2020

Community-Based Workers' Treatment and Relationship With African American Men With Dual Diagnosis

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Walden University
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Abstract

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Philander Smith College, 1998

Dissertation Submitted in Partial Fulfillment

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Abstract

Helping professionals have a role as service providers when working with African American men with dual diagnosis and incarceration histories. The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment and established a helper/helpee relationship with this population of African American men. Hirschi's social control theory provided the framework for the study. Semistructured interviews were used to collect data from 9 helping professionals who worked with this population in the Northeast United States. Yin's 5-step model for case studies was used for data analysis and thematic coding. Findings indicated that professionals lacked competency in accessing community resources. Also, participants reported a need for an integrative dual diagnosis treatment model, cultural inclusivity, and an intrinsic pull that drives the helper/helpee relationship. Findings may be used to help practitioners better understand how to provide treatment to this population and improve system continuity of care. Findings may also be used to contribute to social change to shape future interventions and promote further research on this topic.

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Dedication

This dissertation is dedicated to Christopher “Bolo” Haley. My big brother, my friend, and my biggest cheerleader. Rest in Peace and Power. I love you!!

Acknowledgments

This has been a long journey. I could not have done this alone. It takes a village, and I want to acknowledge the people of my village. First, I want to thank the holy creator to whom I give praise. I want to thank my wife Melinda, “Mindy G.” Haley, Esq. You inspire me daily and have pushed me since the day I met you. I thank you for my beautiful kids (Drea and Haiden). Their future is what drives me to be the best me possible. Thanks to my parents, Gloria and James, for exemplifying hard work and resiliency. Thank you, Dr. Avon Hart-Johnson, for accepting me as your student and always expecting the best out of me. You saw my potential and held me accountable when I looked for every reason to stop.

Dr. Chermack, thank you for sitting with me on this journey. Dr. Benoliel, you always had positive words at our residencies. You are approachable and willing to share your experiences. To my peers, who made me rise to the occasion and allowed me to vent (Eli, Kirby, Dr. Xellex, Erin, Soya, and Drew/Backdoor). To Turrell, Arkansas. Who would have thought the kid from the cotton fields would be here? To my brothers of Omega Psi Phi Fraternity, Inc, Star in the East Lodge No. 1 Prince Hall Masons, and Suakim No. 60 AEAONMS Prince Hall Shriners. To everyone who suffered due to my selfish endeavors. I sincerely thank you and love you all.

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Chapter 1: Introduction to the Study

High incarceration rates of African American men in the United States among those who have co-occurring mental illness and drug addictions have created a public health concern among helping professionals who manage community-based treatment programs (Lamberti, 2016). African American men have one of the highest incarceration rates in the United States (Bond & Drake, 2015). According to the most recent U.S. census, an estimated 16% of the 13.2% of African American men who reside in this country have a mental health diagnosis (Mental Health America, 2019). This population generally receives lower quality mental health care than other ethnic groups and also lacks access to culturally competent service providers (National Alliance on Mental Illness, 2019). Researchers have not established what drives the high attrition rates of treatment for these clients. Scholars have indicated that there are many primary deterrents to these individuals accessing treatment, including lack of trust in providers (Ross, 2016), a need for helping professionals with similar ethnic backgrounds (Rich, Harris, Bloom, Rich, & Corbin, 2016), misdiagnosis (White, 2017) and a need for culturally sensitive providers (Hack, Larrison, Bennett, & Lucksted, 2019). Helping professionals who work with African American men with a history of incarceration and severe mental health disorders have found that this population also has pervasive coexisting diseases (Al-Rousan, Rubenstien, Sielene, Deol, & Wallace, 2017). Professionals in the clinical field refer to clients having a mental illness and substance misuse as dual diagnosis (American Psychiatric Association, 2013). Only 50% of African American men with dual diagnosis seek and maintain treatment from community-based treatment facilities (Dixon,

Holoshitz, & Nossel, 2016). Helping professionals working with this population have come to recognize the correlation between noncompliance to treatment and recidivism (Buckmon, 2015). Researchers have shown that when attendance in treatment is sporadic, the risk for recidivism is high (Dias, Waghorn, Kinner, Ware, & Heffernan, 2018).

Although recidivism and dual diagnosis of African American men were the social problem addressed in this study, the focus was the role of helping professionals and their services in providing culturally sensitive treatment in community-based facilities for this population. Gaining insights in this area may assist helping professionals in identifying the culturally sensitive areas that are opportunities for enhanced training and skill-building to support this population of African American men. Additionally, a better understanding of how helping professionals provide services to this population of African American men may be used to address the problem of high attrition rates and the challenges of inconsistent services (see Browne et al., 2016).

Background

Helping professionals who administer services to African American men with dual diagnosis have experienced mixed results using community-based programs (Huz et al., 2017). These professionals have achieved optimistic results by using community-based program models when working with this population realizing declines in criminal offenses, parole violations, and incarceration rates (Bond & Drake, 2015; Browne et al., 2015). Landess and Holoyda (2017) indicated that many helping professionals have diverse skill sets with comprehensive knowledge, which is useful across systems of care (e.g., mental health, substance abuse, and criminal justice). Browne et al. (2015) also

suggested that these workers have been successful in using alternatives to incarceration when they have diverted those with mental illness and substance misuse to specialized treatment programs in the community.

Although study results have been promising, not all researchers have reported similar findings. Nijdam-Jones, Nicholls, Crocker, Roy, and Somers (2017) found that despite individuals receiving community-based services, their clients had increased police contacts, arrests, and criminal activity. Further, White (2017) indicated high rates of misdiagnosis among African American men. Other researchers have attributed misdiagnosis to helping professionals needing competencies such as cultural awareness or sensitivity (Hack et al., 2019).

The dynamics of African American men with incarceration records who also tend to struggle with social reentry may add to the likelihood of desisting from seeking treatment (Browne et al., 2015). Further, race, social stigma, and police contact tend to complicate the individual's ability to obtain or remain in treatment from community-based workers (Browne et al., 2015). Luckey (2016) posited that attrition rates related to individuals seeking assistance from treatment facilities might be related to the individual's inconsistent behavior and noncompliance. Luckey further reported that only 50% of individuals with a dual diagnosis linked to community-based treatment programs maintain treatment compliance after 1-year post-release from prison. It is unclear what role helping professionals play in assisting or encouraging their client base of African American men. Further, it is unclear what culturally competent techniques they use to promote attendance and compliance with this population. One challenge this group of

practitioners faces is that only 10% of the general population of substance users are in treatment (Corrigan, Krase, & Reed, 2017). Compounding this problem of inconsistent treatment are other factors that influence clients seeking treatment. These issues are beyond helping professionals' control, such as race, education, and a person's age, with African American men having the highest resistance to service utilization (Corrigan et al., 2017).

Helping professionals' cultural-related skill sets can enable them to support an already complex client base of African American men with dual diagnosis and a history of incarceration (Hack et al., 2019). However, these practitioners must use culturally informed interventions (Hack et al., 2019). These professionals may face problems in three key areas when working with African American men with dual diagnosis and incarceration histories placing them at risk for recidivism: (a) high levels of misdiagnoses within this population (White, 2017), (b) unexplained attrition and sporadic compliance with help seeking (Landess & Holoyda, 2017), and (c) a need to develop more significant and consistent cultural awareness (Hack et al., 2019).

In this chapter, I provide the background of helping professionals and their role in providing treatment to African American men in systems of care (i.e., criminal justice, mental health, and substance abuse). Next, I present the purpose of the study, research questions, theoretical framework, and the nature of the study. I also provide the definitions, assumptions, delimitations, limitations, and significance of the research. I conclude this chapter with social change implications and a summary.

Problem Statement

Researchers have documented that African American men are disproportionately impacted by disparities when receiving dual diagnosis treatment (White, 2017). Moreover, they are incarcerated at higher rates than other ethnic groups (Amasa-Annang & Scutelnicu, 2016) and receive less culturally competent help from professionals, which may lead to misdiagnosis and treatment attrition (Hack et al., 2019). When accounting for dual diagnosis and race, recidivism rates have spiked among this population (Zettler, 2017).

African American men are at risk for adverse outcomes related to their dual diagnosis treatment from multiple aspects, especially when they have a history of incarceration (Amasa-Annang & Scutelnicu, 2016; Browne et al., 2016; Hack et al., 2019; Landess & Holoyda, 2017; Ogloff, Talevski, Lemphers, Wood, & Simmons, 2015; Peters, Wexler, & Lurigio, 2015; Thompson, Newell, & Carlson, 2016; Zettler, 2017). Factors that influenced treatment outcomes and made African American men more susceptible to recidivism included mental illness and substance abuse (Ogloff et al., 2015). Ogloff et al. (2015) also reported living conditions, peer relationships, and socioeconomic status as variables related to recidivism. When researchers combined race and ethnicity with these variables, helping professionals experienced more problems related to consistent treatment with this group (Landess & Holoyda, 2017).

Several factors beyond helping professionals' control impede treatment seeking for African American men. For example, many African Americans tend to rely on informal methods of treatment rather than seeking formal treatment in community-based

programs (White, 2017). These informal methods include getting advice from family members or church counseling, which are not adequate when mental health and substance abuse issues are severe (White, 2017). Although some members of this population sought professional-based treatment in a formal setting, African Americans overall were less likely to engage in professional clinical treatment (Carson, 2018). Amasa-Annang and Scutelnicu (2016) specified that men in the African American community were less compelled to seek professional support than their White counterparts.

Another barrier to treatment-seeking is that helping professionals working in community-based treatment programs do not always render positive results. Nijdam-Jones et al. (2017) reported that individuals who seek help from this group of professionals had more police contacts, arrests, and criminal activity, which suggested that elements of the programs did not work effectively. Sue, Sue, Neville, and Smith (2019) indicated that another problem these professionals faced was intervention material designs were too generalized for those not of color. This problem was significant because workers did not design outreach material for African American men (Sue et al., 2019). Therefore, providers' outreach and recruitment strategies did not motivate these individuals for treatment (Sue et al., 2019).

African American men have other factors that impede treatment seeking than their dual diagnosis and incarceration history. These individuals sometimes have multiple identities that helping professionals do not understand (Ratts, Singh, Nassar-McMillan, Butler, & McColugh, 2016). For example, helping professionals may encounter clients who are African American men from the lesbian, gay, bisexual, transgender, and queer

community. This status adds to helping professionals' cultural awareness challenges. Providers are challenged as practitioners to maintain competence in their profession while raising their awareness of cultural subgroups (Ratts et al., 2016) as they work to help their clients achieve compliance with treatment.

Although the literature related to helping professionals who have worked with a high-risk client base of African American men with dual diagnosis has grown, I found a gap in the literature regarding understanding the role of practitioners who work in community-based treatment facilities and their cultural competence when working with African American men with a history of incarceration and recidivism risk. The social problem addressed in the current study was helping professionals who provide community-based treatment to African American men with dual diagnosis and a history of incarceration do not see a significant increase in positive treatment outcomes for this group. These clients continue to suffer adverse impacts of noncompliance with treatment, unaddressed dual diagnosis problems, and risk for recidivism. It was unclear how helping professionals interpreted their roles related to cultural competence, treatment compliance, and working with this high-risk population. Ross (2016) argued that helping professionals are responsible for providing services that account for these African American men's challenges.

Purpose of Study

The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment to African American men with a dual diagnosis, history of incarceration, and high risk for recidivism. By conducting this study,

I intended to better understand this social problem from the context of workers in community-based treatment programs. Understanding cases of helping professionals may provide the basis for further research to illuminate how helping professionals view cultural awareness, misdiagnosis, and unexplained attrition of their clients. Additionally, findings from this study may enable helping professionals to share best practices to enhance treatment provisions across multiple systems of care.

Research Questions

There were two research questions in this proposed study:

RQ1: How do helping professionals provide community-based treatment to African American men with a dual diagnosis, prior incarceration, and who are considered high-risk for recidivism?

RQ2: How do helping professionals establish a relationship with their client(s)?

Theoretical Framework

The theoretical framework for this case study was Hirschi's (1969) social control theory. According to Hirschi, individuals are less likely to engage in deviant behaviors if they have bonded with their community or established interpersonal relationships as support systems. I assumed that helping professionals aspired to develop professional relationships with their clients. Hirschi theorized that there are four tenets of social control theory (attachment, belief, commitment, and involvement) that are major components when conforming to social norms. Although many researchers have accepted Hirschi's theory, others have rejected the social control theory. For example, Akers (1991) countered social control theory based on Hirschi's omission of environmental

factors such as peer influences, race, poverty, and structural barriers. Despite these concerns, social control theory was chosen as the theoretical foundation for this study because of the proposition that individuals gain treatment compliance from community inclusion and building a relationship with their treatment providers. In Chapter 2, I provide further detail about social control theory and Hirschi's extension of Durkheim's (1897/1951) original work on social control.

Nature of the Study

I chose a qualitative methodology for this study. The goal was to increase the understanding of how helping professionals working at community-based treatment programs provided treatment to African American men with a dual diagnosis and incarceration history. These men were also considered a high risk for recidivism. The qualitative design was a single case study. Yin (2009) theorized that a case study is designed to explore, analyze, and evaluate a social phenomenon that is bound by place and time. I was interested in understanding the social phenomenon of community-based treatment administered by helping professionals for this group of African American men. Further, I was seeking to understand current practices (i.e., time) related to helping professionals who render treatment in a state in the Northeast United States (i.e., place).

Yin (2011) noted that in qualitative case studies, participants can be transparent and describe their experiences as the population under examination. Researchers can then analyze this data (Merriam, 1995; Patton, 2002; Yin, 2011, 2014) to understand the phenomenon. For triangulation, Yin (2011) argued that data should be gathered from multiple sources and linked to the research questions. I examined training materials (see

Appendix F) and public community-based program data (see Appendix G) to gain additional insight into community-based treatment. By accessing these data, I got a better understanding of the research problem and the population under examination. Case studies generate a considerable amount of data (Stake, 1995). I analyzed the data for patterns and codes to make sense of the information (see Bromley, 1986; Stake, 1995).

Definitions

In this section, I provide definitions for relevant terms and concepts associated with this study. This section provides the context-specific operationalization of commonly used terms. To the degree possible, I based the following terms on seminal or context-specific references.

Community-based treatment facilities: An outpatient treatment facility in which clients receive assistance such as substance use treatment, mental health intervention, and other social problem support (Goffman, 1961).

Criminal thinking: "Offense-supportive attitudes" or the justification for continuous offending (Caudy et al., 2015).

Criminogenic needs: Risk factors that lead to criminal behavior (Woodhouse et al., 2016).

Deinstitutionalization: A policy intended to reduce society's reliance on large residential facilities that congregate people for care and control under sequestered conditions, frequently against their will and often in centralized public accommodations (Goffman, 1961).

Dual diagnosis: A person having a co-occurring mental illness and substance abuse disorder (American Psychiatric Association, 2013).

Health homes: Facilities that serve as a hub for individuals to live in a private residence but continue to have access to their community-based workers for services (Huz et al., 2017).

Helpee: An individual who benefits from the helper to obtain the desired assistance in the context of social or human services (Riessman, 1965).

Helper/service provider: An individual who assists another individual in the context of social or human services (Riessman, 1965).

In-reach teams: Helping professionals who perform the same functions in prisons as helping professionals do in the community (Samele, Forrester, Urquía, & Hopkin, 2016).

Label avoidance: The avoidance of professional treatment because of public stigma (Dschaak & Juntunen, 2018).

Mental illness: A behavioral or mental disorder that causes significant distress or impairment of personal functioning (American Psychiatric Association, 2013).

Recidivism: Rhe recurrence of criminal behavior by prior offenders (Wolfgang, 1983).

Substance use disorder: The recurrent use of alcohol or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (American Psychiatric Association, 2013).

Assumptions

The first assumption that I made during this study was that each participant would provide exhaustive and honest answers to the interview questions. My next assumption was that social control theory was the appropriate framework for the study. Third, I assumed that participants met the inclusion criteria. Finally, I assumed that by narrowing the unit of analysis to helping professionals with experience working in community-based treatment programs with the identified group of African American men, I would collect enough rich, descriptive data for analysis and coding. The findings from this study may extend the knowledge base regarding this social problem.

Scope and Delimitations

The scope of this study was a purposeful sample of available and willing participants who met the inclusion criteria. The study was based on the participants' transparency and willingness to share their experiences regarding working with the impacted population. I used a purposeful sampling strategy to allow for an in-depth and detailed analysis of the context-specific processes related to helping professionals working in community-based programs (see Patton, 2002). This study was limited to helping professionals who work with African American men with a dual diagnosis and who are at risk for recidivism.

A delimitation of my study was the exclusion of helping professionals in other areas of human services (i.e., inpatient therapists, nurses in psychiatric hospitals, and residential counselors). I based my decision on the high prevalence of community-based helping professionals tasked with navigating the systems of care for African American

men leaving prison and seeking social reintegration. Bond and Drake (2015) asserted that these men have limited knowledge of community resources, have dual diagnoses, have experienced housing problems, and have high rates of unemployment. Bond and Drake noted that these issues are confounders for reoffending. Therefore, I explored how helping professionals provide community-based treatment to this at-risk population.

Limitations

One limitation of this study was the population sample. As a human service professional, I had many of the same experiences as my participants. Therefore, I had to manage researcher bias. To achieve this, I journaled feelings that emerged to abstain from interjecting my experiences as a helping professional. This helped me to refrain from voicing my personal opinions. I reflected on my personal experiences through journaling and peer debriefing to acknowledge my biases (see Patton, 2002) and not allow them to influence the data analysis. Moustakas (1994) theorized that researchers must take self-inventory and become aware of personal involvement with the subject matter and attempt to eliminate preconceptions through epoche.

Another limitation was the interview guide. My interview guide was designed for this study and was not a standardized tool. I followed the template created by Rubin and Rubin (2012) and incorporated their responsive interviewing model. Rubin and Rubin stated that researchers can enhance the interview guide's creditability by using the responsive interviewing model during the interviewing process. I used the tenets recommended by Rubin and Rubin when I used the response interviewing model. I ensured each interview was person-centered, built a rapport through conversation, gained

an in-depth understanding by not generalizing, and used flexible questioning to obtain additional data. Another way I managed this limitation was by getting feedback from my committee chairperson.

Another limitation was related to sample size and gathering data from a single data source. Yin (2014) noted that case studies rely on triangulation of data sources. Therefore, I viewed only interviewing participants as a limitation for this study. To overcome this limitation, I triangulated the data collected between the participants and compared their responses (Yin 2009, 2014). Although I only interviewed participants who worked in community-based treatment programs, I recruited a diverse group who worked in various capacities of human services (e.g., mental health professionals, substance abuse professionals, probation officers, resource case managers). By using this approach, I ensured confirmability (see Yin, 2014). Yin (2014) also theorized that researchers should compare the findings of the data to those reported in prior studies.

