"Tools to Live": Using Community-Engaged Scholarship to Assess the Role of a Canadian Non-Profit Organization in Serving Persons with Mental Health Issues and Concurrent Disorders

by

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Abstract

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Ample empirical evidence highlights the significant prevalence of persons with mental health issues and concurrent disorders involved in the criminal justice system. This population frequently uses services provided by community based non-profit organizations for aid and support. Yet, there is a dearth of research that addresses the prevalence of mental health issues and concurrent disorders amongst those served by such organizations, and the barriers to community reintegration that they face. Focusing on the prevalence of mental health issues and concurrent disorders among individuals involved or at risk of involvement in the criminal justice system, the John Howard Society of Waterloo-Wellington and the University of Guelph embarked upon a mixed-methods community-engaged research partnership. Information for the clients in the ‘Community Aftercare’ program was collected in relation to mental health issues and concurrent disorders. Our data reveal the ‘typical’ profile of the clients accessing the Aftercare program, which includes a high prevalence of mental health issues and concurrent disorders. Further, interviews identified stigma, history of victimization, complex needs, criminal history, diminished welfare state, and a lack of social support/social capital as barriers faced by the Aftercare clients. The Aftercare program, however, acts as a form of social support and builds social capital for the clients. A lack of adequate funding to address the complex needs of the Aftercare clients was identified as a program limitation, and the findings revealed a need for additional funding.
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Introduction

Individuals suffering with mental health issues and concurrent disorders (addictions and mental health issues) have been identified to be at greater risk of involvement in the criminal justice system than their peers (Hartwell et al. 2010; Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001). Due to these individuals ending up in the criminal justice system as opposed to the mental health system (Lamb and Weinburger 2005), there is an over-representation of individuals with mental health issues and concurrent disorders in correctional facilities (Brink et al. 2001; MacDonald et al. 2010; Lafortune 2010; Correctional Services of Canada 2010; Ontario Ministry of Community Safety and Correctional Services 2008). Upon release, these individuals are faced with various barriers and challenges to community reintegration, including accessing mental health and concurrent disorder services that are willing to serve this potentially ‘risky’ and intimidating population (Lamb et al. 2004). Thus, non-profit, community-based organizations are confronted with the responsibility of providing treatment and counseling to these individuals. Often, however, non-profit, community-based organizations are not formally recognized as mental health agencies by the mental health sector, and must work within a limited funding structure to attempt to deliver adequate services to this population.

By using a Community Based Research (CBR) framework and working in partnership with a non-profit, community-based organization (the John Howard Society of Waterloo-Wellington), our study advocates for individuals involved in the criminal justice system suffering with mental health issues and concurrent disorders. Further, our study also helps to provide a platform to promote the advancement of knowledge regarding the challenges faced by the John Howard Society of Waterloo-Wellington (JHSWW).
Our study seeks to address three main research questions (see Appendix ‘A’): What is the ‘typical’ profile of the clients accessing the Aftercare program? What barriers do Aftercare clients experience? And, what is the role of the Aftercare program in Aftercare clients’ lives? The following section will provide an overview of the chapters of this study.

Chapter One of our study provides a review of the sociological, psychological, and criminological literature regarding the prevalence of mental health issues and concurrent disorders within the criminal justice system. This literature identified significant barriers, which include employment, housing, and family/social support, to community reintegration experienced by offenders both with and without mental health issues and concurrent disorders. This chapter also lays out the theoretical framework employed by our study, Social Integration, which helps conceptualize the role of the JHSWW in the lives of its clients.

Chapter Two explains the methods and methodology employed by our study. Following a CBR framework, and incorporating principles of Participatory Action Research (PAR), allowed for a collaborative experience for staff from the JHSWW as the community partner to work together with the University of Guelph through a Masters student to conduct research on an issue the community partner needed. Further, this framework provided the platform for knowledge sharing, mutual benefit and knowledge exchange. The ‘real-world’ knowledge acquired from the JHSWW staff and clients cannot be replicated in a classroom setting, or by doing a more “traditional” kind of research. The chapter discusses the importance of reflexivity and positionality as a researcher when conducting CBR, and outlines the techniques employed to collect the quantitative and qualitative data. The methods of data analysis and challenges to employing CBR are also discussed.
The most significant results are outlined in Chapter Three in response to our study’s research questions, and these results are discussed in more detail in relation to the literature and theory in Chapter Four. This chapter also presents the public policy, CBR, and sociological implications of our study, in addition to its limitations. The chapter, and study, is concluded by suggestions for future research.
Chapter One: Literature and Theory Review

