The literature suggests a continued move away from psychiatric hospitals and towards deinstitutionalization and community-based care (Prins, 2016). As psychiatric hospitals in the United States continue to be closed, future correctional officers at local facilities may be impacted. By gaining specific and detailed information regarding the impact of the lived experiences of correctional officers, administrators, and inmates, the study may provide useful insight about specific outcomes of this form of TI. Implications for positive social change include improving community safeguards at subsequent psychiatric hospital closures or possibly preventing future closures.

The study produced six major themes to illustrate the lived experiences of correctional officers, administrators, and inmates at a correctional facility in the wake of a local psychiatric hospital closure. The findings showed significant support for reopening the hospital. Another key finding was the lack of training for many of the staff. Those who had obtained training found it useful although even among those who had training there was a general belief that the training should be more specific to correctional institutions.

The theme of mentally ill inmates needing treatment in a more clinical setting was another finding, which led to the theme of mental health housing at the jail. The majority of officers said the housing was inadequate for the mental health population at the jail,

while the administrators said the allotted space was adequate. The final themes represented the officers' belief that those who closed the hospital did not consider the jail and that the public was not aware of the impact felt by the officers at the jail. These findings will be discussed in detail in the remainder of this chapter.

Interpretation of the Findings

Six major themes emerged from the interviews conducted during this study:

1. Open the psychiatric hospital back up.
2. Training.
3. They don't need to be here.
4. Mental health housing/they can't function in general population.
5. Public awareness.
6. They didn't think it through.

The study findings support the key results presented in Chapter 2's literature review. Researchers have noted a correlation between the closure of a psychiatric facility and TI (Lamb & Weinberger, 2016). The findings of the study support this relationship, as officers in the study reported an increase in their workload in the mental health units of the jail after the closure of the hospital. Another finding of the study was the belief that financial burdens may have impacted the need to close the hospital. The literature supports this finding, with one set of authors noting that financial obligations increased significantly as the level of expected care rose among psychiatric residential facilities (Tillotson & Colanese, 2016).

The literature regarding PRT shows the low QOL related to incarceration (Farkas et al., 2017). The findings of this study support this finding, as participating officers stated that mentally ill inmates do not belong in jail. Another aspect of PRT literature is the focus placed upon the community to provide care for mentally ill patients (Perry, 2016). The participants noted the support of this ideal, sharing a desire for the public to become better informed of the mentally ill inmate's experience. I found a desire among participants to care for the inmates who suffer with mental illness even if it takes additional time and energy to do so. The findings of the study support that when a hospital is not available inmates will still need to be cared for.

The findings related to the lack of public awareness regarding the experiences of correctional officers, administrators, and inmates are supported by the literature on the gatekeeper theory (Soderberg et al., 2015). Information being held by the gatekeeper (here, the state) can lead to a situation wherein the gatekeeper only permits positive information to be released (Adamson et al., 2016). The gatekeeper theory was supported by the lived experiences of officers who noted that the general public was unaware of the problems faced by staff and inmates at the jail. It was noted that even among family members there was very little awareness of the issues regarding mentally ill inmates.

When a single party controls all the information available for public consumption, the social contract between citizens begins to fail (Adamson et al., 2016). The findings support this assertion. State-run psychiatric facilities are closed by the state, and during their operation and closure, they are required to report to the state officials, or themselves (Adamson et al., 2016). Officers in the study shared that while the closure of the hospital

impacted the jail, there was never any mention of the impact when the state discussed the closure.

The problem with a gatekeeper dilemma can lead to more than simply disinformation. The overall media dissemination of only positive facts can skew the public discourse regarding psychiatric hospitals and their usefulness. Sharing only positive information with the public may give an impression that no negative facts exist. Gatekeepers can also lead to harmful public policy outcomes that can negatively impact the QOL among the mentally ill (Adamson et al., 2016).

Other researchers have found evidence showing the reluctance of mentally ill inmates to accept change (Farkas et al., 2016). The findings of this study are consistent with this research, as the data showed additional time and attention being required among the mentally ill inmates due to their change in treatment location. The literature notes a propensity for families to become emotionally exhausted, leaving mentally ill individuals to care for themselves (Lamb & Weinberger 2016). Officers in this study reported this same behavior among the family members of mentally ill inmates. The officers noted that at times a family member would be responsible for calling the police to incarcerate a mentally ill family member, noting that without a state psychiatric hospital there were no other options.