Significance

This study had several areas of significance. Findings contributed to a better understanding of the effectiveness of community-based treatment programs and the impact of the bond between helping professionals and their clients. The results helped me to better understand the insights of this group of helping professionals. My goal was to improve systems collaboration and reduce treatment barriers for African American men with a dual diagnosis and who are likely to reoffend. Helping professionals may use the results of this study to customize intervention strategies and address related gaps. Practitioners in the field of human and social services may benefit from understanding

cultural sensitivities, obstacles, promising practices, and the effectiveness of helping professionals who work in community-based treatment programs. Experts in the field may be better informed about why African American men desist or avoid formal treatment.

Social Change Implications

This study may contribute to social change by providing an understanding of what works for African American men who receive community-based treatment and remain active in these programs. I will disseminate the findings from this study to researchers and practitioners in multiple capacities related to criminal justice, human services, mental health, and substance abuse. Also, I will share this information with experts at professional training and conferences.

Summary

In this chapter, I introduced the study. I described the foundation for exploring the complex social problem of helping professionals working with African American men with incarceration histories, dual diagnosis, and high risk for recidivism. When combined with mental health and substance abuse problems, issues of recidivism are exacerbated (Zettler, 2017). I discussed how African American men are disproportionately impacted by recidivism and face more barriers when obtaining dual diagnosis treatment compared to the general population (see Moyes, Heath, & Dean, 2016; Thompson et al., 2016). I also described three primary barriers to treatment compliance. These barriers are lack of trust in providers, a need for helping professionals with similar ethnic backgrounds, and

the need for culturally sensitive providers (Blumberg, Clarke, & Blackwell, 2016; Hankerson, Suite, & Bailey, 2015; Rich et al., 2016).

I also provided information about African American men with incarceration histories and recidivism. Having a dual diagnosis contributes to recidivism; however, other factors such as poor living conditions, unhealthy relationships, and housing problems also increase recidivism rates (Ogloff et al., 2015; Peters et al., 2015). The social problem I addressed in this study was the lack of understanding of how helping professionals provide community-based treatment may result in them continuing to miss opportunities to administer formal community-based treatment to African American men. This population's sporadic attendance may be attributed to unaddressed dual diagnosis, environmental risks, and their potential danger of recidivism.

In Chapter 2, I provide the literature review and search strategy. I also describe the theoretical framework (social control theory) and its relationship to this study. In addition, I examine literature related to African American men who struggle with recidivism, dual diagnosis, help-seeking behaviors, treatment disparities, interventions, and other systemic shortcomings that adversely affect this population. I include a review of research methodologies and conclude the chapter with a summary.

Chapter 2: Literature Review

The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment for African American men with incarceration histories, dual diagnosis, and high risk for recidivism. Researchers have focused on the social problem of recidivism (Zettler, 2017). However, there was a paucity of research on the role of helping professionals and their relationship with dually diagnosed individuals with incarceration histories, which led to an adverse impact on treatment (Moyes et al., 2016). The social problem was helping professionals providing community-based treatment for this high-risk group of African American men with dual diagnosis and incarceration histories who continued to suffer adverse impacts of noncompliance with treatment, unaddressed mental illness, and high risk for recidivism. It was unclear how this group of helping professionals viewed their roles related to cultural competence, treatment compliance, and working with this high-risk population. If this problem persists, helping professionals providing community-based treatment will continue to miss opportunities to administer formal community-based interventions for this at-risk population. Sporadic attendance among this group led to unaddressed dual diagnosis, social isolation, unemployment, and potential risk for recidivism (Dias et al., 2018).

In this literature review, I describe the theoretical framework for this study. I also discuss dual diagnosis and recidivism in the context of African American men seeking help for mental illness and substance use disorders. This background provides an understanding of the challenges that helping professionals face in their work

environment. Next, I discuss the role of helping professionals and community-based treatment programs. Additionally, I provide an overview of community-based treatment programs (i.e., assertive community treatment and forensic assertive community teams) as intervention models. I also explore the phenomenon of recidivism and present an iterative review of the literature with a focus on the overpopulation of prisons as it aligned with mental health issues (i.e., deinstitutionalization), dual diagnosis (i.e., mental illness and substance use disorders), and the social implications of recidivism related to this population of men. I grounded this study in empirical data by synthesizing the literature that was specific to environmental stressors, genetics, and substance use as contributors to dual diagnosis as a social problem. I conclude the chapter with a summary of key articles that were germane to understanding the research problem.

Search Parameters

I used several sources to conduct my literature review. Among the multiple sources, I used for Internet queries were Walden University library databases, Google, Google Scholar, and Microsoft Bing. I used EBSCOhost, ERIC, PsychARTICLES, SAGE Full Text, Criminal Justice Periodicals, Pro-Quest, PubMed, PsycINFO, SocINDEX databases, and the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). Most of the articles and resources were peer-reviewed except for seminal works (e.g., theoretical framework), statistics from the Substance Abuse and Mental Health Services Administration (SAMHSA), state publications, and agency-specific literature. The following keywords and derivatives of root keywords were used in literature searches: *African American Men*, *barriers*, *black*,

black men, community-based programs, continuity of care, criminal justice, dual diagnosis, gender, helping professionals, incarceration, interventions, jail, mental health, mental illness, prison, race, re-arrests, recidivism, re-offending, risk factors, stigma, substance use disorder, and *treatment*.

Theoretical Orientation

The theoretical framework for this study was social control theory (Hirschi, 1969). I used this framework to understand better how helping professionals provided community-based treatment for African American men with a dual diagnosis and history of incarceration who were considered high risk for recidivism.

Social Control Theory

Hirschi (1969) suggested that the more a person's core belief aligns with their community's view of social norms, the less likely a person will engage in aberrant or criminal behaviors. Also, Hirschi described four elements of social control theory that are pertinent to this study: attachment, belief, commitment, and involvement. *Attachment* refers to the intrinsic link between a person and another person or entity. (Hirschi, 1969). Hirschi hypothesized that positive ties between two or more individuals or a secure attachment between a person and an entity could reduce the rate of criminogenic behaviors. Akers (1991) partially rejected this assertion. Akers argued that Hirschi's social control theory does not include critical factors such as mental health, substance abuse, and socioeconomic disadvantages that may influence behaviors. Therefore, Akers argued that Hirschi's social control theory does not fully explain criminogenic behaviors and social deviation.

The second tenet of social control theory is a person's belief system. Hirschi (1969) defined *beliefs* as a representation of a person's core moral acceptance underpinned with a specific ideology. Hirschi considered a belief to be intrinsic and guided a person's choice. According to social control theory, an individual's relationship drives their willingness to socially conform, which in the current study was related to African American men's willingness to engage in treatment. The next tenet of social control theory was commitment. *Commitment* refers to how the value placed on relationships can influence behaviors to erode the relationship between people or entities (Hirschi, 1969). Koski and Costanza (2015) provided evidence that substantiated Hirschi's theory by showing the more a client felt connected to their helping professional, the more the client's criminal behaviors decreased over time. Barlow, Gottfredson, and Hirschi (1991) corroborated Akers (1991) by showing that other factors such as lack of a safe living environment, quality education, and employment may also contribute to social nonconformity. I used these elements of social control theory to understand better the nature of helping professionals' struggles with clients' noncompliance or nonconformity and with managing these behaviors.

Lastly, *involvement* symbolizes how a person spends their time engaging in activities within their community. Hirschi (1969) theorized that an individual's involvement in meaningful activities not only strengthens social bonds but also reduces the time available to engage in criminogenic behaviors. This notion was challenged by Akers (1991), who countered that social control theory does not consider how peer influences can have a bearing on criminal behavior. Attachment, commitment, belief

systems, and involvement provided the framework to understand the social problem that helping professionals experience in community-based treatment programs when working with African American men with dual diagnosis and high risk for reoffending. Although researchers introduced social control theory through contemporary sources, this literature review would be incomplete without a discussion of Durkheim's (1897/1951) work on social control theory.

Durkheim and Social Control Theory

Durkheim (1897/1951) introduced the tenets of social control theory. Durkheim suggested that the more isolated a person is from an entity, group, or individual to which they belong, the less likely that person is to rely on those relationships. Durkheim wrote that when an individual does not comply with social norms, they tend to rely on self-serving behaviors that promote private interests. There is a connection between social control theory and understanding the nature of criminal behavior.

Counterarguments to Social Control Theory and Criminal Behavior

Although Durkheim (1897/1951) made a sound argument for social control theory, others have argued against it. Contemporary social scientists and researchers have argued about whether constructs of social control theory contribute to criminal behavior. For example, Smith's (1995) argument revolves around Hirschi (1969) not providing any data or motivation for an individual's criminogenic behaviors outside of the context of social control. Smith postulated that Hirschi's theory is flawed and had traces of bias. Along these same lines, Reed and Yeager (1996) contended that Hirschi failed to

recognize systemic barriers (e.g., racism, classism, and employment). as factors for criminal activities.

The foundation for social control theory is multifaceted. Through the work of Hirschi (1969) and other researchers who provided counterarguments to social control theory, I gained a broader understanding of the contributors to social deviance and recidivism. These theorists provided a broad platform so I could obtain a better understanding of how helping professionals foster community-based treatment relationships (e.g., participants actively engaging in treatment) through attachment, commitment, and belief systems. My findings confirmed three of the four tenets of social control theory. In the next section, I provide an overview of the population aided by the research participants who work in the helping profession.

African American Men Seeking Help

Researchers have explored why African American men are underrepresented in health care treatment (Abracen, Gallo, Looman, & Goodwill, 2016). In exploring African American men's help-seeking behaviors, Rezansoff, Moniruzzaman, Clark, and Somers (2015) attempted to understand why helping professionals had struggled with engaging and keeping this population compliant in community-based treatment programs when they had incarceration histories. White (2017) and Redmond, Watkins, Broman, Abelson, and Neighbors (2017) presented evidence that African American men have underutilized the system of care for mental illness and substance use disorders. The current body of research is inconclusive on why African American men stir away from formal dual diagnosis treatment (Fong, 2017; Hack et al., 2019), thus remaining at-risk for

recidivism. However, researchers revealed why attrition rates and non-compliance to treatment exist within this group. According to Redmond et al. (2017), African Americans are more likely to use informal supports as an intervention to address dual diagnosis problems instead of professional supports. White (2017) opined that the African American community were more comfortable using the church as informal support rather than professionals. Hack et al. (2019) stated that if helping professionals can identify dual diagnosis treatment; they can reduce disparities among African American men and understand what contributes to the inequality of treatment.

Although African Americans men were less likely to seek professional treatment compared to White men, there were barriers that discouraged them from seeking formal help (Hack et al., 2019). Priester et al. (2016) reported obstacles like service availability, disorder identification, service provisions, and insurance-related issues affected African American men seeking professional treatment.

Hack et al. (2019) stated that researchers should continue to explore why African American men refuse to seek professional help. In Lindinger-Sternart's (2015) study, the researcher discovered that African American men demonstrate a dismissive and detached attitude in public, but show vulnerability in the home. Dschaak and Juntunen (2018) suggested that African American men have a public and private persona. Dschaak and Juntunen (2018) went on to describe this unwillingness to seek treatment as *label avoidance*. The authors defined label avoidance as a person with a dual diagnosis who avoids professional treatment because of public stigma (Dschaak & Juntunen, 2018). Researchers have not come to a consensus on how to empower African American men to

seek professional help (Priester et al. (2016). Priester et al. (2016) continued that workers in community-based treatment programs are viable alternatives for African American men to try professional services outside of an outpatient setting. Another challenge this group experienced with maintaining treatment compliance was high recidivism rates among African American men with incarceration histories.

Recidivism

There are many documented reasons for recidivism. Buckmon (2015) defined recidivism as a person committing an act or offense which leads to re-incarceration to prison or the loss of liberty, generally, after one-year post criminal justice involvement. Wagner and Rabuy (2016) reported that there were an estimated 2.3 million individuals incarcerated in the United States. In another study by Alper, Durose, and Markman (2018), the researchers reported that 83% of all prisoners were rearrested within nine years of being released from prison. Lamberti (2016) contended that the cessation recidivism for individuals with a dual diagnosis is associated with the role of community-based workers.

Researchers have focused on quantitative predictors of recidivism, such as unemployment (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016); increased government spending on mental health and substance abuse treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). These predictors aligned with Zettler's (2017) report, when the author wrote that incarceration rates continue to rise among this group of people facing both health and environmental challenges.

Further, researchers reported that a person with comorbidities are more likely to reoffend than the general population (Fong, 2017; Ogloff et al., 2015).

Hack et al. (2019) identified dual diagnosis, inadequate treatment options, and stigma attached to help-seeking as determinants of recidivism which led to declines in professional treatment for this group of African American men. Woodhouse et al. (2016) identified these variables as *criminogenic needs* crimes. Woodhouse et al. (2016) defined criminogenic needs as risk factors contributing to criminal behavior and risk factors that are linked to the commission of crimes by a person with a dual diagnosis. In alignment with Woodhouse et al. (2016) findings, other researchers have presented evidence supporting criminogenic need as a confounder of recidivism (Mandracchia, Gonzalez, Patterson, & Smith, 2015). Caudy et al. (2017) opined that criminal justice experts can decrease recidivism by reallocating funds to treatment modalities designed to interrupt a person's psychopathic behaviors.

According to Walters and Lowenkamp (2016), treatment modalities are becoming more innovative and person-centered. The authors opined that helping professionals focus on the pathological nature of a person with a dual diagnosis to decrease incarceration rates. Caudy et al. (2017) described *criminal thinking* as risk factors that pathologize criminal behaviors as "offense supportive attitudes" that justify continuous offending. Further, Walters and Lowenkamp (2016), identified criminal thinking as a predictor of recidivism.

However, there was a debate about whether the evidence is enough to substantiate Walters and Lowenkamp's (2016) assumption. In a rebutting study, Walters (2016)

yielded disparities in the results related to the perception of criminal thinking and recidivism among subgroups. The author based these disparities on the disproportionate rates of recidivism based on gender, age, and ethnicity. Therefore, the researcher's perception of criminal thinking and recidivism was clouded by conflicting data, which discounted the impact of criminal thinking as a contributor to recidivism (Walters, 2016).

Reentry and Deinstitutionalization Links to Recidivism

Helping professionals working with African American men with incarceration histories must also be aware of the impact of reentry, deinstitutionalization, and how both contribute to recidivism (Carson, 2018). Specifically, African American men are overrepresented in the prison system and underrepresented in therapeutic settings (Marquant, Sabbe, Van Nuffel, & Goethals, 2016). Carson (2018) suggested that the disparity of treatment is related to the overpopulation of African American men in the prison system. In Carson's study, African American men between the ages of 18–19 were 11.8 times more likely to be imprisoned compared to their White counterparts. Amasa-Annang and Scutelnicu (2016) identified dual diagnosis, race, and recidivism as contributors to the overrepresentation of African American men in the United States' prison system. Frazier, Sung, Gideon, and Alfaro (2015) corroborated these findings by asserting that African American men with either a dual diagnosis are more than six times as likely to be incarcerated than White men in the same group. However, conflicting data presented by Spiropoulos, Van Voorhis, and Salisbury (2018) reported a 16% decrease in recidivism rates for African American men with a dual diagnosis who participated in group treatment (i.e., 4 – 8 participants in a group). The researchers informed that when

professionals linked this group of African American men to treatment, there was a decrease in criminal activity (Spiropoulos et al., 2018). The reports from Frazier et al. (2015) and Spiropoulos et al. (2018) highlighted the challenges helping professionals experienced when providing treatment to this population of African American men and their complex needs.

One approach helping professionals used to understand recidivism was from a system perspective (Frazier et al., 2015). Amasa-Annang and Scutelnicu (2016) contended that recidivism was linked to the increase of individuals with criminal justice involvement and flaws in the criminal justice system. Researchers have cited spikes in healthcare costs, loss of work productivity, and broken bonds with natural supports as derivatives of recidivism (Alper et al., 2018; Begun, Early, & Hodge, 2016; Strong, Shipper, Downton, & Lane, 2016). Hamilton and Belenko (2016) argued that the deinstitutionalization of prisons is a daunting systemic issue for criminal justice experts. Along those same lines, Frazier et al. (2015) indicated that reentry provisions were often fragmented and did not address the prison population's needs post-release. The authors contended that this fragmentation resulted in residual criminal justice involvement. Reentry experts have opined that transitional services and community-based treatment programs staffed by culturally knowledgeable workers are key to reentry efforts (Hamilton & Belenko, 2016).

Frazier et al. (2015) opined that proper planning and implementing reentry strategies are vital components to community-based services. Frazier et al. (2015) continued that effective reentry is a result of properly executed deinstitutionalization.

Along the same line, Amasa-Annang and Scutelnicu (2016) recommended that criminal justice workers implement deinstitutionalization in three parts: (a) the release of the individual into the community, (b) diversion programs that promote desistance of criminal behaviors, and (c) innovative community-based treatment programs.

Further, Amasa-Annang and Scutelnicu (2016) stated that deinstitutionalization leads to community members meeting ex-offenders with resistance. Scholars have contended that the inability to meet the needs of this complex population of African American men is the cause of opposition from community members (Frazier et al., 2015). Moreover, Kim (2016) posited that deinstitutionalization leads to more arrests for a person with a dual diagnosis because of an increase in police contact. Hamilton and Belenko (2016) suggested helping professionals focus on developing more integrative reentry models that target dual diagnosis symptoms and limit police contact.

Finally, deinstitutionalization may be an unavoidable condition given the prison population. According to Polcin (2018), the overcrowding of prisons pose threats both inside and outside of the correctional facility. The author asserted overcrowded prisons are detrimental to society because of prison cost and staffing challenges in correctional facilities (Polcin, 2018). Polcin (2018) informed prison staff is challenged to provide safety, basic needs, and treatment for inmates with dual diagnoses. Further, Polcin (2018), reported only 1 of 6 inmates to receive treatment in prison. Polcin went on to inform that inmates rely on outside support for care post-release (Polcin, 2018). Eisen and Cullen (2017) reported despite public perception, incarceration does not always equate to less criminal activity in the community. Consequently, recidivism affects

society from more than a financial standpoint (Elison, Weston, Dugdale, Ward, & Davies, 2016).

Dual Diagnosis and Recidivism

Dual diagnosis and recidivism were at the center of this qualitative study. As stated earlier, according to the American Psychiatric Associations (2013) dual diagnosis consists of both a mental health and substance abuse problem. Wilton and Stewart (2017) reported that dual diagnosis was the cause of almost 40% of incarceration. In their study of 715 federal inmates in a Canadian Prison, the authors reported 38% of the inmates had a dual diagnosis (Wilton & Stewart, 2017). Criminal justice experts contended correctional staff was unable to provide adequate treatment in the prison setting (Bebbington et al., 2017; Peters et al., 2015). In contrast, Samele et al. (2016) presented promising data for individuals with dual diagnoses while in prison. In their research, the authors described an innovative approach to treating inmates with dual diagnoses in prison (Samele et al., 2016).