Introduction

Across North America, there is increasing evidence of a rising prevalence of offenders experiencing mental health issues (Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001). Much of the literature pertaining to the prevalence of mental health issues in offenders is found in the psychological literature and originates from the United States. To date, however, few studies have addressed this issue in the Canadian peer-reviewed academic literature (Brink et al. 2001), and most of those that have are outdated. A thorough search and review of the available sociological, psychological, and criminological literature unearthed ten Canadian studies relating to the topic of mental health in the criminal justice system and the prevalence of mental health issues in Canadian offenders (Allodi et al. 1977; Hodgins and Cote 1990; Motiuk and Porporino 1991; Arboleda-Florez et al. 1995; Wormith and McKeague 1996; Ulzen and Hamilton 1998; Corrado et al. 2000; Brink et al. 2001; The McCreary Centre Society 2005; Gretton and Clift 2011). All of the Canadian studies agree that the prevalence of mental health issues within the offender population is great (Allodi et al. 1977; Hodgins and Cote 1990; Motiuk and Porporino 1991; Arboleda-Florez et al. 1995; Wormith and McKeague 1996; Ulzen and Hamilton 1998; Corrado et al. 2000; Brink et al. 2001; The McCreary Centre Society 2005; Gretton and Clift 2011). These studies, however, were conducted primarily through a psychological lens. There appears to be a dearth of sociological literature relating to the topic of mental health issues in the Canadian offender population.

Within this limited Canadian sociological literature the topic of mental health issues among clients served by community-based, non-profit organizations is also limited. Within this limited literature, studies outline the various services offered by non-profit organizations and
how they differ from governmental services (Lipsky and Smith 1989; Alexander 1999). Some studies reveal that non-profit organizations frequently service an ‘at risk’ population, including clients experiencing mental health issues (Boyle et al. 2007; Alexander 1999). There is an absence, however, of academic literature examining the prevalence of mental health issues in clients involved, or at risk of involvement, in the criminal justice system accessing services from non-profit, community-based organizations, and the barriers faced by this population.

This chapter will review the academic literature regarding the prevalence and characteristics of mental health issues within offenders, which is predominantly found in the psychological, criminological and community health literature. It will also explore the barriers to community reintegration experienced by ex-offenders. Further, this chapter outlines the theoretical framework used in this research, which includes an integration of social support and social capital theories, employed to conceptualize and understand mental health issues within clients accessing services from the JHSWW.

**The Prevalence and Characteristics of Mental Health Issues in the Criminal Justice System**

Foremost, the definition of a ‘mental health issue’ is somewhat vague, and the stigma relating to mental health is primarily revealed in lay concepts of the term ‘mental illness’ (Gaebel et al. 2006). As stated by Ruggeri et al. “there is no internationally agreed definition of severe mental illness” (2000:149). In short, the definition of ‘mental illness’ varies depending upon society’s norms. For the purpose of this research, ‘mental health issues’ and ‘mental illness’ will be interpreted broadly to include: severe and chronic depression, anxiety, Post Traumatic Stress Disorder, various personality disorders, and schizophrenia.
Commonly agreed upon in the psychological and criminological literature is the reality that adults and youth who experience mental health issues are at greater risk of arrest and involvement with the criminal justice system compared to their peers (Hartwell et al. 2010; Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001). This is the result of inadequate or absent psychiatric treatment of mentally ill individuals in the community. These individuals frequently come to the attention of the police, who may not realize that they are dealing with an individual suffering with mental health issues (Watson et al. 2004). In some cases, despite the police recognizing that an individual’s aggressive or bizarre behaviour is due to a mental illness, the police choose to arrest these individuals to manage their disruptive behaviour (Lamb and Weinburger 2005). As a consequence, the mentally ill individual now has a criminal record, which may influence the actions of the police in future encounters with this person. As a result, the tendency to choose the criminal justice system over the mental health system has been reinforced, and the mentally ill individual has been criminalized (Lamb and Weinburger, 2005). The “criminalization of the mentally ill” hypothesis derives from the assertion that individuals with mental health issues access health care and social support services through the criminal justice system and tend to be overpopulating federal and provincial prisons (Brink et al. 2001; MacDonald et al. 2010; Lafortune 2010; Correctional Services of Canada 2010; Ontario Ministry of Community Safety and Correctional Services 2008). Correctional institutions can provide structure in a locked facility, which is comparable to that found in acute, intermediate, and long-term mental health hospital environments. In addition, due to the lack of alternatives in the mental health system, “the criminal justice system has become the system that cannot say ‘no’” (Lamb and Weinburger 2005:532). Consequently, prisons have been affected by “transinstitutionalization”, the entry of individuals suffering from a mental health issue into the
criminal justice system (Diamond et al. 2001; Lamb and Weinberger 2005). The “transinstitutionalization” hypothesis derives from the premise that deinstitutionalization, the decrease of the use of psychiatric hospitals (Lurigio 2001; Lamb and Weinberger 2005; Lamb and Bachrach 2001), triggered a wave of individuals with mental health issues accessing inadequate community-based treatment and counseling. Subsequently, the criminal justice system was forced to respond to the significant increase in problematic behaviour in the community as a result of deinstitutionalization (Prins 2011; Lamb and Weinberger 2005; Lamb and Bachrach 2001). Over thirty years ago, Abramson (1972) warned of the social dilemma posed by the deinstitutionalization of the mentally ill. “[I]f the entry of persons exhibiting mentally disordered behaviour into the mental health system of social control is impeded, community pressure will force them into the criminal justice system of social control” (p.103).