The literature supports the notion that reduced bed space can have a negative correlation with higher suicide risk, homelessness, and disposition to violent crime (Allision et al., 2017). The study findings showed that dedicated bed space for mentally ill inmates in the jail was not sufficient, a belief shared by all officers in the study. The

administrators held a different viewpoint, and one that was explained by Admin A. Admin A noted that when the number of beds was assessed each day, they often found the greatest number of empty beds were in the mental health unit. The explanation was seen in the study findings, where officers noted a need to house many mentally ill inmates in a single occupied cell due to their behaviors.

The officers recognized the need for additional beds dedicated to the mentally ill inmates. Even though the mental health unit held many cells containing two beds, only one inmate was assigned to each cell. Admin A noted that this situation might have resulted from a gap in communication, as he understood the need once he examined the officer's point of view. This example highlights the need for research regarding the impact of a psychiatric hospital on a correctional facility.

I used the PRT theory as a theoretical framework for this study. One of the goals of PRT is to improve training in medical and psychiatric care (Mechanic, 2015). The findings of this study support a need for improved training. The officers in the study routinely noted that while training was provided, they often did not feel adequately trained. The CIT training embraced by the law enforcement community attempts to provide training for crisis intervention (Mechanic, 2015). Although officer participants said that aspects of this training were useful to them, they expressed a desire to have a training dedicated strictly to correctional officers.

One officer noted that a training seminar for correctional officers would not be entirely applicable to a police officer, and others in the focus group supported this point. Those who participated in this study seek training designed exclusively by, and for,

correctional officers. Providing training that is focused only on correctional officers may allow for more useful information to be passed to those who work in correctional facilities.

Limitations of the Study

I faced several limitations in this study. Among these were the available participants, the location and time restraints imposed by the officers, the training each officer had undergone, and the personal background of each participant. This study was limited to the lived experiences of 20 staff at one local correctional facility. Specifically, the study was limited to a single facility in Southern Alabama and is thus geographically limited. Psychiatric hospital closures have occurred in many other states (Prins, 2016). The time required to survey each one argued for this limitation. Information obtained may or may not be similar to the lived experiences of officers at other facilities, especially facilities that are in different states and regions. Even within the state of Alabama, there are multitudes of laws, policies, and standards that vary from facility to facility. Thus, findings may not be applicable to other institutions in the state. The research location for this study was a jail, and the impact of the closure on a jail, which has a transient population, may be markedly different from a prison that may be located nearby.

Participants in future studies may provide differing information, experiences, and results. The use of 20 staff members at the jail for the study's sample met saturation requirements, but this does not mean that the experiences of the participants are

comprehensively representative of every officer who works at this facility (Hennink et al., 2017). A future study at the same facility could provide additional themes.

Another limitation in this qualitative study was the limited participant sample. I was only able to interview officers. Nurses, mental health staff, chaplains, and volunteer staff could have shed additional insight into how lived experiences were impacted by the closure. The scope of this study is limited to the impact on correctional officers, administrators, and inmates.

Recommendations

Policy and Training

This study has presented valuable information in numerous areas, and many areas warrant recommendations. I recommend consideration of the reopening of a state-run psychiatric facility. Numerous stories were shared within the interviews and in this research regarding negative outcomes stemming from mentally ill inmates. Related to this recommendation is a need for additional housing dedicated to the mentally ill inmates. The research provides ample examples noting the difficulty of housing some mentally ill inmates within the general population.

Another recommendation is to provide correctional-specific training to the correctional officers. The training currently provided to the officers is deemed useful and beneficial, but lacking a component to allow an application to their day-to-day work duties. The participants of the focus group desire a training seminar provided by a correctional officer, current or former.

Future Research

I recommend that future research should be conducted with a larger number of participants over a larger geographical region. Studies focusing on other aspects of correctional care, such as medical, mental health, religious, vocational, or volunteer staff may benefit from the overall understanding of the impact of a hospital closure. Researching other factors regarding the incarceration of mentally ill inmates is an additional recommendation, as the literature suggests that factors other than a closure have an impact on the incarceration of mentally ill inmates.

Another issue meriting future research is suicidality of mentally ill individuals. A future research study that would benefit the community would be determining if a correlation exists between suicidality and hospital closures. A specific subset to research could be the mentally ill incarcerated individual. Determining if suicide attempts increased after a psychiatric hospital closure could shed new light on a forgotten population.

The recommendations for future research have positive social implications and could result in strides forward in the knowledge regarding hospital closure implications. Research aimed at these recommendations could limit future incarceration of the mentally ill. Future individuals who are entrusted with the care of the mentally ill population can reference the recommended research to make informed decisions regarding closures.