Samele et al. (2016) identified Primary Healthcare (PHC) as a new intervention for individuals with dual diagnoses in the prison system. The prison staff used *In-Reach Teams*, which were helping professionals who completed the same functions in prisons as helping professionals in the community [i.e., mental health and substance abuse evaluations, risk assessments, and treatment referrals] (Samele et al., 2016). Samele et al. (2016) reported that prison staff used an open referral system and anyone could refer an inmate who is demonstrating symptoms for further evaluation. The goal of the open

referral system was to encourage treatment both inside and outside of prison (Samele et al., 2016).

Prince and Wald (2018) hypothesized that a large social network could be a protective barrier against recidivism. The writers suggested that large social networks help a person access more resources while lowering the risk of re-offending (Prince & Wald). Although strong social supports are linked to lower recidivism rates, conversely Zettler (2017) identified other moderators as threats that increase incarceration.

Researchers have identified gender, socioeconomic status, homelessness, and race as risk factors of recidivism (Thompson et al., 2016). Further, researchers reported that African American men are more susceptible to both dual diagnosis and recidivism (Prince & Wald, 2018; Thompson et al., 2016; Zettler, 2017). Ironically, this same group of men is documented as having a history of sporadic attendance in treatment, leading to overpopulated prisons (Moyes et al., 2016).

Hatchett (2015) elaborated by stating when combined with the stigma of incarceration, dual diagnosis impedes a person's ability to socially function. Hatchett (2015) continued that dual diagnosis accounts for financial stress on various systems of care (Hatchett, 2015). Researchers have examined funding initiatives earmarked to address recidivism. For example, The Second Chance Act (2007) has given more than 500 awards (grants) totaling over a quarter billion dollars for reentry efforts to reduce prison overpopulation. According to Miller and Miller (2017), the cost to care for reentry needs has also increased. These authors postulated the key to reduce reentry cost is diverting funds to individualized dual diagnosis treatment. By reallocating funds for

treatment, helping professionals produced lower recidivism results within this dually diagnosed group (Miller & Miller, 2017).

Social Implications of Recidivism and Community-Based Treatment

Alper et al. (2018) asserted the cost of providing treatment to a person with a dual diagnosis and who are criminal justice-involved has risen. The researchers further asserted that policymakers are tasked with easing the financial strain on tax-paying citizens (Alper et al., 2018). Frazier et al. (2015) reported that some state officials have reduced taxes by redirecting individuals with dual diagnoses and histories of nonviolent crimes to community-based treatment programs. One assumption by Peters et al. (2015) was that community-based treatment programs are more equipped for dual diagnosis treatment as opposed to rehabilitation reincarceration. These researchers emphasized that law enforcement personnel, judges, and prison reform advocates have contributed to lowering the cost of treatment by reducing the rate of incarceration of nonviolent offenders with a dual diagnosis.

Wagner and Rabuy (2016) reported there were approximately 2.3 million people with a dual diagnosis in prison. A year later, researchers estimated that there were over 20 million individuals either previously or currently incarcerated in America (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). The writers reported that authorities arrested individuals with mental health and substance abuse problems at an estimated rate of two to four times more than the general population (Rubenstein et al., 2017). Further, scholars projected that there were ten times as many people with a mental illness in prison than psychiatric treatment facilities (Al-Rousan et al., 2017). When they adjusted

for dual diagnosis problems, the statistics were higher (Al-Rousan et al., 2017). Kim (2016), in comparison, presented data that aligned with uneven prison rates for people with a dual diagnosis compared to the general population. Consequently, the social problem of recidivism continues to burden the country (Wagner & Rabuy, 2016).

Kingston et al. (2016) argued that the impact of recidivism on communities is more significant than the price associated with incarceration, dual diagnosis treatment, and increased taxes. As I previously stated, this social problem adversely impacts social bonding, desistance of criminal activity, and familial relationships (Smith, Mays, Collins, & Ramaswamy, 2019). The interpersonal problem causes stress on the individual and their significant others, which does not directly show in the cost of imprisonment (Ogloff et al., 2015). However, researchers have posited that this rupture of pro-social relationships far supersedes the financial blowback absorbed by taxpayers (Kingston et al., 2016).

Polcin (2018) reported a link between healthy relationships with individuals who have a dual diagnosis, recidivism, and treatment fidelity. According to at least one source of scholarship, Blank, Finlay, and Prior (2016) informed that society tends to minimize individuals with a dual diagnosis. Blank et al. (2016)went on to say when the dual diagnosis is combined with criminal justice involvement, these individuals are marginalized and do not receive personalized treatment. Consequently, these systematic shortcomings result in higher recidivism rates (Blank et al., 2016). Further, Lamberti (2016) argued that until human services providers (e.g., dual diagnosis clinicians, criminal justice professionals, probation officers, etc.) become less fragmented and

implement an integrative multi-systems approach, this group of consumers with dual diagnosis will continue to overpopulate correctional facilities.

Lamberti (2016) informed that the presence of a dual diagnosis increases the chance of incarceration and detaches a person from their social supports. Based on previous studies, researchers have found treatment models that simultaneously address both mental illness and substance use disorders lower the risk of recidivism (Prince & Wald, 2018; SAMHSA, 2020). Similarly, other researchers have corroborated this claim of concurrent treatment for people with dual diagnosis (Dias et al., 2018; Elison et al., 2016). Begun et al. (2016) went on to write that recidivism contributes to social deprivation, poverty, environmental risks, and decreased natural supports. The authors contended that helping professionals in community-based treatment agencies positively impact treatment outcomes (Begun et al., 2016).

Helping Professionals and Community-Based Treatment Programs

Helping professionals in community-based programs have become influential in providing quality treatment to individuals who are underrepresented in the various systems of care (Browne et al., 2016). Helpers who provide community-based treatment bolster recovery, decrease police contact, and create opportunities for participants to seek treatment within the clients' environment (Bond & Drake, 2015). However, when working with dually diagnosed individuals, helpers experienced complex challenges. Nijdam-Jones et al. (2017), detailed how individuals with a dual diagnosis are more adversely impacted by other conditions (i.e., more police contact and higher arrest rates) when compared to the general population. The authors offered that despite working with

community-based professionals, this group of consumers face barriers such as changes in political administrations, stricter civil commitment laws, and decreased funding for treatment Nijdam-Jones et al., 2017). Over time, both formal and informal support dissipates, and this population is thrust into a cycle of incarceration or recidivism, generally referred to as the *revolving door of criminal justice* (Nijdam-Jones et al., 2017). Further, reentry efforts for these individuals are thwarted by declining independent living skills and persistent reincarceration (Huz et al., 2017).

Helping professionals are tasked with providing treatment to this population and often lacked access to proper resources (Thompson et al., 2016). Kim (2016) contended that community-based treatment programs staffed with knowledgeable workers are positive emergent interventions for individuals with dual diagnosis and considered high risk for reincarceration. Peters, Young, Rojas, and Gorey (2017), in comparison, asserted that community-based treatment programs that focused on the problems associated with dual diagnosis, criminal justice involvement, and culturally incompetent workers are best suited for this population.

Cultural Awareness

Collins (2017) informed that agencies generally train helping professionals in cultural awareness for the populations the workers serve. However, despite continuous training, there continues to be a divide between African American men and healthcare (Samuel, 2015). Most providers offer treatment from a Eurocentric worldview, which make it a challenge to understand the needs of this group of African American men (Collins, 2017). This disconnect is significant because when helping professionals are

creating outreach strategies, it is essential to understand the cultural nuances of this group (Ratts et al., 2016). The authors went on to suggest that helping professionals take an inclusive cultural ecological approach to tailor services to this population of African American men.

Gender role is also a cultural phenomenon in the African American community (Harris et al., 2016). Mirowsky and Ross (2017) opined that masculinity is a social construct among African American men. Also, this social construct makes it difficult for African American men to seek treatment for problems like dual diagnosis because of the stigma from community members (Mirowsky & Ross, 2017). Hack et al. (2016) reported that in the African American community, mental illness and substance abuse are considered signs of weakness. In general, community members are less likely to support these individuals, as many believe that dual diagnosis in a personal choice (Harris et al., 2016). Towns (2018) recommended that treatment providers hire helping professionals who are educated on cultural diversity and also have personal experience in accessing treatment (i.e., counselors that have direct experience with mental illness or substance abuse).

Workers should consider African Americans' belief systems in specific areas of healthcare when they are establishing a therapeutic bond with this group (Hack et al., 2016). For example, older African American men believe age is the biggest cause of mental illness (Hack et al., 2016). In contrast, younger men in this same group identified stress, exposure to violence, trauma, substance abuse, and criminal offenses leading to incarceration as the primary causes of mental illness (Griffin, 2018). In seminal literature

from the Association for Multicultural Counseling and Development (AMCD), researchers communicated that it is critical for treatment to be individualized. They went on to write that helping professionals should be strategic in their outreach attempts to ensure they are not only culturally aware but also sensitive to this population's environmental stressors (Arredondo et al., 1996). The researchers hypothesized that these environmental stressors could lead to under or overdiagnosing [i.e., misdiagnosis] (Arredondo et al., 1996).

Misdiagnosis Among African American Men

African American men are often at higher risk for overall health problems compared to the general population (Plowden, Adams, & Wiley, 2016). The authors informed that this group presentation of dual diagnosis and other comorbid symptoms are often misdiagnosed (Plowden et al., 2016). According to Plowden et al. (2016), this population is more likely to access their primary care physician for generalized issues. These issues are often associated with mental illness but may present as somatic symptoms (e.g., irritability, mood swings, fatigue, etc.) [Plowden et al., 2016]. Medical providers have also reported that African American men minimize healthcare concerns by normalizing theses symptoms, which also contribute to misdiagnoses (Hack et al., 2017).

African Americans are distrustful of the healthcare system based on past ethical issues involving healthcare research and the government (Cobb & Shervin, 2019). As such, when African Americans present at treatment facilities, these individuals may withhold pertinent information making accurate diagnosing a challenge for healthcare

providers (Cobb & Shervin, 2019). Although this population of African American men continues to be underrepresented in quality mental illness and substance abuse treatment, community-based treatment programs appear to be critical components for narrowing the disparity gap between this group and the general population (Cobb & Shervin, 2019; Hankerson et al., 2015).

Community-Based Treatment Programs Used by Helping Professionals

In the following section, I provided an overview of two community-based treatment programs commonly used for individuals with incarceration histories, whereby helping professionals' primary role is to engage the targeted population in treatment within the clients' environment. These two programs have become the standard by which providers administer provisions to this population with a documented history of nonengagement.

Assertive Community Treatment

One community-based treatment program is the Assertive Community Treatment team (ACT). Abracen et al., (2016) described the ACT team as an intensive, evidence-based intervention model geared towards treating individuals with dual diagnosis and who are at risk for criminal justice involvement. Also, some helping professionals consider the ACT consumers difficult to engage, and as a result, ACT participants experienced more problems associated with dual diagnosis (Clark et al., 2016). Bond and Drake (2015) informed by providing training and support in the community setting, completing real time assessments for program participants, crisis management, and taking a holistic approach to treatment, ACT teams reduced criminal exposure for ACT

consumers. Also, the authors postulated that because community health administrators highly fund ACT teams, these community-based workers can address multilayered needs such as dual diagnosis, housing problems, unemployment, case management, and medical necessities.

Huz et al. (2017), wrote that the ACT team model is a robust inexpensive alternate approach to workers placing consumers in prison or inpatient facilities. Clark et al. (2016) suggested that the ACT team's ability to render individualized treatment to this high risk population within their environment is the reason for the quality of life improvements and consumers having less police contact. By using this model, helping professionals maintained treatment fidelity and focused on providing services for those who experienced problems associated with sporadic dual diagnosis treatment (Huz et al., 2017). Huz et al. (2017) found that the median time (i.e., time a participant is in the ACT program) subsided, and the turnover rate or the time for new participants to enter the ACT program was fast-tracked. These findings validated the success of the ACT team model (Huz et al., 2017). Finnerty et al. (2015) asserted that these positive outcomes continued to reinforce the paradigm shift from managing multifaceted participants in institutions to a focus on community-based treatment. Because of these favorable outcomes, program participants transitioned to less intensive treatment or total independence (Huz et al., 2017).

Although these outcomes were positive, helping professionals working on these ACT teams faced push back from other community workers. According to Finnerty et al. (2015), community workers viewed ACT consumers as difficult to engage and

noncompliant with treatment. Further, Finnerty et al. reported the stigma attached to this group created challenges transitioning these consumers to less restrictive treatment. However, the ACT staff circumvented this obstacle by establishing *Health Homes*. Health Homes were facilities that served as a hub for a person to live in a private residence but continue to have access to ACT services (Pincus, Scholle, Spaeth-Rublee, Hepner, & Brown, 2016). Helping professionals working in other systems of care (i.e., criminal justice) began to take notice of these positive results and duplicated this approach.

Forensic Assertive Community Team

Criminal justice experts, judges, and probation officers adopted the ACT model to replicate success in the criminal justice system. Nijdam-Jones et al. (2017) reported that ACT participants are at higher risk for criminal justice involvement compared to the general population. As a result, criminal justice professionals fused the ACT model with the criminal justice system of care and created the Forensic Assertive Community Team (FACT; Marquant et al., 2016). Marquant et al. (2016) reported The FACT model emerged as a result of individuals with a dual diagnosis experiencing a surge in police contact which lead to more arrests.

Carson (2018) reported that prisons were becoming overpopulated with African American men with a history of nonviolent offenses and who were diagnosed with either a mental illness, substance use disorder, or both. Landess and Holoyda (2017) reported as the prison overpopulation issue persisted; criminal justice workers focused on diversion.

Similar to ACT teams, criminal justice professionals utilized FACT teams as a standalone treatment model for this high-risk population (Marquant et al., 2016).

Marquant et al. (2016) reported positive outcomes from the FACT model. However, because of the lack of reliable research, critics discounted the results (Marquant et al.,2016) Although criminal justice experts cited low rates of arrests for this population, Landess and Holoyda (2017) reported there were no significant marked disparities among the in-group (i.e., FACT participants) and out-group (i.e., non FACT participants). The researchers reported there were higher instances of hospital admissions, which accounted for the decrease in criminal justice involvement, and skeptics of the FACT model did not see this as a positive outcome (Landess & Holoyda, 2017).

Zettler (2017) and other researchers contended that, given their transient nature, individuals with dual diagnoses tend to have irregular attendance at treatment programs (Moyes et al., 2016). Ward and Merlo (2016) asserted that community-based treatment programs that are fluid and able to manage these individuals' needs within their environment are ideal. Although the treatment options have shifted to community-based treatment, helping professionals experienced not only structural barriers [i.e., legal, insurance coverage, transportation, etc.] but also professional barriers [i.e., individualized treatment] (Priester et al., 2016). As a result, experts confirmed these as significant impediments for this group of African American men and contributors to the spike in sporadic treatment attendance (Hack et al., 2016).

Unexplained Attrition (Sporadic Attendance in Treatment)

African American men with a dual diagnosis are disproportionately impacted by untreated mental illness and substance abuse treatment, higher rates of recidivism, and related health problems when compared to the general public (Amasa-Annang & Scutelnicu, 2016; Frazier, 2015; Zettler, 2017). However, this population remain less likely to stay engaged in treatment or have sporadic treatment attendance records (Hack et al., 2016). This population of African American men who are inconsistent in treatment attendance may be largely shaped by their assumptions of helping professionals' cultural perception. Researchers indicated that African American men with dual diagnosis reported distrust of providers (Hankerson et al., 2015), lack of provider collaboration with the consumers' support (Hack et al., 2016), and stigma in the African American community of mental illness and substance abuse (Lindinger-Sternart, 2015) as factors of treatment compliance. Helping professionals who are not only culturally competent as providers but who can also integrate natural supports and build trust are more likely to sustain treatment over time (Kim, 2016). Peters et al. (2017) went on to report that by taking an inclusive approach to treatment that entails a person's support system, who the consumers consider as assets in treatment, helping professionals can close the disparity gaps in healthcare treatment.

Dual Diagnosis as a Social Problem for Helping Professionals to Manage

There are multiple implications aligned with social responses to people who are post incarcerated and who have a dual diagnosis. In brief, helping professionals working with this population must understand the mental illness, environmental factors, genetics,

and the nature of substance use. In the context of this study, I framed three possible contributors as challenges clients face that may pose problems for practitioners regarding treatment compliance. These foci are related and integrated into the aforementioned areas of helping professional roles, community-based treatment, dual diagnosis, and the other specific literature related to this study's research question.

Mental Illness

Mental illnesses are diagnosable disorders that can range from being mild to seriously persistent (American Psychiatric Association, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Data put forth by researchers illustrated that approximately 20% of all adults living in the United States have at least one diagnosable mental health condition (National Alliance on Mental Illness, 2019). According to Woodhouse et al. (2016), although mental illness is treatable, factors such as environmental stressors, genetics, and substance abuse can exacerbate mental illness. White (2017) theorized that historically, society had minimized mental health conditions, which in some cases have resulted in stigmatization.

Environmental Stressors as a Contributor

Lockwood, Nally, and Ho (2016) found that environmental stress could be a contributor to mental health challenges. Similarly, other researchers brought forth data substantiating that mental health can worsen with the presence of environmental stress (Vassos, Agerbo, Mors, & Pedersen, 2016). Griffin (2018), in comparison, suggested that urban environments increased the chances of either developing or exacerbating mental health problems. Keeping with the theme of environmental factors, Vassos et al. (2016)

used the term "*urban environment*" as a variable that contributed to mental illness. In their study, the authors framed urban environment(s) as a geographical area not considered rural (Vassos et al., 2016). Vassos et al. (2016) established that urban environments contributed not only to mental illness but also drug problems. Woodhouse et al. (2016) had similar findings corroborating that the urban environment influenced the stabilization of mental health. Woodhouse et al. reported that compared to rural areas, urban areas are generally more populated and more susceptible to drugs, alcohol abuse, and criminal behaviors.

Further, researchers have found similar findings in other studies. In a quantitative study examining 130 participants with a diagnosable mental illness, Ogloff et al. (2015) reported that 18% of the participants had a criminal offense. Also, the researchers went on to state that of the 130 participants, 82% of the participants had a mental illness (Ogloff et al., 2015). In contrast, Tost, Champagn, and Meyer-Lindenberg's (2015) study indicated that individuals dwelling in urban areas faired healthier than their rural equivalents when accounting for factors such as better education systems, access to medical care, and more economic opportunities. However, the same is not consistent with mental health disorders when controlling for groups who resided in urban areas (Tost et al., 2015).