More recently, the “transinstitutionalization” hypothesis has been disputed. Osher and Han (2002, as cited in Prins 2011) assert that not only does community-based treatment prove to be effective for most people with mental health issues, but that individuals with a mental illness who are currently incarcerated do not possess the same characteristics as those who were deinstitutionalized from psychiatric hospitals. Further, after conducting a review of the literature critiquing the “transinstitutionalization” hypothesis, Prins (2011) found that the majority of individuals discharged from psychiatric hospitals do not become incarcerated. The dispute surrounding the “transinstitutionalization” hypothesis, however, stands to be contested as research has found that the offender population contains three times more mental health issues than the general Canadian population (MacDonald et al. 2010; Lafortune 2010). Women are reported to experience greater mental health problems compared to men, particularly in reference to moderate to severe depression (MacDonald et al. 2010; Lafortune 2010; Laishes 2002).
Laishes reports that “[s]ome mental health problems experienced by women offenders can be linked directly to past experiences of sexual abuse, physical abuse, and assault, as well as substance abuse and poverty” (2002:10). Further, differences exist in the behavioural manifestations of mental illness between the genders. Women offenders tend to be self-mutilating and engage in slashing, while men offenders are more assaultive as well as sexually and physically threatening (Laishes 2002).

Further, one out of ten men offenders, approximately 13 per cent, in the Canadian federal correctional system have been identified at admission as suffering with mental health issues, and this population has almost doubled since 1996/97 (Correctional Services of Canada 2010:1). Meanwhile, 29 per cent of women offenders in the federal correctional system were identified as presenting with mental health problems and this percentage has also more than doubled since 1996/97 (an increase from 13 per cent to 29 per cent) (Correctional Services of Canada 2010:1). The Province of Ontario has experienced a similar increase in the number of offenders with mental health issues. In 2008, the Ministry of Community Safety and Correctional Services reported that 15 per cent of offenders in custody in provincial correctional facilities required some form of treatment for mental health issues (Ontario Ministry of Community Safety and Correctional Services 2008:7). In addition, the Province reported that the number of individuals with mental health issues on remand had increased by 44 per cent in the last decade (Ontario Ministry of Community Safety and Correctional Services 2008:7). Offenders with mental health issues are entrenched in the criminal justice system, and findings suggest that these offenders will recidivate the majority of their lives and at significantly higher rates than the general criminal population (Constantine et al. 2010). They tend to be incarcerated for a longer period, have less of a chance to be considered for community supervision, and in comparison with others
charged with similar offenses, are almost twice as likely to have their probation or parole revoked (Prins 2011; Prins and Draper 2009).

**Concurrent Disorders**

The connection between mental health issues, substance abuse, and incarceration is strongly supported. Brems and Johnson suggest that the presence of a mental health issue almost triples the likelihood of substance use (1997). Moreover, the existence of a substance use issue increases the risk of incarceration for those suffering from a mental health issue (Kubiak et al. 2011). The occurrence of mental health issues along with substance use issues, frequently referred to as a ‘concurrent disorder’ in Canadian psychological and health literature, is prevalent in three out of four individuals receiving treatment for a substance use disorder (Centre for Addiction and Mental Health 2010). Individuals categorized as suffering with a concurrent disorder are at a greater risk of multiple incarcerations compared to offenders with either a mental health issue, or a substance use issue alone (Kubiak et al. 2011; Baillargeon et al. 2010). Numerous studies have theorized as to why individuals experiencing mental health issues have higher rates of substance use than the general population. One explanation, derived from a mixed-methods study, is that non-prescribed drugs are used to self-medicate their mental health disorders (Saddichha et al. 2010). Another theory hypothesizes that those suffering from mental illness are more vulnerable to substance use, which may provoke psychosis (Saddichha et al. 2010). Moreover, offenders suffering with a concurrent disorder tend to be “sicker”, and use more in-prison health services than do those with only a mental health problem or only a substance use issue (Hiller et al. 2005). Hiller et al.’s study found that significantly more of the offenders in the concurrent disorder group reported dental, traumatic injury, ear/nose/throat,
neurological, skin, stomach and intestinal, cardiovascular, liver, bone and muscle problems, and respiratory issues (2005:14). This group also frequented the emergency room more often, and had higher lifetime rates of and more recent use of medical services (Hiller et al. 2005).