Implications

This study has provided several positive implications for the creation and implementation of positive social change. There have been negative outcomes listed by participants within this research and within the literature, which show the impact of mentally ill patients becoming snagged in the legal system. This study is a leading step towards future empirical qualitative studies aimed at impacting the design of future mental health policy regarding mentally ill inmates.

The goal throughout this research is to create positive social change by examining the impact a hospital closure has on a local jail. The use of a qualitative instrument met the goal to capture empirical evidence. While the prevention of future hospital closures would be a positive social change, the study persists in providing additional measures. The increase of mental health housing within correctional facilities can be a temporary stopgap measure to allow for the mentally ill inmate to be safeguarded from traumatic events within a correctional facility.

The lowest level of QOL listed by PRT theorists is incarceration. Thus, the incarceration of an inmate with mental illness can be a traumatic experience. Taking steps to decrease the trauma by providing adequate and separate housing for those inmates with mental illness will be a positive social change.

Another positive social change outcome from this study is an increased awareness of the need for improved training among correctional officers. Improved interactions between correctional officers and the mentally ill inmates will increase the chances of successful treatment and can ultimately lead to rehabilitation. Through the gathering of

data, analysis, and offered recommendations, I hope to provide the community with an understanding of the lived experiences of officers, administrators, and inmates in the wake of a psychiatric hospital closure.

Conclusion

The closure of psychiatric hospitals has had a significant impact in America (Sylvestre et al., 2017). Deinstitutionalization has led to transinstitutionalism, and some mentally ill patients have become incarcerated (Lamb & Weinberger, 2016). Given the financial burden placed upon states, additional hospital closures can be anticipated. The present study has examined the impact that a psychiatric hospital closure had on a local jail by examining the lived experiences of the staff. The increased understanding of the experiences of correctional staff may serve to focus lawmakers on the incarcerated mentally ill. The study provides rich, full data to steer safeguards preventing a similar impact on other facilities.

The need to focus on the care of the mentally ill is demonstrated by the recent Affordable Care Act (Kennedy-Hendricks et al., 2016). Specific areas of need have been discovered that communities could focus on to improve mental health care. These include avoiding future hospital closures, improving correctional mental health bed space, and providing correctional-specific training for staff at the jail.

This study may inspire additional empirical studies to explore the lived experiences of mentally ill inmates by providing qualitative and quantitative data gathered from this protected population. Inmates are often overlooked as a forgotten population, which has led to a few research studies being conducted. Additionally, the

classification of a protected population can intimidate researchers and may prohibit research in an underserved population. The more information that is gathered on the impact of hospital closures on correctional facilities, the greater the opportunity to mitigate the negative outcomes on mentally ill patients across America.

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Appendix A: Interview Questions

Questions for Correctional Officers:

1. How do inmates with mental illness impact your daily experiences?
2. Describe the training that you receive regarding inmates with mental illness.
3. If the local psychiatric hospital were still open, how would the experiences of inmates with mental illness at the jail be different?

Questions for Administrators:

4. Using a scale of 1-10, how comfortable are you with the level of mental health training of your officers?
5. What budgetary impact exists due to inmates with mental illness?
6. How has the number of man-hours related to staffing the mental health units changed since the closure of the local psychiatric hospital?
7. What administrative changes have you experienced since the closure of the psychiatric hospital?

Questions for both Correctional Officers and Administrators:

8. How does the jail determine who needs mental health housing versus general population?
9. How adequate is the available bed space for inmates with mental illness?
10. How has the closure of the local psychiatric hospital impacted your daily experience?
11. What training would adequately prepare an officer to provide care at the level it was provided at the psychiatric hospital?

12. What areas of mental health services are offered which appear helpful, and which would benefit by being improved at the jail?
13. What can be done to achieve improvements in mental health services at the jail?
14. Do you believe those who closed the hospital considered the impact on the jail?
15. Is the impact on the jail well known to the members of the community?

Appendix B: Demographic and Salient Factor Questionnaire

1. Please list your gender: _____.
2. Please list the number of years you have worked in corrections. If you have worked for less than one year please list one (1): _____.

For the rest of the questions, please circle the correct answer.

3. Do you work with mentally ill inmates?
    a. Yes
    b. No
4. Do you believe it is appropriate to house mentally ill individuals in a jail?
    a. Yes
    b. No
5. Do you enjoy working with mentally ill inmates?
    a. Yes
    b. No
6. Does any member of your family have a mental illness?
    a. Yes
    b. No