Griffin (2018) provided an example presenting how mental health experts have made the argument linking mental illnesses such as Post-Traumatic Stress Disorder (PTSD) and the likelihood of police contact when living in the urban environment. According to the American Psychiatric Association (2013), PTSD emerges when a

person is triggered or reexposed to an event that may have caused anxiety, fear, or adversities. Underpinning this assumption, Parish (2015) reported growing evidence connecting PTSD and exposure to high-risk environments. Griffin (2018) went on to assert that although PTSD is prevalent among individuals raised in urban environments, most of this population do not receive treatment. White (2017), in comparison, provided further evidence suggesting minorities (i.e., African American men) are overrepresented in the urban environment and are inherently at higher risk for problems associated with mental illness (i.e., incarceration).

In contrast, other researchers contended that one's environment alone does not contribute to mental illness. In Uher and Zwicker (2017) study examining the relationship between genetic variants and environmental factors, the authors produced evidence which linked mental illness to both components (e.g., genetics and environment factors). In their study, the researchers contributed both genetics and environmental factors to more than 50% of all mental health diagnoses and protesting that independently, environmental stressors do not contribute to mental illnesses (Uher & Zwicker, 2017).

Genetics as a Contributor to Mental Health Issues

Uher and Zwicker (2017) reported that as researchers continue to examine mental illness from multiple perspectives, they identify the etiologies for specific disorders. The authors went on to write that genetics affect mental illness (Uher & Zwicker, 2017). In their study examining the influences of mental illnesses, Uher and Zwicker (2017)linked genetics to approximately two-thirds of all mental illnesses. Along similar lines, Cho et al. (2017) conducted a quantitative study that yielded evidence corroborating the

relationship between genetics and mental illness. In Cho's et al. (2017) study, experts associated 7.6% of all mental illnesses to genetics compared to 6.8% of experts linking medical conditions to genetics.

Along the same line, Haworth, Carter, Eley, and Plomin (2017) reported that mental health professionals linked genetics to more instances of depression and emotional disorders. In their study, Hawthorn et al. (2017) found that genetics accounted for 45% of symptoms related to depression. To counterargue this claim is the lack of biomarkers as scientific evidence (Parish, 2015). Parish (2015) went on to argue that much of mental illness has little or no substantial evidence of biomarkers. Further, Paris postulated that the evidence is primarily a human assumption (i.e., mental health professionals). Parish (2015) contended that the question of whether mental illness is derived solely from genetics remains inconclusive. In addition to environmental factors and genetics as contributors to mental illness, researchers have traced substance use to mental health problems (Kingston et al., 2016).

Substance Use Disorder

Researchers exploring the influences of mental illness and criminal justice involvement have also alluded to substance use disorder as a contributor to recidivism (Krona et al., 2017; Prince & Wald, 2018). The American Psychiatric Association (2013) defined a substance use disorder as the recurrent use of drugs, which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Fong (2017) asserted that individuals with substance use disorders are more problematic because of the stigma

attached to drug use, lack of available quality treatment (Marquant et al., 2016), and disparities in individualized interventions (Ogloff et al., 2015).

As stated by Hamilton (2015) and based on the evidence relating to these barriers, efforts to create a system of care with quality evidence-based treatment is a challenge. Clement et al. (2015) opined that although substance use disorder(s) may be the identified problem when seeking treatment, researchers have pointed to substance use disorder as a mask for mental illness problems. In contrast, mental illness problems can also mask substance use problems (Clement et al., 2015). As with mental health problems, substance use disorder has a wide range of risk factors commonly associated with drug use (Begun et al., 2016).

Researchers have associated environmental stressors, socioeconomic status, and limited social supports with dual diagnosis (Woodhouse et al., 2016). Miller and Miller (2017) corroborated this assumption that mental illness and substance use disorder increased because of vicarious stressors (e.g., environmental stressors, socio-economic issues, and lack of social supports, etc.). To overcome the problems of mental illness and these associated components, experts continue to advocate for individualized community-based treatment as an effective intervention (Begun et al., 2016; Miller & Miller, 2017).

Summary

Given the breadth of literature related to helping professionals who work with African American men with dual diagnosis and incarceration histories, I explored the cultural aspects of this population first. I found the nature of helping professionals' responsibilities and their roles when working in community-based programs to be

challenging when empowering clients to maintain treatment compliance. While various systems of care exist, these systems have not effectively maintained the continuity of care for African American men with a dual diagnosis (Buckman, 2015; Elison et al., 2016; Kingston et al., 2016). This population has more police contact, housing problems, less natural supports, and sporadic participation in treatment relative to the general population (Kingston et al., 2016; Ogloff et al., 2015). Al-Rousan et al. (2017) offered evidence showing that this population is incarcerated at a rate four times higher than other ethnic groups. These disproportionate levels of incarceration rates have led to additional financial stress on taxpayers (Kingston et al., 2016; Ogloff et al., 2015). Further, disparities in treatment and negative outcomes within this group makes this research problem a critical area to examine.

Blank et al. (2016) suggested that the lack of quality treatment and excessive criminal justice involvement perpetuates African American men continued marginalization in society. Further, the barriers that helping professionals experience when providing services to this vulnerable population may add to the problems this group faces (Vassos et al., 2016). While helping professionals continue to provide services to this population, African American men remain susceptible to higher incarceration rates, and when researchers consider race, arrests are even higher (Eisen & Cullen, 2017). It is reasonable to assume that this scenario can make for complex treatment planning and strategies.

Although past scholars have examined African American men and treatment, when I compared the treatment challenges to treatment successes, there remains to be a

gap in understanding the context in how they provide community-based treatment to those African American men with a dual diagnosis and who are post criminal justice involved. Therefore, African American men with a dual diagnosis who are considered high-risk for recidivism and understanding how community workers provide treatment to this group was instrumental in gaining insight into this phenomenon. However, at present, researchers continue to experience a lack of understanding of how the helper/helpee relationship impacts treatment fidelity (Abracen et al., 2016; Rezansoff et al., 2015). The theory used to understand this problem is social control theory. Social control theory suggests that the bond between a person and their community which leads to a regression in criminal activities (Hirschi, 1969). In the context of this study, I understood social control theory by exploring the bond between the helper/helpee relationship and if this bond impacted the fidelity of treatment.

In Chapter 3, I restate the research questions and outline the research design and rationale for this study. I explain my role as the researcher and offer strategies to address potential biases. Next, I provide information on the population under study, sample size, and inclusion criteria. Then, I explain my data management plan. I end the chapter by addressing, trustworthiness, informed consent, and ethical implications.

Chapter 3: Research Method

The purpose of this qualitative single case study was to understand how helping professionals provide community-based treatment to African American men with a dual diagnosis, incarceration histories, and high risk for recidivism. This chapter addresses the research methodology used to conduct this study. This section includes the methodology for recruiting participants and securing data. Additionally, I review the role of the researcher (i.e., instrumentation), the methodology used, the rationale for using this methodology, how I collected and analyzed data, issues of trustworthiness, and safeguards I used to meet credibility and ethical standards for participants in this study.

Research Questions

There were two research questions in this study:

RQ1: How do helping professionals provide community-based treatment to African American men with a dual diagnosis, prior incarceration, and high risk for recidivism?

RQ2: How do helping professionals establish a relationship with their clients?

Research Design and Rationale

I used a qualitative single case design to answer the research questions. A qualitative design was best suited for this study because I wanted to acquire deep and rich content while also adhering to a rigorous and systematic approach to data collection and analysis (see Yin, 2009, 2011, 2014). Merriam (1995) theorized that a core competency aligned with qualitative research is for the researcher to understand how participants view or make sense of an event, occurrence, or experience.

Although I considered the quantitative approach for this study, I did not want to explore the cause and effect relationship between helping professionals and individuals with a dual diagnosis at risk for recidivism (see Auerbach & Silverstein, 2003). I wanted to understand better how helping professionals provide community-based treatment to this population. Therefore, I chose a qualitative single case study for my approach.

Although qualitative research has an array of approaches such as grounded theory, narrative and constructiveness, ethnography, and phenomenological and heuristic (Chermaz, 2006; Clandinin & Rosiek, 2007; Elliott, Fisher, & Rennie, 1999; Ellis, Adams, & Bochner, 2011), for the current study a single case study design was the most appropriate. Although the various qualitative approaches are different, some commonalities exist (e.g., the use of journals, artifacts, memos, and the analysis of words gleaned from in-depth interviews; Moustakas, 1994). Each method is unique in its approach, but my core intent required a single case study design.

Moustakas (1994) theorized that phenomenology and heuristic inquiry are two types of qualitative research that address the experiences of a specific phenomenon. I considered these two approaches for this study. However, in contrast to my goals, Moustakas indicated that phenomenology and heuristic inquiry consider the researcher's experience of a phenomenon. In my study, I examined the phenomenon in a context that was bounded by place and time (see Tellis, 1997; Yin, 2009). The case study design allowed me to study the targeted population in this context.

Further, the ethnographic approach was not ideal for this study. Ellis et al. (2011) noted that researchers immerse themselves in the culture and lifestyle of the targeted

population for ethnographic studies. In the current study, because of the research questions and the subject matter, this approach was not feasible. I considered the constructiveness and narrative approach for this study, as well. Both approaches are used to study participants in their environment, and the participants have experienced the phenomenon of interest (Clandinin & Rosiek, 2007). However, Clandinin and Rosiek (2007) noted that these approaches are in contrast to single case studies. Clandinin and Rosiek stated those who use these two approaches analyze the data collected and attempt to construct reality or what is their perceived reality. Ravitch and Carl (2015) observed that quantitative methodology is used to examine the correlation between variables (e.g., target population and the phenomenon under examination). However, for the current study, I did not want to examine the relationship between variables.

Stake (1995) theorized that qualitative analysis is an iterative process, and researchers should obtain information while data are being collected as opposed to after data are collected. Stake also noted that the qualitative method is used for researchers to hear the participant's experience verbatim (emic) and not the researcher's experiences (etic). In contrast, Ravitch and Carl (2015) wrote that quantitative methodology is used to examine the correlation or causality between variables. Crabtree, Stange, and Miller (2006) described qualitative inquiry as a dance as much as an art. Crabtree et al. also noted that the two dancers are the interpreter, and the text is the art. The goal is to identify meaning and modify the text to create categories and codes (Crabtree et al., 2006).

The central topic that I explored in this study was how do helping professionals provide community-based treatment programs to African American men with a dual diagnosis, incarceration history, and high risk for recidivism. Also, I wanted to know how helping professionals established relationships with their clients. My study addressed how African American men sought help at community-based programs (e.g., assertive community treatment [ACT] and forensic assertive community treatment [FACT]. I explored this population from the perceptions of helping professionals working in community-based treatment programs.

Role of the Researcher

I was the primary instrument for this study. As the researcher, I analyzed the data, interpreted the data, and reported the results. Maxwell (2013) asserted that the researcher is the primary instrument in qualitative studies. In this role, I designed a semistructured interview guide (see Appendix A). Maxwell also indicated that the researcher should follow all ethical standards and protect human subjects throughout the research process. As a student and novice researcher, I followed Walden University's protocol to protect the participant's confidentiality and privacy. In addition to standard procedures (e.g., data management, confidentiality, and informed consent), I followed other guidelines that I discuss later in this chapter.

Addressing Potential Bias

As the researcher, I had personal experiences directly and indirectly with the targeted population. I am a helping professional in my field of work. As I built the foundation of my research findings, I acknowledged my personal biases. Patton (2002)

stated through journaling and peer debriefings, researchers can address personal feelings in research. By following this protocol, I remained aware of my biases and prevented these thoughts from influencing or limiting my interpretation of the data. Janesick (2015) wrote that journaling serves as a conduit for researchers to continuously self-reflect. Keeping with the theme of potential bias, Moustakas (1994) theorized that researchers must take self-inventory and become aware of personal involvement with the subject matter and attempt to eliminate preconceptions through epoche.

Consistent with case study methodology, I adhered to Yin's (2011) recommendation of using journaling as a form of developing self-awareness by considering the cues from the natural environment either directly or indirectly. By doing so, I attempted to minimize the risk of transferring biases to the study. Also, I conferred with my committee throughout the study to ensure I followed all of Walden's protocols and operated within the confines of academic integrity.

I interviewed all participants with sensitivity, respect, and dignity by utilizing my 10 years of clinical experience. During over 10 years of clinical experience as a therapist, I learned to actively listen while withholding judgment (i.e., epoche). I chose qualitative methodology because I wanted to derive knowledge from the experiences of the participants in this study (see Patton, 2002). To validate my competency as a researcher, I completed the National Institutes of Health (2016) Protecting Human Research Participants training (see Appendix B). The training emphasized justice, beneficence for all human subjects, and protecting all human subjects in any research study. As the researcher, I was responsible for recruiting and interviewing participants. Also, I

analyzed all data. I collected data by using qualitative semistructured interviews. All interview questions were open-ended so I could elicit exhaustive responses. I did not disclose any personal experiences because I did not want to lead or unintentionally influence the participants (see Patton, 2002). Before the interviews were conducted, all questions were preapproved by my dissertation committee.

Methodology

The design for this study followed Walden's University IRB protocol, which included but was not limited to population and sampling strategy, recruitment and inclusion criteria, informed consent, documentation management, and data analysis.

Population, Sample Size, and Inclusion Criteria

The research population, the desired sample size, and inclusion criteria were part of the research methodology and design considerations. The population of focus for this study was helping professionals who work in community-based treatment programs. Yin (2014) theorized that there should be no a priori test used to predetermine the number of participants needed in case studies. Yin also noted that sample sizes in case studies are not determined beforehand, but rather are determined by data saturation. Aligning with Yin, Mason (2010) wrote that data saturation is the point of a study when no new themes or information emerges and there are enough data to replicate the study.

Sampling Strategy

For my study, I used a criterion and snowball sampling strategy. Patton (2002) indicated that qualitative researchers use purposeful sampling strategies to determine the participants' characteristics and shared experiences. Patton also noted that criterion

sampling is the selection of individuals based on a continuum of predetermined criteria. Rubin and Rubin (2012) asserted that snowball sampling occurs when one participant informs others who meet the eligibility requirements. I used social media boards, unrestricted information boards (e.g., public bulletins), and fliers at coffee shops to recruit participants (see Patton, 2002).

Recruitment and Inclusion Criteria

For this study, I recruited from a state in the North Eastern United States, because the proximity was feasible to my location as the researcher. I used multiple modes of recruitment tactics. With Walden's IRB approval, I disseminated formal invitations to all potential participants about my case study and the inclusion criteria. The inclusion criteria for this study entailed:

- Helping Professionals over 18 years of age (i.e., clinicians, caseworkers, social workers, etc.).
- The participant must have at least one year of work experience with African American men with a dual diagnosis, incarceration history, and who are considered high-risk for recidivism in New Castle County, DE.
- Each participant had at least one year of self-identified community-based treatment program experience within the last five years.

Informed Consent

Once I received responses, I contacted each person through email, text, or by phone and provided further information about the study. When the person replied,

agreeing to participate in the study, I sent the Walden's IRB approved informed consent agreement.

After I secured informed consent and an agreement from each participant, I asked if they knew others who met the study's criteria and may be interested in participating (e.g., snowball sampling). After I received the responses from eligible participants and referrals, I sent the informed consent to each person. When I confirmed their interest, I scheduled an appointment. Lastly, I interviewed each person at a place and time that was convenient for us. At the end of each interview, I scheduled a time with each participant to follow up with any additional questions or concerns as needed.

Sample Size

Yin (2014) asserted that although there is no predetermined number of interviewees for a case study, however, 6 – 10 participants can yield enough data for coding and identifiable themes. Therefore, according to Yin's (2014) assertion, I interviewed nine individuals who self-identified as meeting the study's inclusion criteria. I conducted in-depth interviews and took field notes during data collection. I provided each person with an overview of the study and their role as participants. I reviewed the informed consent with each person. During this review, I emphasized that this study was voluntary, and they could stop participating for any reason without notice or fear of retaliation. When I disseminated the informed consent, I allowed participants to ask any questions at that time, and I encouraged them to ask any follow-up questions after the interview.

Data Saturation

As mentioned earlier, I continued with the interviews until I reached data saturation. Guest, Bunce, and Johnson (2006) theorized that saturation is the gold standard for all qualitative studies. Ravitch and Carl (2015) wrote that data saturation is apparent when there is no new information or changes to be made to existing data. Small studies with few participants, selection criteria, and heterogeneity of population are all factors that affect data saturation (Mason, 2010). With the intent of reaching theoretical saturation, Seidman (2012) asserted that researchers should keep in mind the ultimate goal for interviews is to understand the lived experience of the subject and how they view that experience.

In keeping with the premise of saturation, I interviewed participants until I confirmed the quality of data that each person provided in the study (Seidman, 2012). Burkholder, Cox, and Crawford (2016) opined that the most common way for researchers to determine the quality (validity) in qualitative research is to test the results of a particular phenomenon on multiple participants. In this study, I continued to recruit and interview until no new information emerged (i.e., data saturation). I reached data saturation after the seventh interview.

Instrumentation

Maxwell (2013) asserted that the researcher is the primary instrument in qualitative studies. As a researcher, I designed a semi-structured interview tool to guide my questions. In the following sections, I explain the steps I took to collect and analyze

the data. Before I collected any data or conducted any fieldwork, I worked with my committee to obtain approval through Walden University IRB.

Data Collection

In addition to interviewing participants, Yin theorized that documentation, archival records, interviews, direct observation, participant observation, and artifacts are all methods of collecting data. Yin went on to assert that researchers should use multiple sources when collecting data because a single source is unable to produce all the required data. For my study, I used in-depth interviews, archival records, analyzed past studies, and obtained public records from state and government databases to secure multiple sources of data collection.

In-Depth Interviews

I interviewed helping professionals who have worked in community-based treatment programs for at least one year within the last five years. I used Walden's approved interview guide to guide my research. Also, I followed Rubin and Rubin's (2012) responsive interview model to direct the interview process. I chose this guide to help me construct the interview questions. The helping professionals provided (or have provided in the past) community-based treatment to individuals who identified as African American men with a dual diagnosis and who were considered high risk for recidivism. I recruited key informants (participants) who worked at multiple community-based treatment agencies in this region. Due to confidentiality and privacy concerns, I limited data to company records that were available to the public (Yin, 2011). Yin (2011)

theorized that the interview protocol is the foundation that guides data collection and ensures the collected data is relevant and able to answer the research question(s).

I conducted all interviews at private locations that included a library meeting room, a work conference room, and an individual's home. I ensured confidentiality and neutrality by meeting at these private locations. I informed each participant that the interview could take up to 75 minutes. I conducted all interviews in person and recorded all responses on two separate audio recording devices.