**Community Treatment Services**

In addition to the finding that mental health, substance abuse and incarceration are connected, there is consensus within this literature that there is a need for more and better community treatment of offenders experiencing mental health issues and concurrent disorders (Lamb et al. 2004; Lamb and Weinberger 2005; Baillargeon et al. 2010b; Kubiak et al. 2011; Wolff 2005). More recently, the Canadian federal correctional system has reported that “emphasis has been placed on designing comprehensive interventions, based on a continuity of care, to provide consistent assistance to offenders within and beyond prison” (Griffiths et al. 2007:3). Continuity of care requires the development of community-based treatment models to address the unique challenges and barriers faced by offenders with mental health issues and concurrent disorders (Griffiths et al. 2007; Conklin et al. 2000; Wolff 2005). Griffiths et al. report continuity of care to be “an essential component of effective mental health treatment for mentally ill persons who are involved in the criminal justice system” (2007:3). These treatment models can potentially provide a diversion program from the traditional criminal justice system, reduce the risk to the public and the offender, and reduce recidivism for offenders with mental health issues (Conklin et al. 2000; Laishes 2002; Lurigio 2001; Hammett et al. 2001; Wolff 2005). However, one problem with the continuity of care approach is that many rehabilitation and community-based mental health programs will not provide services to individuals involved in the criminal justice system, due to the possibility of violence or intimidation (Lamb et al. 2004).
Another commonly reported finding in the psychological and criminological literature states that offenders who participated in treatment programs while incarcerated were more likely to continue treatment upon release. These individuals, however, will often not follow through with their treatment if adequate planning is not completed prior to release (Kubiak et al. 2011; Kola and Kruszynski 2010). In addition, scholars agree that an absence of resources and a lack of communication between the criminal justice system and community-based services can result in offenders with mental health issues leaving incarceration without the adequate supports or connections for assistance and continuity of care (Griffiths et al. 2007; Conklin et al. 2000; Wolff 2005). In response to this concern, The Sentencing Project\(^1\) recommends allocating funding for “community-based alternatives to incarceration and increased capacity to deliver essential services to probationers and others with mental illnesses” (2002:13). Mental health clinics will frequently refuse to treat individuals with mental health issues who are also substance abusers, while drug treatment centres report that those who are mentally ill are too disruptive (The Sentencing Project 2002). Thus, there is an absence of community-based treatment centres that serve the concurrent disorder population. Concurrent disorder offenders, in particular, respond better to non-traditional programs that do not solely emphasize substance use issues, or mental health issues alone (Brems and Johnson 1997; Prins and Draper 2009). Brems and Johnson (1997) suggest that the integration of the two approaches will more effectively and efficiently serve these clients. This treatment approach is ideally conducted at the same location, in order to increase accessibility and to increase familiarity with treatment professionals. In general, the literature strongly supports community-based treatment and continuity of care for concurrent disorder individuals (Baillargeon et al. 2009).

\(^1\) Established in the United States, the Sentencing Project is an organization that promotes reform in sentencing policy, advocates for alternatives to incarceration, and brings national attention to inequities in the criminal justice system.
I now turn to literature from within the disciplines of psychology, criminology and sociology that moves from the prevalence of mental health issues and concurrent disorders in the North American offender population to what happens to this population while attempting to reintegrate into the community.

**Barriers to Community Reintegration**

Reintegration is defined as “all activity and programming conducted to prepare an offender to return safely to the community and live as a law-abiding citizen” (Thurber 1998:14). The process of reintegration also includes correctional programs in prisons, as well as aftercare interventions once released (Griffiths et al. 2007). This issue is particularly pertinent to our study and barriers to reintegration have been extensively reviewed in the criminological, psychological, and sociological literature (Graffam et al. 2004; Baillargeon et al. 2010; Draine et al. 2005; Visher and Travis 2003; Mallik-Kane and Visher 2008). In particular employment, housing, and family/social support challenges not only populate the literature but are encountered by concurrent disorder and single disorder offenders alike upon release into the community (Hartwell 2004; Griffiths et al. 2007). The following section will review and expand upon these most influential barriers to reintegration.