Archival Records

Another method I used to collect data was from archival research records. Yin (2009) wrote that archival records could either be qualitative or quantitative. Further, Yin (2009) stated that archival records are subject to biases and other shortcomings. When reviewing the documents, researchers must take into consideration the source and exercise prudence in analyzing the findings (Yin, 2009; 2011). According to Yin (2009), researchers relying too much on archival records should seek opposing views from various media outlets to ensure balanced reporting.

Member Checking and Transcript Review

Lastly, I offered follow-up interviews for member checking, to answer any additional questions, and to address any concerns from the participant(s). I also completed transcript reviews with each participant. I provided each member with a verbatim transcript of our interview. Each participant authorized me to use our interviews for data analysis and to present emerging themes (Kvale, 2008). By offering member checking and transcript reviews, I gave participants a chance to clarify any data I may

have misinterpreted. However, none of the participants requested a follow-up interview. I discussed data management and the coding processes in the next section.

Data Management

In the next section, I describe data coding and analysis as it related to understanding the social problem and addressed this study's research questions.

Data Coding and Analysis

Chermaz (2006) conveyed that the analysis plan consists of an inductive process and comprised of thematic schemes, coding, and taking notes or memos. As previously stated, I used this single-case study approach with the application of in-depth semi-structured interviews with individuals who work or have worked at community-based treatment programs with the identified group of African American men.

To begin the coding process, I immersed myself in the data and compared the data to the primary research questions. Next, I interpreted the data to answer the research questions. Then, I extrapolated reoccurring ideas (Chermaz, 2006). The interview guide was a deconstruction of the research questions. Therefore, the participants' responses were the raw data used for coding. Charmaz (2006) theorized that there are two phases of coding (e.g., initial coding and pattern/second coding). Initially, I analyzed all words to create broad summarizing codes or categories, and from this data, I completed pattern/second phase coding to polarize emerging themes (Miles, Huberman, & Saldaña, 2014).

To analyze the data, I used personal memos to record reoccurring themes or patterns from each participant (Miles et al., 2014). In addition to personal memos, I used

Microsoft Word and an “app” on my phone called Ottr to transcribe the data in vivo (i.e., verbatim responses). I used Microsoft Excel as a repository for extracted common thematic schemes that emerged from the interviews. Kvale (2008) recommended that researchers recode and combine common words, thereby raising these constructs to higher-level categories. Kvale indicated that coding involves attaching one or more keywords to a text segment so researchers can identify and categorize similar themes. Kvale (2008) and others theorized that data saturation could occur at this point when no new information emerges (Burkholder et al., 2016; Mason, 2010).

According to Glaser and Strauss (1967), the tenants of data interpretation are data collection, data analysis, and the data modification process. When I started analyzing the data, the categorization of information was not pre-formed (Glaser & Strauss, 1967). I recorded the participants’ responses and combined them with my analysis to generate the categories codes (Miles et al., 2014). During the initial interview, I created categories that emerged from the interview data through coding. Once I completed the initial interviews, I transcribed the responses and presented the data to the participant within seven days for their approval. Once the participant approved the transcription, I offered follow-up interviews within 30 days to clarify any information (i.e., member checking). I also completed transcript reviews with each participant. I gave each participant a copy of the transcription of the interview and they gave me verbal permission to use for data analysis. None of the participants disputed the transcriptions and no one requested follow-up interviews.

Morse (2015) informed that researchers should address any negative case analysis by denoting data outliers, or unique findings. The researcher opined that data outliers could be traced to the research pool and be a catalyst for further examination. Morse continued that researchers should highlight all commonalities and acknowledge the participant's unique experiences. There were no data outliers during the data collection process.

Securing Sensitive Data

After I identified the participants, I scheduled an interview based on the person's schedule. I audio recorded the interviews using a digital recorder and my cell phone. For security, I used a password and encryption design to protect the audio recordings. I labeled each interview according to the participants' pseudonym that included the date and length of time for each interview (e.g., 06.19.2019.57, 06.20.2019.35, etc.).

Although I used pseudonyms for each, I kept a master copy of each participant's information double-locked in my house (i.e., locked file cabinet and locked in my garage), and I will destroy all data in five years. Once I transcribed all the information, I permanently deleted all the audio recordings. I assigned each participant their unique pseudonym to protect their identity. I conducted all interviews at a private office, library, work conference room, and one participant's home. Again, the participant decided on all meeting locations. I transcribed all audio data to limit the risk of a security breach. Once the participant provided feedback or approved the transcription, I deleted all interviews from my recording devices. As an additional safety precaution, I copied and pasted all interviews from a word document to an Excel spreadsheet. I managed all aspects of the

security of the data by creating an encrypted password folder on my computer to reduce the chance of data exposure. Also, I had a different encryption and password for my phone and computer.

Exiting Procedures

I offered each person a follow-up interview to complete member checking upon completing the interviews and exiting the study (see Lincoln & Guba, 1985). These theorists proposed that the goal of member checking before and exiting a study is for participants to voice concerns, problems, or report their experiences while participating in a research study. I contacted each person and offered a follow-up interview, but each person declined. All participants also declined to offer any edits to their transcripts.

Issues of Trustworthiness

As the primary instrument for this research study, one goal was to ensure that others can follow-up and extend on the findings from this study. One method I used to ensure generalizability was by obtaining information from multiple sources. Merriam (1995) theorized that triangulation is the process of getting data from various sources and through multiple methods. Merriam continued that by investigating data or the confirmation of findings, qualitative research is deemed more credible. In comparison, Golafshani (2003) wrote that researchers use different data sources and look for similar results to strengthen triangulation.

Babbie (2017) stated the ingredients of generalizability are ensuring quality, creditability, and trustworthiness. Babbie went on to write that generalizability is threatened if researchers do not examine participants within context. When research

studies are context specific (purposive), researchers increase the chance of generalizability (Babbie, 2017). Once various testing can reach the same outcome, generalizability emerges, and the study is more valid and easily replicated (Golafshani, 2003).

Ravitch and Carl (2015), indicated that qualitative research creditability is achieved when the instrument is aligned with what is supposed to be explored. The authors continued that, like quantitative studies, researchers directly related internal validity to the research design. Trustworthiness/validity "is a researcher's approach to achieving complexity through systematic ways of implementing and assessing a study's rigor" (p. 187).

Other strategies to ensure generalizability is through member checking, external auditors, peer debriefing, and having prolonged engagement in the field (Ravitch & Carl, 2016). When keeping with the theme of contextual relevance, scholars should be intentional in ensuring that the participants' views are conceptualized, thus underpinning qualitative study as a valid method of conducting research (Ravitch & Carl, 2015). I used in-depth interviews, previous research studies, compared participants' findings and obtained training materials that corroborated my findings to strengthen trustworthiness.

Validity Threats

Moustakas (1994) theorized to reduce threats to validity, scholars must be mindful of researcher bias, reactivity, and faulty reasoning. From working in this field, I understood my assumptions and predetermined notions about the study (Kowalczyk & Truluck, 2013). In comparison to other researchers, Moustakas (1994) encouraged

researchers to document their assumptions and continuously self-reflect. Maxwell (2013) posited that the primary goal of documenting one's thoughts is to compare with the actual findings. Patton (2002) provided more clarity on research biases. Patton informed that researchers could not completely bracket their cognitions from a study; however, it is important not to project personal judgment and bias, based on past experiences.

As stated by Maxwell (2013), being mindful of leading behaviors (i.e., nonverbal cues) should be at the forefront of the interview process. To limit bias, I adhered to my semi-structured interview guide. Maxwell theorized that reactivity through awareness of one's behavior and acknowledging the power differential between the researcher and participant(s); researchers can reduce the chances of leading or swaying one's response. Additionally, I geared my research questions toward the respondent, so they were empowered and recognized as the subject matter experts (Cook, 2012).

A formal strategy used was peer debriefing. I debriefed weekly with my committee member or a colleague(s) not involved in the study. Creswell and Creswell (2017) opined that debriefing with individuals outside of the study could add rigor and challenge the procedures related to the study. Throughout the study, I had an ongoing dialogue with my committee chair via email, text, and regularly scheduled conference calls. Also, I debriefed with other colleagues multiple times a week about my study. My colleagues and committee members challenged me to think critically and consider my biases.

To ensure transferability, I provided a full description of each participants' responses (Creswell & Creswell, 2017). The authors elaborated that transferability allows

other researchers to apply similar constructs because of shared characteristics. Because I anticipated working with a relatively small group, I provided as much description as possible to get an accurate picture of their experiences. I used other formal processes (e.g., triangulation, offered follow-up interviews, transcript review, and offered member checking through follow up interviews (though no participants opted for a follow up), and addressed discrepant and disconfirming cases) to decrease validity threats (Morse, 2015). I thoroughly discussed these processes in the previous section under data management.

Ethical Procedures and Protection of Participants

Maxwell (2013) theorized that researchers are the main instrument when conducting qualitative studies. In keeping with this theory, I attempted to adhere to the highest standards of ethical safeguards. To reiterate, I gave all participants pseudonyms to ensure I concealed any identifiers. I gave the date and length of time of interviews as a pseudonym for each participant. Although the participants were working professionals, I used the American Counseling Association code of ethics as a template which guided me through the interviews (ACA, 2014).

I addressed these issues by ensuring that, (a) precautions were in place to protect participants according to Walden's University IRB and by following ACA ethical guidelines; (b) I promoted autonomy and empowered the participants to be transparent without fear of retaliation of any kind, (c) I was rigorous in protecting each person's privacy and confidentiality. Although I followed ACA ethics, I did not operate in a dual role. A breach of privacy and confidentiality was always a threat in this study. By following the standard tenants of commonly used safeguards (i.e., IRB and ACA Code of

Ethics), I mitigated these risks (Patton, 2002). Data misinterpretation was a concern, and as previously stated, I conferred with my committee chair, journaled, offered member checking, and conducted transcript reviews to reduce the chances of data misinterpretation. Lastly, I gave each participant a $10 gift card of their choice before their interview.

Summary

In this chapter, I provided a rationale for selecting qualitative methodology and using a single-case study as my approach. I re-stated my study's research questions, study purpose, problem statement, and provided an overview of how I conducted my interviews and the safeguards used to ensure the participants' rights. I addressed my role and responsibility as a researcher, with steps taken to managing power differentials, potential biases, conflicts, and an exit plan for each participant. Next, I addressed the data collection techniques that I used for my study. I outlined details specific to data management and data interpretation.

Also, I provided strategies to achieve trustworthiness, generalizability, validity, and saturation. Finally, I discussed ethical considerations and precautions, which ensured I follow standardized practices to protect human subjects. In Chapter 4, I detail information on the research setting, participants' demographics, the data collection process, and the impact of these steps used to ensure the validity of the research study.

Chapter 4: Results

The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment to African American men with a dual diagnosis, history of incarceration, and high risk for recidivism. I collected data through semistructured interviews with nine participants who met the inclusion criteria. Next, I coded and analyzed the data using thematic analysis. In this chapter, I provide an overview of the findings from my interviews. I reiterate the research questions and describe the study setting, ethical considerations, and demographics. I then describe data collection, participant recruitment, and data analysis. Evidence of trustworthiness and thematic findings are followed by a summary to conclude the chapter.

Research Questions

There were two research questions in this study:

RQ1: How do helping professionals provide community-based treatment to African American men with a dual diagnosis, prior incarceration, and high risk for recidivism?

RQ2: How do helping professionals establish relationships with their clients?

Setting

I conducted each interview for this case study in the Northeast United States. I started interviewing on January 4, 2020, and the final interview was on January 20, 2020. I gave participants the option to meet in person, by phone, or by video. All participants chose to meet in person for the interview. I conducted each interview at a private location

determined by the participant. Locations included conference rooms at a local library, business offices, and a participant's home.

Participant Profiles

Each participant self-identified as meeting the inclusion criteria on the demographic screening questionnaire (see Appendix C). The participants' ages ranged from 27 to 68, and their work experience ranged from 2 years to 40 years in the helping profession. I excluded other demographic information to ensure confidentiality. The data I collected during the interviews included participants' roles while working in community-based programs, length of time in the field, how they provided treatment, and information on the helper/helpee relationship. I included some of this information in the data analysis (i.e., barriers, challenges, successes). This information assisted in answering the research questions.

Descriptions of the participants are as follows; pseudonyms were used to replace their names:

- 1.4.2020.KC.31: A 17-year human service professional who has worked with African American men in inpatient and community-based programs. Identified as a peer specialist.
- 1.6.2020.RI.37: An 8-year licensed professional counselor with a private practice. He currently works with adolescents with mental illness but has worked as a community-based therapist for multiple organizations. Identified as a peer specialist.

- 1.10.2020.SW.40: An assistant director presently working for an agency in the Northeast United States. Her clients have a dual diagnosis and are reintegrating into the community from prison and mental illness institutions. Identified as a peer specialist.
- 1.13.2020.GZ.52: A 20-year human service worker who provides clinical services to African American men with a dual diagnosis who are incarcerated at Level 4 facilities (i.e., halfway houses). This participant is responsible for linking these individuals when they leave the halfway house and reenter society.
- 1.16.2020.PBH1.47: A 40-year community-based state worker who was a police officer for 20 years. He works with individuals and families to ensure they are receiving state benefits and other entitlements.
- 1.16.2020.PBH2.31: A social worker who has worked in community-based programs for over 10 years. In the past, she worked for the Department of Corrections as a therapist and caseworker.
- 1.16.2020.PBH3.21: Has worked for over 5 years as a caseworker and treatment coordinator. She currently oversees service provisions for African American men with dual diagnosis and who are at risk for recidivism.
- 1.20.2020.ACFMW.40: A helping professional who identified as a peer specialist with over 20 years of experience working with the impacted population as a direct care worker in the community and as an administrator.

- 1.20.2020.CCCS.30: A team leader for the FACT and ACT teamss for an organization in the Northeast United States. Self-identified as an African American male in recovery. He went on to disclose that he has a dual diagnosis and had been incarcerated.

Data Collection

For this study, I interviewed nine helping professionals who had worked or were currently working in community-based treatment programs within the last 5 years. I used the interview guide for all participants. I referred to Rubin and Rubin's (2012) responsive interview model, which guided the interview process. I used this guide to construct the interview questions. Participation was voluntary, and each participant contacted me through Walden University's email address. Also, I provided a temporary cell phone number from an application on my cell phone (TextNow). Through TextNow, I got a temporary phone number and used the application to maintain contact with each participant. When the participants responded, I discussed the nature of the study as outlined in the participant recruitment flyer (see Appendix E). I emailed participants a copy of the informed consent and did not have to make any modifications. I audio recorded each interview. The interviews lasted between 21 and 57 minutes, with a total time of 329 minutes. I used two separate handheld recording devices (cell phone and manual recorder) in case one of the devices failed during the interview. Once I completed each interview, I transferred the audio files to my password-protected computer and assigned an alphanumeric pseudonym for confidentiality (see Patton, 2002) and

transcribed each interview. Once I moved the recordings to my password-protected computer, I deleted the files from both recording devices.

Recruitment

I recruited participants by posting flyers on public message boards, in area coffee shops, in libraries, and online public forums (i.e., LinkedIn, Facebook, Twitter). One participant referred four of her coworkers, and each person met the inclusion criteria. Three participants responded after seeing the flyer from an online posting forum, and one participant reported seeing the flyer in a local coffee shop. The respondents worked in community-based treatment program agencies in the Northeast United States. One participant is currently working in Pennsylvania but has worked in other states within the last 5 years. I interviewed nine individuals out of 12 people who responded to my recruitment efforts. Three respondents did not meet the inclusion criteria.

Interview Process

Before each interview, I reviewed the informed consent with each person and offered to answer any questions or make any modifications. After I received a signed informed consent from participants, I provided them with a copy. I archived a masked copy of each signed informed consent that I secured under a double-locked subfolder on my personal computer. Next, I provided each participant with a list of community mental health agencies to contact if any issues arose while recalling painful or emotional experiences as a helping professional. I conducted all interviews in person at a location chosen by the participant. I received permission from each person to audio record the

interview. I stored all notes and cross-referenced documents in a secure location in my home under a double-lock protocol on my personal computer.

Transcribing Interviews and Transcript Review

After I completed each interview, I immediately began transcribing. I used an application from my cell phone provider (Ottr App) to complete my initial round of transcribing. The Ottr App was free and easy to use. As I conducted the interviews, the Ottr App recorded the conversation and transcribed the data in-vivo. I reviewed the transcript after each interview and made all the necessary corrections. I sent all transcripts to participants within 7 days. All participants approved their transcripts and gave verbal permission for me to use them for data analysis.

Data Analysis

The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment to African American men with a dual diagnosis, history of incarceration, and high risk for recidivism. I also explored how helping professionals establish relationships with their clients. I sought to better understand this social problem in the context of helping professionals working at community-based treatment programs. To mitigate researcher bias, I excluded anyone with whom I had a professional relationship, including students, relatives, or clients. I did not identify any discrepant cases during the data analysis process.

In the first phase, I immersed myself in the data to find similar codes or patterns (see Yin, 2009). After listening to each interview approximately five times, I transcribed and read over the data collected (see Yin, 2009). The author posited that coding could

begin at this point if the researcher is familiar with the data (Yin, 2009). As someone who worked in the helping profession for over 10 years, I recognized emergent codes from the first three to four participants. Yin (2009) noted that an advantage of pattern matching is the contribution to internal validity if consistent patterns emerge. I examined the data through the theoretical lens of Hirschi's (1969) social control theory by looking for concepts that underpinned the helper/helpee relationship. Also, I focused on ideas that revealed how participants provided community-based treatment.

To begin the coding process, I took an inductive approach and examined all of the data in their raw form. I examined the data approximately five times before identifying emergent codes. As Yin (2009) theorized, researchers should develop codes as they examine the data to identify emergent codes. In contrast, researchers can also identify a priori codes before examining the data (Yin, 2009). I compared the data to the research questions and the theoretical framework to ensure that I answered each question (see Yin, 2009). Next, I extrapolated any recurring ideas (see Chermaz, 2006). I created a coding log that categorized all of the codes identified throughout the data analysis process (see Miles et al., 2014). At this point, I examined all of the data from each interview between three and five times to identify themes in my codes (see Yin, 2009).

After approximately 3 weeks of reviewing the themes, I began to define or explain the themes. Charmaz (2006) theorized that there are two phases of coding (e.g., initial coding and pattern/second coding). Yin (2009) identified this as the explanation building stage of data analysis. I recorded a log that captured all the data I collected from

the respondents, and then I grouped the data into two categories (i.e., tangible and intangible outcomes).

Yin (2009) asserted that in the explanation building stage of data analysis, researchers put forth meaning to the phenomenon under examination. At this point, I compared the theoretical framework (i.e., Hirschi social control theory) with the emergent themes. This study proposed that the helper/helpee relationship impacted treatment outcomes. I was especially mindful of any themes that corroborated this proposition. The participants used phrases such as “being consistent” and “following through on promises.” This type of initial or first cycle coding allowed me to categorize and begin to interpret the data into analyzable pieces (Miles et al., 2014). Yin (2011) theorized that it is essential for researchers to seek rival explanations that can add rigor to a research study. Yin (2011) continued that researchers can consider, accept, or reject the competing explanation. After going through each interview and analyzing the data approximately 5 times over 5 weeks, I did not identify any rival explanations or discrepant data that could be an alternative answer to the research questions. Next, I analyzed all the responses to create broad summarizing codes, and, I completed pattern/second phase coding that supported the emerging themes (Miles et al., 2014).

The next steps outlined by Yin (2011) [i.e., time-series analysis and logic models] were not appropriate for this single-case study. Yin (2011) theorized that time-series analysis and logic models are used to dispel rival explanations or for evaluations after an intervention, respectively. As previously stated, there were no alternate explanations or discrepant cases that emerged from this study.

Evidence of Trustworthiness and Credibility

Marshall and Rossman (2006) asserted that credibility is when the findings of a research study are believable. I attempted to ensure credibility by taking all precautions to minimize my personal biases (see Goldblatt, Karnielli-Miller, & Neumann, 2011; Zikmund & Babin, 2012). The first measurement of trustworthiness and credibility I took was by following the proposal and application that were approved by the IRB. Also, I documented any pre-conceived notions before the interviews (see Moustakas, 1994). From working in the field for over ten years, I anticipated some of the answers from the respondents. However, I made every attempt not to project my experiences or lead the participants during the interview (see Moustakas, 1994). As Moustakas informed, I continuously reflected on my experiences and tried to minimize reactivity to the responses and I remained mindful of biases.

To manage my biases, I also participated in peer debriefing. I attempted to maintain the integrity of the study by using these safeguards throughout the data collection process (see Creswell & Cresswell, 2017). Lastly, to increase creditability, I used an interview protocol to ensure all participants were asked the same primary interview questions (see Zikmund & Babin, 2012). I maintained a comprehensive journal and took notes during the research process so I could justify the specific measures I took during the case study and documented any follow-up questions.

I triangulated the data by comparing the participants' responses with previous research studies, training materials from community-based agencies, archival records, and by analyzing the responses according to social control theory. My dissertation

committee served as my peer review team to further promote trustworthiness. I also used direct quotes from participants to add rich data description and reinforce my findings.

Transferability, Dependability, and Confirmability

As recommended by Creswell and Creswell (2017), I provided rich description of each participants' responses, themes, and case descriptions. In doing so, the authors contended that transferability allows other researchers to apply similar constructs because of shared characteristics. According to Morse (2015), because I worked with a relatively small sample group, I provided as much description as possible to get an accurate picture of each participants' experiences. To further decrease validity threats, I used other formal processes (e.g., triangulation, transcript reviews, and offered to schedule member checking; see Morse, 2015).

As previously stated, I interviewed a small group of individuals, thus making dependability a challenge (see Morse, 2015). Although I interviewed a small group, I recruited a diverse sample of individuals who have worked in different capacities in community-based programs. I also analyzed the data in a way to address each participants' background experiences as it pertained to the helper/helpee relationship. By exploring their work experiences, I collected an array of data within the sample and coded common themes related to the sample as a group. I kept a research journal to check my findings and manage my biases. I used the journal for auditing purposes and to ensure generalizability (i.e., transferability; see Morse, 2015). I triangulated the data by comparing my findings to the theoretical framework and the individuals' responses. I also compared my findings to past research literature reviews to confirm my findings.

Ethical Considerations

I followed all the ethical considerations identified in Chapters 2 and 3. Before I began data collection, The Walden University Institutional Review Board approved my research study and associated informed consent forms. My IRB Approval for this study is (12-18-19-0652205). The ethics review board thoroughly vetted my study before data collection and the study was supervised by the university's doctoral oversight committee. I followed all ethical protocols, which made this study ethically sound (Ells, 2011).

Results of Data Analysis

The purpose of this qualitative, single case study was to understand how helping professionals provided community-based treatment to African American men with a dual diagnosis, incarceration histories, and who were considered high-risk for recidivism. After analyzing the data, I created two categories.

The first category was tangible outcomes. I created this category to address the primary research question. The leading research question was how do helping professionals provide community-based treatment to African American men with a dual diagnosis, prior incarceration, and who are considered high-risk for recidivism? When the participants answered this question, their responses alluded to measurable results by which they can quantify their level of competence when providing treatment.

As I compared the different responses, I found that there were re-occurring identifiers that the participants denoted when they described how they provided treatment in the community. I placed these themes under the broader scope of tangible outcomes. These major themes were: (a) lack of knowledge of resources, (b) accessing resources,

and (c) completing treatment. I extracted direct responses from the participants during the interview and embedded some of the answers into this study to visually supplement my findings. In this section, I explain the process used to move inductively from coded units to larger representations, including categories and themes.

First Category Tangible Outcomes (Providing Treatment)

Theme 1: Lack of Knowledge of Resources

The first theme that emerged under the tangible outcomes category was helping professionals and their perception of the lack of knowledge of resources. The participants contended that there are community resources available for their clients. Still, it is incumbent of the helping professional to familiarize themselves with the various systems of care and what these systems offer for their clients. The participants reported that the more familiar a helping professional is with community resources, the likelihood the client can successfully move throughout the continuum of care. Some of the helping professionals denoted having a good professional relationship with workers from other systems of care.

Participant 1.10.2020.SW noted the following:

> For me, I want to be able to connect them [clients] to a service that's going to benefit them. So, as I'm hearing their story in my mind, and I'm already thinking, what place, what provider, what agency would be a good fit for them.

Another worker further confirmed this theme and explained the importance of providers strategically placing services where the clients can easily access the services.

Participant 1.16.2020.PBH.21 add the following:

> I would say that for the community-based programs to even get off the ground, and they have to be in the environment where they need them the most. We (i.e., service providers) tend to isolate where the providers are located, which is a barrier in transportation. Most of the clients that we serve are not going to be able to access the community-based resources if it's not in the areas that needed the most. I would say cost. How does somebody pay for services that they may need? Insurance is a barrier when you compare private insurance versus Medicaid. Providers should be able to adjust to the needs of each individual person.

Participant 1.16.2020.PBH.31 observed the following:

> And I think it makes a big difference for the community to trust in the service. I think it needs to be consistent services as often as we can, and once that can actually provide assistance, beyond just wanting to sit and talk to you like really wanting to expand your quality of life. But like, we don't we don't have that opportunity right now, we're really working on limited resources. And that's a big barrier.

One participant went on to talk about how the resources in this state differ depending on where the client resides. He went on to say that clients in downstate (i.e., Southern region) face transportation barriers, and providers do not offer as many resources as upstate (i.e., Northern region).

Participant 1.6.2020.RI.37 noted the following:

> You had smaller agencies that were doing inpatient and outpatient groups for people so there was much more access upstate. It was it was a little bit easier to also get resources. It was much easier to go to state service centers up here. Downstate, the service centers are spread out few and far between Dover, and you have you Georgetown. So, it was it was very difficult downstate. And then, of course, with transportation when you have a hard time getting around downstate. You really need to know where to find additional resources.

Theme 2: Accessing Resources

When I started to analyze the data and extract themes, accessing resources emerged as a major theme under tangible outcomes. The participants indicated that providers are not equipped to manage the needs of this population within the system of care. They went on to identify several barriers (e.g., individualized treatment, inadequate funding, integrative healthcare, etc.). The participants expressed frustration about all the systemic shortcomings they face when working with this group. The workers reported that there are many needs, but the system does not provide the necessary resources for clients to be successful. The lack of individualized services emerged as a deterrent to accessing resources.

Participant 1.4.2020.KC.31 reported the following:

> You know, I want to talk about recidivism. I mean that that's part of it. We have individuals engaged in a program for a specific amount of time, and we don't give them the proper tools for the next level of care, and recidivism becomes greater. So complete, individualized, wraparound services, is what I envision.

Participant 1.13.2020.GZ.52 talked about a successful model used at a past community-based program. He used the term "*in-reach*" opposed to "*out-reach*" and went on to describe this treatment model:

> If you can afford to staff, those particular resources [with-in the program] you know, if you can have a relationship where you have instead of out-reach, you have in-reach. You have those service providers coming to you on a daily basis, and then we're literally providing those services in house.

Participant 1.20.2020.ACFMW.40 cited inadequate funding as a barrier:

> Overall, the politics of the budget in this state is wrong. Each department is trying to get a slice of the pie. And, you know, it kind of seems like, you know, like there's always money for roads, there's always money for construction, there should be more money allocated for treatment, as well as education. I firmly believe the more education people have, the more they know about a topic, the less likely they are to engage in those negative behaviors or if they've been in the system, be incarcerated. The more knowledge you have on the topic, substance abuse, mental health, and if they're getting the proper treatment, the less likely they re-offend.

Participant 1.13.2020.GZ.52 spoke about his vision of the perfect community-based program. He described a facility where a person leaving prison can get all their needs met in one place and slowly transition back into the community.

> When you come to get what you need from them in the inpatient setting, and they do individual and groups (e.g., counseling), they are more willing. But when

you're not providing those things for them, and they feel constricted, restricted confined and, you know, nothing never seems to go their way and, you know, so creating a setting, and a program where there's constant inflow and outflow, right? Where they can kind of feel like they are home, but they are out in the community, they are receiving services, and it's helping them to like kind of really really adapt and adjust to what real living in the community would be like.

Theme 3: Completing Treatment

After accessing the appropriate resources, these helping professionals measured outcomes according to successful treatment completion rates or readmission. The workers from my study emphasized completing treatment is not solely the responsibility of the client. They opined the system lacks an evidenced-based model or a process that can improve treatment completion.

Participant 1.16.2020.PBH.47 noted the following:

I've always said you have to have a "one-stop" shop. You know where you start on the ground floor, and by the time you get to the top floor, you're ready to graduate, or you have graduated. And now you're just taking the elevator out the door. You're going down, but you're taking the elevator out to success.

Participant 1.16.2020.PBH.21 added the following:

I think one of the challenges is especially with dual diagnosis is that the clients get ping pong back and forth because it's either a substance abuse problem, or it's a mental health problem, and people don't like to focus on dual diagnosis they

like to ping pong the client back and forth to whatever they think the primary diagnosis is and not deal with both.

Participant 1.13.2020.GZ.52 spoke about the need for additional training and implementing evidence-based practices. He talked about how helping professionals should continue to educate themselves on the newest approaches when working with these men:

> Well, I'm a big stickler on being current evidence-based practice, right? Reading up on new, new practices or theoretical approaches, right? I think that we have too many professionals, still operating in old theories and practices right and have not come up to today's understanding of mental health, severe persistent mental health, traumatic experiences, trauma-informed care. And really, really don't understand you have to address both issues (i.e., mental illness and substance abuse).

Participant 1.4.2020.KC.31 observed the following:

> That's the the biggest gap in the services, not addressing both. It's like we start, but we don't finish guys. I hate to put it that way, but you got to go point it out, you know. We start, but we never finish right, it's kind of almost like this, it stops then just start up (again) they keep coming back. Another significant finding under completing treatment was the lack of housing. The participants reported that many of their clients struggle with completing treatment because basic needs (i.e., stable housing) go unmet.

Participant 1.10.2020.SW.40 reported the following:

> Housing is where we are struggling with a lot of individuals who are coming out of prison. The reentry programs are able to provide many of the services, and they provide the resources that these individuals need. Housing is where they get stuck.

Second Category Intangible Outcomes (Helper/Helpee Relationship)

To address the research sub-question, I created a second broad category (intangible outcomes). The subquestion was, how do helping professionals establish a relationship with their client(s)? When answering this question, the respondents described their approach to creating a rapport with their clients as a transactional engagement with intrinsic values being the foundation for the helper/helpee relationship. Again, I extracted three significant themes and placed them under a broader scope (i.e., intangible outcomes). The major themes under category two were: (a) helper's motivation, (b) perception of the helper/helpee relationship, and (c) helper's fidelity.

Furthermore, when I started to compare the responses to the theoretical framework, I created subthemes. The subthemes illuminated how the answers aligned with Hirschi's social control theory. After completing my data analysis, three of Hirschi's social control theory tenants emerged thus, further confirming the theoretical framework and its impact on the helper/helpee relationship. The subthemes were (a) helpers' motivation (subtheme – intrinsic pull [belief]), (b) perception of the helper/helpee relationship (subtheme - cultural inclusivity and consistency [commitment]), (c) helpers' fidelity (subtheme: protecting the therapeutic alliance [attachment]).

Theme 1: Helpers' Motivation (Subtheme: Intrinsic Pull)

When analyzing the data to understand better how helping professionals establish relationships with their client(s), the first theme that emerged from my analysis was the participant's motivation to provide treatment to this specific population. The subtheme "intrinsic pull" emerged as an outlier for the helper's motivation when working with this group. During the interviews, several of the participants cited themselves, family members, or significant others as individuals who had a history of substance abuse, mental health, or legal problems. Some asserted their job does not pay a lot of money and can feel "thankless," but the intrinsic value is what drives the helper/helpee relationship. Participant 1.20.2020.ACFMW.40 stated the following:

> Well, to be a helping professional. You have to have a desire to want to work with these clients and their families. I consider it to be *God's Work.* It's a thankless job. It requires a lot of patience, a lot of understanding. A lot of thick skin and the ability to really go above and beyond and think outside the box and be unorthodox. Sometimes to help the family or client with whatever needs they have. I have family members that have needed services, and I would want someone to help them as well.

I noticed when the participants began to talk about their past lived experiences, they reflected on their struggles or that of a loved one. Participant 1.6.2020.RI.37 spoke about his past issues and his first experience with receiving services from a helping professional:

> I started to have some of my own issues, and my parents actually sent me into counseling early. My parents felt like it was necessary, and I also had some court-mandated counseling. I did have my first counseling session with a black male. He worked with adults that were going through mental health and drug abuse problems, and he saw me as a favor to my mother.

Participant 1.6.2020.RI.37 shared more about what motivates him:

> You know, I'd like to say that it's something deep-rooted from the past. But I can't quite say that. Obviously, I haven't shared their story. You know, of course, I have empathy from the standpoint of, I can understand some sorts of loss in different times in my life, but not to the same degree. So, I do sympathize with the situation. I do want them to understand that whatever they feel like they've lost before, they can rebuild. I just feel like if I give up, then they'll give up. So that's really just what drives me. I just can't give up.

Participant 1.16.2020.PBH.47 discussed how one of his childhood coaches motivated him to treat others with respect and dignity despite their differences:

> I always go back to the experience I had as a kid. I played little league baseball in a community that was completely different from my own. And one of the coaches, his name was Hutch. And it was in the early 60s, a time of racial segregation. I was new. Integration was also new in the community. And I happen to be one of four African Americans on his on his team, but he treated each and every kid that tried out for the team equally. And if there was any type of

discrimination or racial disparity among the other kids' parents or the communities that we played, he stood up for me, and that struck me.

Theme 2: Perception of the Helper/Helpee Relationship (Subtheme Cultural Inclusivity and Consistency)

The perception of the helper/helpee relationship proved to be an essential piece when establishing a relationship with community-based clients. The subthemes that emerged were cultural inclusivity and consistency. The participants reported that their clients placed value on how workers included natural supports and demonstrated cultural awareness. They went on to discuss how most of their clients had bad past experiences with helping professionals and tend to have negative perceptions of professional supports. However, in their experiences, by taking a culturally inclusive approach and utilizing natural supports as assets in treatment (i.e., family members), the workers were able to change the clients' perceptions of professional supports.

Also, according to the participants in the study, most of the clients place a high degree of value on consistency. The workers reported that many of their consumers had been involved in the system for a long time, and providers gave them false expectations of treatment. The workers recommended managing the consumers' expectations and demonstrating consistency to maintain a positive perception of the helper/helpee relationship.

Participant 1.4.2020. KC.31 noted "and I see that consistency helps you know. Because individuals they look for some consistency, you know, um, when they're they're at their most vulnerable state, you know, and they look for consistency from us."

Participant 1.13.2020.GZ.52 noted the following:

You know, they're so good at calling you on your stuff, right? Because they see you every day and I tell my staff all the time. Like, make sure whatever you do with these members, you're consistent and be fair, because they're going to call you on it, you know? And so I think it's important "*man"* that that we demonstrate, you know, appropriate ethical and professional behavior.

Participant 1.16.2020.PBH.31 add the following:

I think that a big strategy that I use is that I'm not trying to interact directly with that individual, but I try to maybe find ways into forging a connection with them through other people in their community or in their life. So, if, you know. If I have to work with the individual but I can also work with their children, that's a little bit easier of a group for me to kind of infiltrate and get working with. And then I can earn the trust of, you know, the adult men that are needing to participate in these things and needing to get help. If they see that, I'm kind of there for their family and they can see trust that way.

Participant 1.13.2020.GZ.52 observed the following:

Well, the first piece again is meeting the client where they are, you know, understanding the cultural dynamics of that particular person getting to know them, you know, always making them feel like they're important. Following up and following through. You know, if, if I say I'm going to do something I need to make sure that I do it, right? Not interrupting the therapeutic relationship process, right? Being who I'm supposed to be to them, right, because the actual reality is, I

work for them, right. And so, my attitude, my professionalism, my being there on time, my leaving at the right time, modeling for them. So, I think that's important.

Theme 3: Helpers' Fidelity (Subtheme Protecting the Therapeutic Alliance)

Although many of the participants admitted they were frustrated with the systemic barriers (i.e., lack of resources, location of services, insurance challenges, and housing), overall, they remained positive and valued the helper/helpee relationship. When I analyzed the data, Helper's Fidelity was a significant finding. Specifically, protecting the therapeutic alliance emerged as one of the most critical components in the helper/helpee relationship. Several of the participants used the term "*hopeful.*

Participant 1.10.2020.SW.40 noted the following:

I always have hope for my people - always have hope. So, you're not going to connect with everybody as a helping professional, you just not, but it makes it difficult because you know once you have someone that's negative, that's not open or willing to accept the services it's is like, what more can I do? How can I go about this differently to let them see that I have hope for them, other than telling them hey, I'm holding the hope for you?

Participant 1.16.2020.PBH.21 added the following:

So, I think to build a good strong therapeutic alliance is really important. And part of building a therapeutic alliance is really showing the individual that you're, and you're going to do what you say you're going to do. You're going to be on time, and you're gonna follow through. So, starting off on really building that therapeutic alliance before you can really make any meaningful changes.

Participant 1.16.2020.PBH.47 observed the following:

That's probably the toughest part is keeping them engaged. But if you've been consistent, and you've been honest, and you've given them a sense of hope and knowing that you're simply a phone call, e-mail, away - then, if you've established the trust, if you established consistency. Then they will come to rely on you to a degree.