**Barrier to Reintegration: Employment**

In Canada, approximately 70 per cent of offenders and ex-offenders do not have a high school diploma, and about half are “functionally illiterate” (Holzer et al. 2003). Further, approximately 75 per cent of offenders who enter the federal correctional system are identified as having employment needs (Griffiths et al. 2007). Prior to incarceration, the employment rates of
individuals involved in crime were generally low, even in comparison to other young men who lived in poor inner-city neighbourhoods, and had limited skills (Holzer et al. 2003). In addition, gaining work experience has been hindered by an offender’s term of incarceration, and the opportunity to network with potential employers has been greatly restricted. It is likely that offenders will, eventually, acquire some form of employment upon release, but these jobs have low wages and little benefits (Holzer et al. 2003). Motiuk and Vuong found that employment related indicators, such as ‘unemployed 50 per cent more’, or ‘unstable job history’, coupled with ‘lacks a skill, area, trade or profession’ (2005:21-22) were significant predictors for readmission for men and women offenders. In terms of hiring, employers have mixed feelings regarding individuals with criminal conviction backgrounds (Dale 1976). Research findings have reported that 70 per cent of employers would not hire an individual with a sex offence conviction, while 71 per cent of employers would not hire a person with a conviction for arson (Gillis et al. 2005).

Despite the potential barriers, recent research suggests that securing employment can facilitate a successful process of reintegration into the community (Gillis et al. 2005; Gillis and Andrews 2005). In addition, social support for employment (e.g., affective ties to employment and resources for finding work) has been identified as one of the most influential factors contributing to ex-offenders’ ability to secure and maintain employment while in the community (Gillis et al. 2005; Gillis and Andrews 2005). Securing employment can also aid in reducing recidivism. Gillis et al. (2005) found that offenders who secured employment remained in the community an average of 26 months longer than those who did not. In addition to reducing recidivism, employment can also have a positive impact on mental health issues in the ex-offender population (Samele et al. 2009). Specifically, research indicates that work “promotes
recovery from mental illness, leads to better health, minimizes the harmful effects of long-term sickness absence, improves quality of life and wellbeing and reduces social exclusion and poverty” (Samele et al. 2009:2). As mentioned above, the process of securing employment for an ex-offender with mental health issues, however, can be quite challenging.

The dilemma surrounding the disclosure of a criminal history, coupled with a mental health issue, can prove to be stigmatizing for an ex-offender (Gillis et al. 2005; Tschopp et al. 2007; Draine et al. 2002). Stigma, which is defined by Link and Phelan as the co-occurring presence of components of discrimination, status loss, separation, stereotyping, and labeling within a social system possessing diverse amounts of power (2001:377), is frequently experienced by many individuals involved in the criminal justice system. Further, these combined elements can be intended for “any potentially stigmatizing attribute (e.g. mental illness, deafness, or colour of the skin)” (Gaebel et al. 2006:42). Tschopp et al. (2007), however, found that a criminal history can be less stigmatizing than mental illness, but certain crimes, like sex offences, can create significant challenges when securing employment. In addition, the presence of a mental illness may affect the ex-offender’s ability to apply for jobs and their capacity to perform in a job interview. The inability to cope with the stresses of work, diminished cognitive abilities, and poor social skills may also contribute to the demise of an ex-offender with a mental health issue in the workplace (Draine et al. 2002).

Recognizing that securing and maintaining employment is beneficial to help reduce recidivism and to promote successful community reintegration, Correctional Service Canada (CSC) has increased its focus on employment training (Klassen 2005)\(^2\). The provision of services

\(^2\) CSC offers an employment program, CORCAN, for male and female offenders that builds employment skills during incarceration and “for brief periods of time” after release (Correctional Service Canada 2008:2). Additionally, CSC introduced the National Employability Skills Program which builds generic employment skills,
and programs to facilitate the process of securing employment in the community for ex-offenders appears to not only aid in reducing recidivism, but to also be cost effective for the federal criminal justice system (Public Safety Canada Portfolio Corrections Statistics Committee 2011). However, despite efforts to provide employment programming for federally incarcerated offenders, there is currently a lack of employment services for offenders with mental health issues in Canada. Samele et al. (2009) have outlined and reviewed numerous employment programs for incarcerated offenders with mental health issues, and conclude that some of the best employment schemes for this population are located in the United States. Further, the authors state:

Targeting mental health issues as part of a package to support offenders into employment is essential. But the search for employment should not become a lesser priority if a person has significant mental health problems or becomes very unwell. Support for mental health problems should be managed well but should not detract from finding work thereafter, particularly in view of the enormous benefits employment brings. More importantly, offenders with severe mental health problems should not be excluded from training and employment opportunities (Samale et al. 2009:8).