Participant 1.20. 2020.CCCS.30 contributed the following:

What I do is I show up anyway. In spite of whatever is going on, I'm gonna show up anyway. Now you have a choice not to get in my car when I show up, but I'm gonna be there at eight o'clock in the morning to get you to the appointment. So, despite of what happened the day before, I'm not taking it personal. I'm modeling that behavior and showing them that you got to continue to press forward, no matter what. Nine out of ten, they get in the car with you. You gotta stay consistent, man.

Summary

In this chapter, I provided an overview and a detailed report of my findings. Each participant voluntarily agreed to participate in this study. Everyone met the specific criteria for participation and completed individual interviews that lasted up to 57 minutes. This timeframe included a question and answer period. I transcribed and coded each interview(s) using a combination of Yin's (2009) and other seminal researcher's theories on data analysis for case studies (Chermaz, 2006; Saldaña, 2014).

After analyzing the data multiple times, I constructed two categories and used them as depositories for the emergent themes. The first category was tangible outcomes (providing treatment). There were three themes for this category: (a) lack of knowledge of resources, (b) accessing resources, and (c) completing treatment. The second category was intangible outcomes (establishing the helper/helpee Relationship). Three primary themes emerged from the findings: (a) helper's motivation (b) perception of the helper/helpee relationship, (c) helper's fidelity. Respectively, the subthemes under category two were intrinsic pull, cultural inclusivity and consistency, and protecting the therapeutic alliance.

During the interview process, I noticed that most of the participants experienced many of the same barriers when providing treatment. When I conducted the interviews, I asked each helping professional about their experiences when working with the targeted population in the community-based setting, and immediately barriers to providing treatment emerged. The participants identified location, lack of transportation, fragmented services, safe housing, and the need for treatment continuity (i.e., one-stop treatment facility) as some of the barriers. The participants also provided suggestions on how clinicians in this area can improve service provision and how agencies can better understand the impact of the helper/helpee relationship relating to successful treatment.

In the following chapter, I will discuss how the findings from the study's subquestion substantiated Hirschi's theory on social control, and it's how the tenants promoted social conformity (i.e., treatment compliance). Also, I will detail how my findings further extend the knowledge in the human services field by comparing the

outcomes with past studies. Lastly, I will discuss the limitations of the study and recommendations for the implementation of the findings and future research.

Chapter 5: Results Discussion, Conclusions, and Recommendations

The purpose of this qualitative single case study was to understand how helping professionals provided community-based treatment to African American men with a dual diagnosis, history of incarceration, and high-risk for recidivism. I sought to explore how helping professionals provided treatment to this population, and how, if at all, the helper/helpee relationship impacted treatment outcomes. Given the lack of literature on the experiences of helping professionals working in community-based programs, I used a qualitative approach to elicit a rich description of community workers' experiences. Because qualitative research focuses on generating meaning and understanding through the rich description of experiences (Merriam, 1995), I used qualitative methodology to explore and understand the participants' experiences regarding their provision of treatment to this population of African American men.

Interpretations of the Findings

There were several key findings from this study that aligned with current research. These findings emphasized barriers that helping professionals faced when working with African American clients in community-based programs. The helping professionals reported a lack of knowledge of specific community resources, an inability to access other resources, and a need for clients to complete treatment in lieu of facing recurring obstacles. I also designed this study to gain a better understanding of how this sample of helping professionals established the helper/helpee relationship. Key findings indicated that workers' intrinsic motivation, perception of the helper/helpee relationship, and the helpers' fidelity contributed to the therapeutic relationship. The tenets of

Hirschi's (1969) social control theory that aligned with my findings were attachment, belief, and commitment. These constructs confirmed the study's proposition that the helper's relationship with their client had a significant influence on treatment compliance (i.e., social conformity). Yin (2011) advised that when conducted a case study, the researcher must seek to answer the research questions by aligning the propositions with the findings.

Theme 1: Lack of Knowledge of Resources

This study extended the knowledge from prior studies in the human services and criminal justice field. Ogloff et al. (2015) found a correlation between systemic barriers, substance abuse, mental illness, and treatment outcomes. Ogloff et al. also confirmed that individuals with a dual diagnosis are at higher risk for reoffending if not paired with knowledgeable helping professionals. Peters et al. (2017) argued that helping professionals should not only have a thorough understanding of resources but should also understand these resources within the context of their culture. Kim (2016) recommended an interdisciplinary team approach with workers from other systems of care when working with this population. The results from my study were consistent with the recommendation of an interdisciplinary team approach. Participant 1.16.2020.PBH.21 stated that workers need to understand the needs of the clients and "know what resources are in their communities." However, another participant shared that the system of care is too fragmented in this region.

Further, my research revealed that it is not enough to have a core competency of being a knowledgeable helping professional; workers also need to know how to navigate

the systems for this heterogeneous group of African American men. Bond and Drake (2015) recommended that workers should be familiar with different systems of care to better address the needs of this complex group of clients. Nijdam-Jones et al. (2017) provided insights on how practitioners are not the only consideration when it comes to this group of consumers accessing health care resources. Nijdam-Jones et al. suggested that these workers should understand and address the cultural needs of the disproportionally affected group of African American men who are less likely to have access to resources than the general population. Redmond et al. (2017) advised that the lack of knowledge of resources can be attributed to workers not knowing what resources are available in their clients' communities and that this gap in knowledge further compounded problems for this group. Collectively, the literature indicated that integration of services is required but not all practitioners understand how to navigate those resources in a manner that addresses clients' needs on a holistic level.

The current study illustrated how working with individuals with a dual diagnosis might enable a helping practitioner to develop a knowledge base of resources that could be aligned with a culturally specific group. This finding is consistent with Hamilton and Belenko's (2016) study, which suggested that within the context of seeking to provide effective community-based services to this group, a helping professional could adequately address the needs of the population if they were familiar with the systems. To further substantiate these claims, Peters et al. (2017) indicated that helping professionals working within the dual diagnosis system of care who knows the criminal justice system and cultural awareness have better outcomes when working with this population.

A protective barrier against recidivism is the ability to navigate the various systems (Kingston et al., 2016). In my study, this concept was illustrated by Participant 1.10.2020.SW.40 who stated “as soon as she assessed the needs of her client, she immediately started to think of a program or provider that specialized in those needs.” This finding underscores the importance of practitioners not only understanding the needs but also anticipating the needs of the marginalized group of African American men adversely impacted by their life circumstances and dual diagnosis.

The current study revealed a risk for gaps in service provisions for African American men with dual diagnosis on multiple levels. The findings indicated how organizations and helping professionals can be more effective when they are knowledgeable of other systems of care, are culturally competent, and are able to ensure resources are culturally relevant to the client. Collins (2017) explained how most providers’ treatment approach is Eurocentric and widens the gap between this population of African American men and helping professionals. As I analyzed the data from my findings, I identified a nexus between knowledgeable workers and positive treatment outcomes for this group of African American men. This finding is important because when organizations are creating treatment strategies for this group, it is critical to understand the barriers these individuals face and take an integrative approach when working with this group (see Ratts et al., 2016). This gap in the resources and knowledge of wraparound services for this population of clients suggests that there are opportunities for training to address this need for intraagency coordination and information sharing.

Theme 2: Accessing Resources

Client access to community resources appeared to be a prevalent need for African American men with a dual diagnosis and high risk for recidivism. This finding illustrated a concerning trend, from Buckmon's (2015) study, which highlighted the challenges this group of African American men experience when trying to access resources. This group remains more susceptible to reoffending than other ethnic groups (Hack et al., 2017). Buckmon (2015) hypothesized that the continued disparities in education, employment, and disjointed dual diagnosis treatment were contributors to criminal activities. Prince and Wald (2018) corroborated these conclusions by indicating individualized dual diagnosis treatment decreased the rates of criminal justice involvement. Hack et al. (2017) also confirmed that African American men with a mental illness, substance abuse problem, or both are at higher risk for police contact compared to the general population. The findings from my study suggested similar concerns when working with this group.

Several participants from my study suggested there is a heightened risk for incarceration for African American men with a dual diagnosis. Participant 1.20.2020.ACFMW.40 reported that his region does not have enough resources to compensate for this group. He also noted that the system allocates money for "infrastructure" (i.e., roads, construction, prison) but not "treatment." Other participants' alluded to how the system of care for this group is underfunded when compared to other systems of care (i.e., criminal justice). The helping professionals from my study were consistent in reporting how this group of men continues to struggle to get their needs met. The participants in my study also reported that regional policymakers have not allocated

enough resources to community-based programs for this group. The responses from participants in my study were consistent with Miller and Miller (2017) who made a case for legislators to earmark more capital for individualized treatment for this group.

Amasa-Annang and Scutelnicu (2016) also emphasized the importance of having additional resources for this group of consumers. Clark et al. (2016) cited inadequate funding, providers' perception of working with this group, and difficulties accessing individualized treatment for individuals with a dual diagnosis. Clark et al. also suggested that providers should take an innovative approach and create treatment initiatives for this group. Finnerty et al. (2015) provided insights on how resource planning plays an intricate role in accessing resources. Finnerty et al. recommended pretransition meetings, multiple phone contacts with new providers, and having a liaison (i.e., case manager) as the point of contact to make a more seamless transition to the next level of care. Participants in my study also emphasized the relationship between individualized treatment and higher success rates. This finding was important because it built on the social construct of how this group of men lack the support of knowledgeable helping professionals. Also, the findings indicated the paucity of accessible integrative health care and treatment continuity for this group of African American men.

In this section, I detailed challenges for workers when accessing individualized treatment, advocating for additional funding, and accessing the resources to transition from community-based treatment to less-intense treatment. In the next section, I will discuss the findings which were associated with African American men in this group completing treatment.

Theme 3: Completing Treatment

The final theme that emerged from category one (i.e., tangible outcomes) was the problems associated with completing treatment. The participants from my study informed that by addressing both mental illness and substance abuse together, the clients saw higher rates of treatment completion. My findings confirmed past evidence by Lamberti (2016) and others, who suggested this segment of African American men, with a dual diagnosis, are incarcerated at higher rates than the general population and are less likely to complete treatment (Buckmon, 2015; Prince & Wald 2018). Researchers went on to emphasize the importance of treating both mental health and substance abuse at the same time to improve treatment outcomes (Elison et al., 2016). Other scholars have reached the same conclusion and have reported more positive results for this group when providers treat both problems simultaneously (Dias et al., 2018). My findings echoed a more current study on addressing dual diagnosis (SAMHSA, 2020). The researchers presented recent data showing that helping professionals who treated both mental illness and substance abuse together experienced better outcomes for this group in community-based treatment programs (SAMHSA, 2020). Several of the participants from my study highlighted the need for treating both problems to improve treatment completion rates. My findings aligned with the scholarly literature by corroborating that providers who address both mental illness and substance abuse simultaneously have better treatment outcomes. Also, I am noting that treating dual diagnosis concurrently overlapped in both theme one and three. This connection is significant because it reinforced past studies that

detailed how knowledgeable community-based workers are invaluable to treatment success.

Another emergent factor in completing treatment was *one-stop* or *wraparound* services. The participants reported that the rate of completing treatment improved based on continuity of care. Along these same lines, researchers found this one-stop treatment approach to be easily transferrable to other systems of care [i.e., criminal justice] (Marquant et al., 2016). The helping professionals in my study substantiated findings from past researchers recommending that community-based providers take a holistic approach when working with dually diagnosed individuals (Abracen et al., 2016). One participant (1.13.2020.GZ.52) described this approach as an" *in-reach model"*. The participant stated that once a consumer has stability (e.g., housing, primary treatment provider, employment, etc.), workers should direct all their energies towards bringing services to the client. This response was similar to a model first used in prisons to help treat individuals with a dual diagnosis. In their study, Samele et al. (2016) found that inmates were more receptive to treatment when providers came inside the prison as opposed to referring them to treatment postrelease. The researchers reported improvements in treatment continuity both inside and outside prison (Samele et al., 2016).

In comparison, Zettler (2017) reported findings that identified unstable housing as a problem when working with this population. Zettler's (2017) findings aligned with accounts from my study. In an interview, one respondent stated that the primary reason this group does not finish treatment is that "they get stuck with finding housing." The

participant suggested without stable housing, workers are not able to streamline the necessary resources to the client(s). These findings confirmed previous data that illuminated the success of robust community-based treatment models that addresses all consumer needs within the same program (i.e., ACT and FACT) [Nijdam-Jones et al., 2017]. My study confirmed this assertion by reiterating the necessity for a unique program that can support the myriad of needs for this population. The workers from my study indicated there is an agency that provides ACT services in his region. However, the participants went on to opine that the ACT program is fragmented and underfunded by state policymakers (as previously stated under theme two). Therefore, these individuals remained in treatment longer and continue to place financial strains on taxpayers (Kingston et al., 2016). The workers stated that the system in this area lacks a robust program that can cover both dual diagnosis and basic needs. Thus, the perception is that clients expect to fail before they begin to work with helping professionals. Therefore, this group of helping professionals are constantly challenged to stay motivated.

Theme 4: Helper's Motivation

The next theme to emerge was the helpers' motivation for working with this population. The subtheme was the intrinsic pull, which guided the helper/helpee relationship. The participants described this pull as a motivational factor that stemmed from past experiences (either themselves or significant others) with the helping system. This finding was interesting as it aligned with a SAMHSA (2020) study that reported on this phenomenon. The researchers from the SAMHSA (2020) study identified this group of helpers as mutual supports. In another study further indicating the value of mutual

supports, researchers established that mutual supports are critical in providing treatment to this population and strengthening the helper/helpee relationship (Penn, Brooke, Brooks, Gallagher, & Barnard, 2016). The researchers' findings aligned with participants from my study. The participants from my study stated because of their shared experiences, the consumers trusted mutual supports and are more likely to engage in treatment. In some regions, this group of helping professionals are called peer support specialists or recovery coaches (Appendix F) and work within an interdisciplinary team to support clients [Division of Substance Abuse and Mental Health] (DSAMH, 2019). The participants from my study reported that peer supports are more like family and can better understand the challenges these consumers face. The workers also informed that the value placed on their roles is what motivates them when working with this challenging population. Keeping in line with these findings, other researchers have detailed how this group of helpers have improved clinical outcomes when working with this group of African American men. Bassuk, Hanson, Greene, Richard, and Laudet (2016) reported that peer supports promoted drug and alcohol abstinence, decreased inpatient utilization, and improved overall functioning. In other findings, researchers indicated that this specialized group of helping professionals have seen success because of the intrinsic value of the helper/helpee relationship developed through fellowship building (Roush, Monica, Carpenter-Song, & Drake 2015). The participants from this study had similar views. One participant who identified as a peer support (1.20. 2020.ACFMW.40) referred to his role as doing "God's work." Further substantiating their perception of working with this at-risk group of African American men.

Theme 5: Perceptions of the Helper/Helpee Relationship

The next theme that emerged was the workers' perceptions of the Helper/Helpee relationship. A subtheme (i.e., Cultural Inclusivity and Consistency) reoccurred as significant factors when defining the helper/helpee relationship. My findings suggested that helping professionals who take an inclusive approach strengthened the helper/helpee relationship. Participants from this study reported that it is critical to understand the clients' family traditions, express interest in understanding the clients' culture, and include natural supports in treatment. Also, the participants talked about understanding the stigma associated with different subgroups within this pocket of African American men (i.e., lesbian, gay, bisexual, transgender, and queer community). This finding was significant because they were parallel to similar conclusions in past research, which underpinned stigma as a significant influence on this group of African American men (Mirowsky & Ross, 2017). The Association for Multicultural Counseling and Development (AMCD), produced seminal findings that promoted individualized treatment and cultural awareness when working with this underserved population (Arredondo et al., 1996). Ratts et al. (2016) findings were similar to the AMCD report. The researchers suggested taking a socio-ecological approach and customize treatment across all facets of the cultural environment (Ratts et al., 2016). Other studies have aligned with the subtheme of cultural inclusivity to establish a strong foundation for the helper/helpee relationship (Collins, 2017; Mirowsky & Ross, 2017).

Some researchers have contended that despite evidenced-based data, there continues to be a divide between African American men and healthcare (Samuel, 2015).

As with theme one (i.e., lack of knowledge of resources), researchers and participants from this study have emphasized cultural awareness. For example, a participant from the study (1.16.2020.PBH.3) talked about her experience as a Caucasian female working with a specific African American male within this population. She went on to state that she did not know much about African American men and their culture. She reported that African American men appeared "ashamed*"* to be in treatment and often acted like they were "too tough." She stated they only came to treatment to "check off their list" from the courts. I found this to be significant because it aligned with findings from other studies that described the gender role among African American men as an overarching social construct in this community (Harris et al., 2016). Mirowsky and Ross (2017) went on to specify masculinity as a cultural phenomenon among African American men and impede on healthcare treatment. In general, people in the African American community view mental illness and substance abuse as a sign of weakness (Hack et al., 2016). Other scholars have written that African American community members see mental illness and substance abuse as a personal decision. Therefore, these individuals do not experience the full amount of support from the African American community (Harris et al., 2016).

Along with being culturally inclusive, participants identified consistency as a critical piece of their relationship with clients. One worker (1.4.2020. KC.31) stated when the clients are in their most vulnerable state; they look for *"*consistency from us.*"* Another helper from the study indicated that these individuals tend to be "more transparent" if the helping professional demonstrates professionalism and consistency (1.13.2020.GZ.52). There have been previous studies that have corroborated these

findings. In one study, the researchers presented data indicating how individuals with a dual diagnosis established a therapeutic alliance faster when providers are consistent with treatment (Kidd, Davidson, & McKenzie, 2017). This phenomenon also aligned with Shattock, Berry, Degnan, and Edge's (2018) study that provided insight by reporting data showing a reduction in dual diagnosis symptoms and improved quality of life. In alignment with these findings, Kelly, Greene, and Bergman (2016) hypothesized that the cornerstone of working with this population is establishing a foundation of trust and maintaining the therapeutic alliance.

Theme 6: Helper's Fidelity

The helpers' fidelity to their client(s) was the last theme that emerged from my findings. The subtheme that the participants repeated was protecting the therapeutic alliance. The individuals in the study reported that once the client allows for the helper/helpee relationship to emerge, the worker must continue to work on maintaining the therapeutic relationship. The findings from my study suggested that the workers were mindful of protecting the therapeutic alliance to keep the clients active in treatment. One worker (1.16.2020.PBH) stated to protect the therapeutic alliance, and the worker must "do what he/she say they are going to do." This response was consistent with Kelly et al. (2016) findings that emphasized how the therapeutic alliance impacts treatment fidelity and program attendance. This study corroborated one of the workers from my research who indicated that the most challenging part of working with this population was "keeping them engaged." However, he went on to state that "once you establish that trust, they come to rely on you" (1.16.2020.PBH.47). This participant confirmed findings from

a study that also highlighted how the helper/helpee therapeutic relationship improved clinical outcomes in community-based programs (Kidd et al., 0217). Further, Sattock et al. (2018) confirmed my findings along with other multiple sources of scholarship, by illuminating the link between protecting the therapeutic alliance and establishing the helper/helpee relationship.