Thus, providing employment programming for offenders with mental health issues not only has the potential to further reduce recidivism in this population, but to enhance the work skills of this already marginalized group (Samale et al. 2009; Gillis et al. 2005; Klassen 2005; Draine et al. 2002).

**Barrier to Reintegration: Housing**

In addition to the challenge of securing employment for ex-offenders, and ex-offenders with mental health issues, finding adequate housing is also identified as a major barrier. As a result of a lack of employment opportunities, many ex-offenders are unable to find suitable, secure and

such as communication, problem solving, etc., through a combination of classroom and workforce training to incarcerated male offenders (Latendresse and Cortoni 2005).
sustainable living arrangements. Recently released offenders generally received little pre-release support and aid in securing living arrangements and many find themselves homeless (Griffiths et al. 2007; Graffam et al. 2008; Baillargeon et al. 2010; Mallik-Kane and Visher 2008; Solomon et al. 2001). As a result, ex-offenders are concentrated in the most problematic areas of the community where there are high crime rates and little to no support services (Griffiths et al. 2007). Further, many ex-offenders identify a lack of suitable housing as an important factor in their unsuccessful reintegration into the community, and a leading cause of their reconviction (Griffiths et al. 2007; Fisher et al. 2008; Baldry et al. 2003; Solomon et al. 2001). Fisher et al. (2008) report that homeless ex-offenders were more likely to have been arrested for nuisance offenses, such as indecent exposure and camping without a permit, than those with secure accommodations. Moreover, homeless individuals suffering with mental illness may be prone to criminal activity as the lack of stable living conditions could hinder their ability to maintain a structured environment. As a result, these individuals have difficulty accessing services and acquiring prescribed medication to treat their mental health conditions (Fisher et al. 2008).

Attempts within established and cohesive communities to subsidize forms of affordable housing for ex-offenders are often met with hostility. Generally, the community attitude may be sympathetic to the struggles of this population, but services are not supported because of the “Not-In-My-Back-Yard” (NIMBY) syndrome (Scally and Newman 2003; Rasmussen 1992; Galster et al. 2002). Motivated by fears of heightened crime rates, property value erosion, unsightly facilities and increased noise, many community groups rally to limit the location of treatment centres or transitional houses (Scally and Newman 2003; Galster et al. 2002). These challenges are further exacerbated by the discriminatory practices of landlords when ex-offenders attempt to secure private housing. Landlords frequently request a job history and/or
references from previous landlords as part of the application process, and those who cannot provide this information are automatically disqualified (Scally and Newman 2003). Motivated by similar fears as the community at large, such as declining property value and the increased threat of crime, landlords will more likely choose the applicant without a criminal record.

Ex-offenders with mental health issues face the double stigma of a criminal record and mental illness while attempting to secure housing (Mallik-Kane and Visher 2008; Hartwell and Benson 2007; Clear et al. 2001; Winnick and Bodkin 2008; Celinska 2000; Visher and Travis 2003; Shantz et al. 2009). Hartwell and Benson (2007) report that approximately one third of ex-offenders with a mental health issue are homeless upon release from a correctional facility. Moreover, this population frequently admits that they would like to live “on their own” in the community, which in reality can prove to be detrimental due to limited social supports (Hartwell and Benson 2007). Their next preferred option is supportive housing, which is frequently not available for ex-offenders. In addition, ex-offenders are not always welcome in cohesive communities with social networks of engaged individuals and informal supports (Hartwell and Benson 2007; Scally and Newman 2003). For those ex-offenders with mental health issues, socially integrating into these established and cohesive communities can be a significant barrier. This population tends to drift to disorganized or weak communities where there are more institutional supports to make up for the lack of cohesive, integrated supports. There, the ex-offenders are integrated in more formal services and networks, such as institutional supports, which do not have the same effect on reintegration as residing in cohesive communities (Hartwell and Benson 2007).
Barrier to Reintegration: Family/Social Support