Theoretical Framework

For this research study, I used Hirschi's (1969) social control theory. While analyzing the data through his theoretical framework, I found several commonalities that were consistent with three of the four tenants of social control theory. The participants gave rich and descriptive insight into their experiences when working with this population and how they established the helper/helpee relationship. The first tenant, belief, aligned with the theme of helping professionals' motivation. The findings proved that the value workers placed on their relationship with their client improved treatment outcomes. The subtheme was the intrinsic pull of helping professionals. The participants talked about their experiences or the experiences of a significant other when they tried to access services. Because of what the workers described as the "shared experiences", I noticed that the workers felt an inherent obligation to their clients. Their responses reinforced the body of research as outlined in the previous sections that illuminated the role of mutual supports and workers who have shared some of the same experiences as their client(s). Individuals who have both accessed services and also work in the helping field are vital team members when working with this group (Acri, Hooley, Richardson, & Moaba, 2017). In supporting research, other scholars produced findings that informed

how this unique group of service providers helped to reduce relapse in this population and increased treatment attendance (Bassuk et al., 2016). Chapman, Blash, Mayer, and Spetz (2018) study produced similar findings showing an increase in improved treatment outcomes for clients working with peer supports.

The second theme from my findings under the subquestion was the Perception of the Helper/Helpee Relationship. The subtheme that emerged was cultural inclusivity and consistency. The next tenant of social control theory that aligned with this theme was commitment. The participants stated they formed a more secure bond with their clients by including all aspects of the cultural environment, and by being consistent. They continued that by including the extended ecological cultural network, the consumers recognized the value placed on the helper/helpee relationship. The SAMHSA (2020) researchers recommended that workers educate themselves on the clients' cultural environment, which included natural supports, who clients described as assets in treatment. Hirschi (1969) theorized that the value placed on relationships could influence behaviors that could erode the relationship between two individuals or entities. Hirschi (1969) continued that commitment in a relationship promoted positive influences and reinforced the security of the relationship (i.e., helper/helpee).

Along these same lines, other researchers extended on the knowledge by producing results that showed a decrease in criminal activities when adjusting for the individual's perception of the helper/helpee relationship (Koski & Costanza, 2015). Barlow et al. (1991) theorized that other factors contributed to conforming to social norms (i.e., treatment compliance). The findings from my study aligned with Barlow et

al. (1991) and denoted factors such as the cultural environment, safe housing, education, and employment as contributors to social conformity. Akers (1991) also presented confirming evidence that explored the impact of environmental factors. These elements of social control theory helped me to understand better both the nature of the helper/helpee relationship and commitment, which leads to treatment compliance and social conformity (Hirschi, 1969).

The last tenant that aligned with this study, attachment, referred to the psychological connection between a person and an institution such as school, family, or an organization (Hirschi, 1969). This tenant aligned with the primary theme of helpers' fidelity and the subtheme of protecting the therapeutic alliance. The data I presented suggested that helping professionals place a significant amount of importance on protecting the therapeutic alliance with their clients. In research by Kidd et al. (2017), the researchers contended that maintaining a therapeutic alliance is the foundation for effective, clinically sound, client-centered treatment for individuals with a dual diagnosis. Other scholars have produced findings that detailed how people with dual diagnosis often experienced social stigma, mistrust of the system, and have sporadic treatment engagement (Kelly et al., 2016). However, other researchers have gone on to write that by protecting the therapeutic alliance, providers experienced better treatment results overtime and overcame the perception of social stigma (Sattock et al., 2018). My findings aligned with these researchers and corroborated this concept of social control theory [i.e., attachment] (Hirschi, 1969).

Limitations of the Study

A limitation of this study was managing researcher bias as I interviewed my research respondents. As a human service professional, I anticipated having many of the same experiences as my respondents. Therefore, I was careful to manage this bias. I journaled my feelings, thoughts, and ideas as they emerged. I tried not to offer solutions or interject my experiences as a helping professional. At times, I found myself suppressing the urge to interject or steer the question so the responses would align with my research questions. I debriefed with individuals outside of this study, and surprisingly, these individuals experienced this during their study. Through journaling and peer debriefing, I brought my biases to the forefront and continuously acknowledged them (Patton, 2002). Moustakas (1994) theorized that researchers must take self-inventory and become intimately aware of personal involvement with the subject matter and attempt to eliminate preconceptions through epoche.

Another limitation was the interview guide. My interview guide was designed specifically for this study and is not a standardized tool. I followed the template created by theorists Rubin and Rubin (2012) and incorporated their responsive interviewing model. Rubin and Rubin (2012) stated researchers could give the interview guide creditability by using the responsive interviewing model during the interviewing process. I used the response interviewing model to ensure the interview was person-centered, build a rapport through conversation, and gain an in-depth understanding by not generalizing and using flexible interviewing to obtain additional data.

The study's sample size and gathering data from a single selection source was a limitation of this study. Yin (2014) theorized that case studies could be a small sample size and typically rely on triangulation of other data sources. By only interviewing helping professionals that worked for community-based treatment programs, it narrowed the scope of experiences from others in the helping profession. To manage this shortcoming, I triangulated the data collected among all the participants (Yin 2011; 2014). Although I only interviewed participants that worked in community-based treatment programs, this group worked in various capacities of human services (e.g., mental health and substance abuse professionals, police officer, administrators, managed care providers, and a social worker). To further triangulate, I compared the data to past studies (Yin, 2011). Also, I analyzed the data through the theoretical framework selected for this study (i.e., social control theory). This multidimensional triangulation approach allowed for the cross-validation of data.

Recommendations

This study's initial focus did not intend to identify the barriers that these helping professionals experienced in community-based treatment. Although I anticipated barriers to emerge, I wanted the research questions(s) to bring forth the data. During the data collection process, the findings confirmed that there is a significant gap in services in the region where I conducted this study. Additional research recommendations would include studies that evaluate the programs that provide these services (i.e., housing, dual diagnosis providers, probation and parole, etc.). By exploring the helping professionals' experiences with providing services and understanding the helper/helpee relationship,

further research that explores this same social problem from the perception of the consumer could further close treatment disparities among this group. Human service providers can use these findings to customize intervention strategies and address other related gaps. Not only in this region, but these findings are transferrable. Practitioners in the field of human and social services can apply these findings to get a better understanding of cultural sensitivities, treatment obstacles, promising practices, and the role of the helper/helpee relationship. I recommend helping professionals across the various systems of care utilize my findings and develop training materials that are culturally specific to this group of African American men to integrate into their clinical practices. Also, I will use these findings along with past corroborating data to develop and maintain a centralized database to share culturally relevant evidence-based information to all facets of the helping system and other related organizations.

Social Change Implications

I conducted this study intending to create positive social change. First, I wanted to understand the social problem and then polarize the gap in service provisions in this region. As previously stated, one of the primary findings was the lack of resources for this group of African American men consumers. Specifically, the system of care is fragmented and lacks cohesion. This system problem not only impedes on this group of helping professionals. This problem trickles down to all the consumers who depend on community workers to help them access these services. Therefore, as my social change initiative, I intend to bring awareness to this gap in the system of care and ensure that agencies are aware of the experiences these workers face when working with this

marginalized population. In the first phase of my social change goal, I will disseminate my research findings to agency leadership and community organizations that also have a vested interest in this underserved population. Next, I will distribute this study's findings to the research community, professional conferences, and local legislative members. These findings are essential in promoting awareness of these African American men who risk reincarceration because of systemic barriers. The firsthand experiences from the participants in this study will help to legitimize the growing concerns of this community. In doing so, I hope to add to scholarly discussion on how to ameliorate the social problem of African American men with dual diagnosis and a history of incarceration not experiencing a significant increase in positive treatment outcomes. Finally, practitioners can use this study to create evidenced-based training for helping professionals to establish a better helper/helpee relationship through a culturally ecological approach.

Conclusion

I believe that change comes from the top. In this case, through policymakers. I will use this case study as a conduit to offer insight from helping professionals who work with marginalized individuals daily. My findings suggest community workers are not equipped with the training, resources, funding, and cultural awareness to work with this population. For example, each participant in this study cited the need for a one-stop treatment facility in this region. Therefore, it is paramount that funding is allocated to defragment the helping system and extend treatment to include various systems of care. By allocating more funds, there will be less financial stress on taxpayers, less recidivism, and better continuity of care for individuals with a dual diagnosis. Researchers have

documented that African American men are overrepresented in the prison system and underrepresented in the mental health and substance abuse treatment systems. Therefore, it is incumbent for helping professionals to use the findings from my study to generate new innovative methods of providing service to this targeted population.

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Appendix A: Interview Guide

Recidivism among African American Men with Dual Diagnosis

To the Participant: This research is about you and your experiences with potential barriers when providing community-based treatment to African American men who are post-criminal-justice-involved, with a dual diagnosis, and considered high-risk to recidivate in New Castle County, DE.

a) Are you okay to move forward with this interview? If so, today, we are here to talk about your experience with potential barriers when providing community-based treatment to African American men who are post-criminal-justice-involved, with a dual diagnosis, and considered high-risk to recidivate. Examples of questions might include:

- Can you please talk about what it means to be a helping professional?
- Can you tell me how long you have been in the helping profession?
- Do you enjoy your line of work? If yes, why? If no, why not?

Helping Professional

A. Please talk about what it means to be a helping professional.

B. Please describe your experiences when providing services for the population you work with?

C. As a helping professional, please talk about the barriers you have experienced when providing services to this group?

Community-Based Programs

A. Please, talk about your vision of effective programming?

B. Once you have identified client needs, what has been your experience in linking these individuals to resources?

C. How do you develop and maintain a therapeutic relationship with your client(s)?

- How does your relationship with your clients impact the completion of your program?

Closing Questions

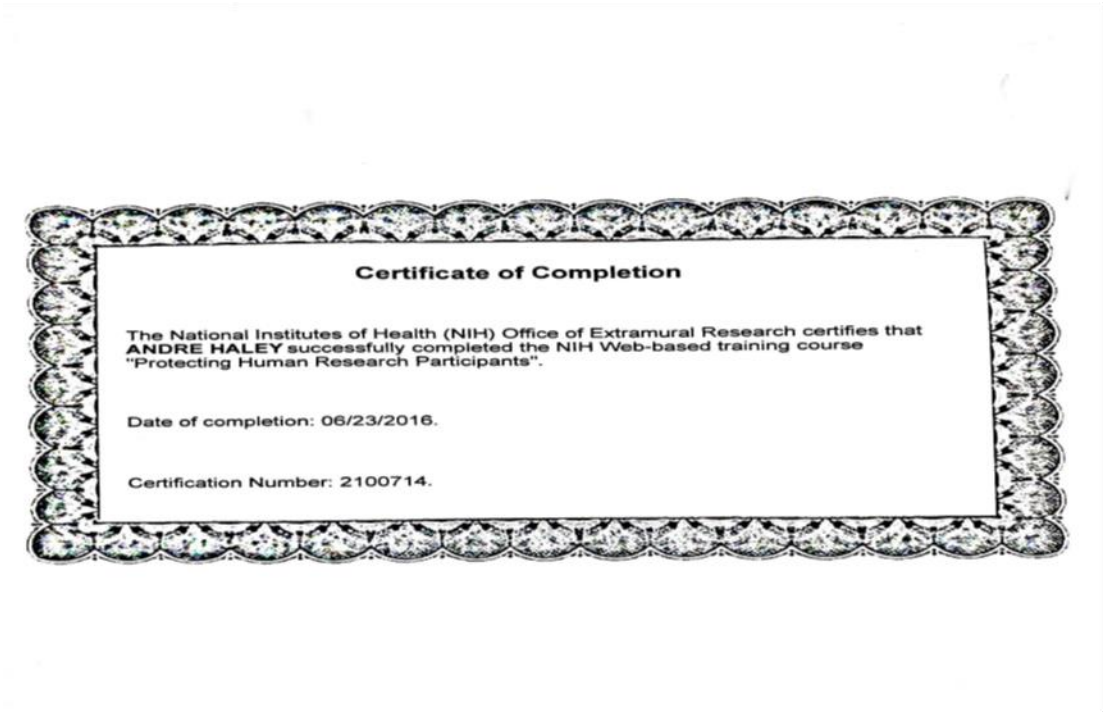
1. Is there anything you would like to ask me?
2. Are there any questions that you wish that I had asked you?

Closing out the Interview/Debrief (Script):

- Next steps (e.g., the data will be transcribed, and participant will receive transcription within seven days).
- The participant will be asked to follow up to transcription within 30 days, or I will assume the participant approved the transcription.
- Explain Confidentiality and how data will be managed (i.e., locked/secured, destroyed in five years, and no identifiers).

Appendix B: National Institutes of Health Training Certificate

Recidivism Among African American Men with Dual Diagnosis



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **ANDRE HALEY** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/23/2016.

Certification Number: 2100714.

Appendix C: Demographic Screening Questionnaire

Recidivism Among African American Men with Dual Diagnosis

Interview Identifier/Code:___ Date:__

The purpose of this form is to screen potential participants to ensure that they meet the criteria for the study.

This research is designed with the intent to minimize the risk to **human subjects.** My research is designed to focus specifically on the individuals who are ideally suited to answer this study's research question, without burdening others unnecessarily. Now, I would like for you to answer a few questions to determine if you are the best fit to participate in helping to answer this study's research questions through the interview process.

Part to be read to the Participant:

1. Participant must be a self-identified, helping professional, working in a community-based program in the New Castle County, DE area.
2. To participate, you must have worked in a community-based program that provides services to individuals with either a mental illness, substance use disorder, or both for at least one year within the last five years.
3. You must provide or have provided services to African American men with a dual diagnosis and considered high-risk for re-offending/recidivism.

You cannot participate if (exclusion criteria): You are a student, client, or employee of the researcher.

If you qualify to take part in this study and would like to participate in a private interview, I will schedule our interview at this time. On the day of the interview, I will further inform you of the study's detail by reading a form known as informed consent.

Appendix D: Resource Listing (New Castle County, DE)

	Agency Name	**Address**	**Phone No.**	**Hours of Operation**	**Cost**
1	Brandywine Counseling	2713 Lancaster Ave, Wilmington, DE 19805	(302) 656-2348	8am – 6pm	Free
2	Christiania Behavioral	205 W. 14th St., Suite 100, Wilmington, DE	(302) 733-1000	24 Hours	Free
3	Crisis Intervention Services	14 Central Ave, New Castle, DE 19720	(302) 577-2484	24 Hours	Free
4	Delaware Psychiatric Center	1901 North Du Pont Highway New Castle, DE 19720	(302) 255-2700	8:00 a.m. - 4:30 p.m.	Free
5	Meadowwood Behavioral	575 S Dupont Hwy, New Castle, DE 19720	(844) 283-1030	24 Hours	Free
6	Rockford Center	100 Rockford Drive, Newark, DE 19713	(866) 847-4357	24 Hours	Free

Appendix E: Recruitment Flier

Research Participants Needed

Are you at least 18 years of age or older?

Have you work in the helping field for at least a year within the last five years?

Have you worked with African American men with a dual diagnosis and who are considered high-risk for recidivism in New Castle County, DE?

If you have answered yes to the above questions, I would like to **interview** you for at least **75 minutes** for my dissertation study to understand the barriers to helping professionals achieving effective, community-based treatment programs for post-criminal- justice-involved, African American men with a dual diagnosis who are considered high-risk for recidivism in New Castle County, DE?

Your participation is **voluntary,** and your responses are **confidential**. In appreciation for your time, you will receive a $10 gift card as compensation for your participation. If you think you are eligible and would like to participate, please contact me via e-mail at andre.haley@waldenu.edu or call me at (302) 585-5912. This study has been approved by the Institutional Review Board (IRB) of Walden University. The Walden University IRB has reviewed this study to ensure that the researcher complies with the university's ethical standards and the participants are treated in an ethical manner.

Appendix F: Peer Support Training Material

Peer Employment Training Course Syllabus

Week One

Day	Homework Assignment Due	Class Activity	Homework Assignment for Next Class
One 8:30 AM-4:30 PM Monday	*Modules 1: Introduction* & *Module 2: Recovery* have been read and answers to all questions are written in your workbook	Getting Started on Our Journey; Discuss Module 1; Activity L; Discuss Module 2; Laying Our Pathways to Recovery	Read *Module 3: The Power of Peer Support* and *Module 4: Developing Self Esteem and Managing Self Talk* and write your answers to all questions in your workbook
Two 8:30 AM-4:30 PM Tuesday	*Module 3: The Power of Peer Support* and *Module 4: Developing Self Esteem and Managing Self Talk* have been read and are answers to all questions written in your workbook	Discuss Module 3; Identifying cognitive distortions; Discuss Module 4: Building Self-Esteem; Validating Strengths; Role Play	Read *Module 5: Community, Culture and Environment* and *Module 6: Meaning and Purpose* and write your answers to all questions in your workbook
Three 8:30 AM-4:30 PM Wednesday	*Module 5: Community, Culture and Environment* and *Module 6: Meaning and Purpose* have been read and answers to all questions are written in your workbook.	Discuss Module 5; Diversity Bingo; The New View; Cultural Scenarios; Discuss Module 6: Meaning & Purpose; Opening Your Gift;	Read *Module 7: Emotional Intelligence* and *Module 11: Communication Skills* and write your answers to all questions in your workbook
Four 8:30 AM-4:30 PM Thursday	*Module 7: Emotional Intelligence* and *Module 11: Communication Skills* have been read and answers to all questions are written in your workbook (Pages 91-117).	Discuss Module 7; Not eating the marshmallows; Discuss Module 11; Communication Role Plays Review personal story guidelines; Chris shares his story	Read Modules 8 & 9 and write your answers to all questions in your workbook. Prepare to tell your personal story.
Five 8:30 AM-4:30 PM Friday	Modules 8 & 9 read and written answers to all questions in your workbook Prepared to tell your personal story.	Personal Story Day	Take Home Test for Modules 2-7 and 11. Read *Modules 10: Employment as a Path to Recovery* and *Ethics and Boundaries Handouts* write your answers to all questions in your workbook .

All classes begin at 8:30 AM and conclude at 4:30 PM, with one-half hour for lunch. We'll also take a 15-minute break in the morning and the same in the afternoon. ***Please be sure you clear your calendars for the next 2 weeks!

Appendix G: DSAMH TASC Program

DHSS Menu
(http://delaware.gov)
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Listen ▶

TASC Programs and Drug Courts

Substance Abuse and Mental Health Menu

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(/dhss/dsamh/)

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Services ▶

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