The last of the three significant barriers identified in the literature for many offenders during the process of reintegration is the absence of family and social support (Griffiths et al. 2007; Jacoby and Kozie-Peak 1997; Visher and Travis 2003; McCoy et al. 2004; Baillargeon et al. 2010b; Graffam et al. 2004; Solomon et al. 2001). Sociologists Visher and Travis make a significant contribution to understanding the complex role the family can play. They identify family support to be “critical in explaining individual pathways after release from prison” (2003:99). The families of ex-offenders can provide assistance upon release, however little is known about the precise impact of this form of support (Visher and Travis 2003). Families can also represent a negative form of support for ex-offenders. They may enable substance use, criminal behaviour, or they may be the victims of the ex-offenders. Moreover, relationships with criminal peers in the community, and connections with peer networks while incarcerated can potentially affect post release offending, while supportive peers and networks who refrain from criminal activity or drug use can prevent recidivism (Visher and Travis 2003; Graffam et al. 2004; Solomon et al. 2001).

Nelson et al. (1999, as cited in Visher and Travis 2003) conducted a study on ex-offenders released from New York state prisons or city jails during the 30 days immediately following their release. The researchers found that family support, specifically emotional support and housing assistance, played a significant role during the first 30 days of community reintegration. Further, Nelson et al. (1999) identified family acceptance and encouragement in addition to perceived emotional family support to be linked to successful re-entry. The ex-offenders who “talked most about their family’s acceptance of them” (Nelson et al. 1999, as cited in Visher and Travis 2003:101), were less likely to abscond from parole, and experienced
the greatest success in securing employment and abstaining from drugs (Visher and Travis 2003).

The role of parenting and re-establishing a commitment to family roles after release can also be important to develop a pro-social identity for an ex-offender (Uggen et al. 2003; Graffam et al. 2004; Solomon et al. 2001). The reintegration to a family role of husband, wife, partner, or parent that involves day-to-day responsibilities can be a difficult task for a newly released offender, however “the importance of this role for identity transformation toward law-abiding citizen after release is highly significant” (Visher and Travis 2003:97). Further, women in particular emphasize the importance of returning to their family role (such as mother, daughter, sister) and other informal networks of support for assistance during the process of reintegration (Hartwell and Benson 2007). A recent Canadian study focusing on women offenders’ community reintegration directly following release from incarceration demonstrated that a lack of social supports and access to health care had a direct effect on recidivism rates (Culbert 2012).

Research has also indicated that providing social services to families of recently released offenders can lead to decreased substance use, fewer mental and emotional problems, and a reduction in recidivism (Visher and Travis 2003; Graffam et al. 2004). For those ex-offenders with mental health issues, however, there is an increased risk of social isolation, from both family and community ties (McCoy et al. 2004). This can be a result of the erosion of supportive relationships while the offender is incarcerated, negative influences (such as close contact with other current or ex-offenders), or crimes committed against family members or supportive ties (McCoy et al. 2004). Entrenching themselves further into the criminal justice system, ex-offenders with mental health issues frequently fare poorly with mandated community formal supports, such as probation. This population often violates their conditions of release, and
subsequently returns to the justice system network that offers few informal social network ties (Hartwell and Benson 2007).

Jacoby and Kozie-Peak (1997) recommend policy implications to address the issue of offenders with mental health issues continuously revolving through the criminal justice system. The first strategy to enhance the social adjustment of ex-offenders with mental health issues is to emphasize the establishment and maintenance of offenders’ social support networks while they are still incarcerated. This objective could be met by “[e]ncouraging and enabling family and friends of inmates to correspond with and visit inmates, and to participate in planning for post release housing, employment, and coordination with community mental health programs” (Jacoby and Kozie-Peak 1997:499). Another strategy would be the development of community-based, informal and formal support networks for newly released offenders. By encouraging follow-up contact with community-based mental health agencies, and providing education and assistance to families and friends, mentally ill ex-offenders can be supported through the process of reintegration (Jacoby and Kozie-Peak 1997).

In response to the demand for continuity of care for offenders with mental health issues and concurrent disorders, both the federal and provincial (Ontario) correctional systems have adopted mental health strategies. These mental health plans provide treatment and counseling for offenders with mental health issues while incarcerated, and attempt to aid in the successful reintegration of this population into the community. The Province of Ontario, along with other Canadian jurisdictions, has introduced mental health diversion and court support programs to provide services to adults with mental health issues involved in the criminal justice system (Ministry of Health and Long-Term Care 2006). These diversion and court support programs have the potential to improve mental health functioning and outcomes for individuals, reduce
recidivism and hospitalization, reduce pressure on the criminal justice system and, increase access to mental health services (Ministry of Health and Long-Term Care 2006). Moreover, Toronto is one of the few jurisdictions in the country that has implemented a Mental Health Court as a component of the mental health diversion program. Additional mental health courts have been introduced by other jurisdictions throughout Canada, including three others in the province of Ontario, since the inception of the Toronto court in 1998. These courts were established in Kitchener, Saint John, Halifax, Ottawa, Sudbury, and Winnipeg, however Toronto’s mental health court is the only one that operates full-time (Slinger and Roesch 2010).

These courts were established in response to the elevated numbers of individuals with mental health issues in the criminal justice system, the inability of the regular courts to effectively respond to this population, and the delayed processing of these cases (Hartford et al. 2004). Additionally, the Corrections and Conditional Release Act (CCRA) requires CSC to “provide essential health care, including mental health care, and reasonable access to non-essential mental health care services to incarcerated federal offenders” (Correctional Services of Canada 2010:1).

CSC is also responsible for providing mental health services through various specialized forensic psychiatric hospitals (Brink et al. 2001). Further, aligned with Jacoby and Kozie-Peak’s (1997) policy recommendations, CSC suggests that offenders with mental health issues are linked to community services to ensure the maintenance of treatment gains along with reducing the risk of recidivism. These services include referrals to community mental health agencies, finding employment, supportive housing, substance use programs, social assistance, and educational/vocational training (Laishes 2002).

Literature points to the importance of stable familial and social supports, and the need for further community-based programming and interventions for offenders with mental health issues.
issues. Although both the provincial and federal governments have implemented legislation and strategies to aid this population, little is known about the true outcome of these individuals when attempting to access services upon release. Further, these mental health strategies are structured for individuals who have been through the formal court system, or who have been incarcerated. The literature fails to address those individuals with mental health issues who are at risk of becoming involved in the criminal justice system. The extent or stability of preventative measures for this population is unknown. Along with the recommendation of expanding community-based mental health programs is the recognition that funding must now be allocated to these organizations (Trueman 2003). In order to provide efficient and effective services, these organizations must be adequately equipped to deal with the various challenges posed and encountered by offenders with mental health issues re-entering the community.

A review of the academic literature revealed a high prevalence of mental health issues and concurrent disorders within the North American offender population. In addition, the literature also highlighted various barriers to community reintegration experienced by this population. The prevalence of mental health issues and concurrent disorders within the offender population is adequately addressed in the psychological, criminological, and community health literature. There appears to be a dearth, however, of sociological literature on this issue. While this gap in the sociological literature is important to note, there are notable commonalities across the various disciplines regarding mental health and concurrent disorders amongst offenders. The psychological literature focuses primarily on the assessment and prevalence of mental health issues and concurrent disorders in the offender population, while the sociological literature tends to focus on the multitude of barriers (including the complex connection of issues surrounding social structure, social process, and social conflict) experienced by this population upon release.
Furthermore, the literature in these disciplines employs similar language and methods, and reveals few debates, if any. Most notable is the concurrence by all disciplines that the prevalence of mental health issues and concurrent disorders is a prevalent and serious issue that has implications for the individual and for society as a whole.

Frequently discussed in the sociological literature is the employment of social capital and social support theories to explain the sociology of mental health. The following section will introduce the theoretical foundation for our study. It will introduce social capital and social support theories and then demonstrate the ways in which the integration of these theories contributes to a more sophisticated understanding of the role of community-based organizations in the process of reintegration of offenders with mental health issues and concurrent disorders. More specifically, our study will foster understanding of how involvement in a community-based program can provide various forms of social support and build social capital for this population.

An Integrated Theoretical Framework: Social Capital and Social Support

Employing a theoretical framework to adequately conceptualize and help to make sense of the issues facing individuals involved in the criminal justice system suffering with mental health issues and concurrent disorders who access services from a non-profit, community-based organization is a daunting task. The sociological literature identifies social supports and social capital as crucial components to encourage well-being and buffer against stress (Maulik et al. 2010; Cohen and Willis 1985; Cummins 1988; Vilhjalmsson 1993; Cohen 1992; Chakraborty et al. 2010; Cobb 1976). Thus, borrowing from social support and social capital, an integrated theoretical framework, social integration (Hartwell and Benson 2007), offers a useful theoretical perspective to advance our understanding and thereby affect policy and resource allocation,
which impacts offenders with mental health issues and concurrent disorders who rely on community-based services.

The following section will provide a review of the foundations of the sociology of mental health, along with the epistemological origins of social capital and social support theories. Further, the application of social integration will be discussed, followed by the criticisms and limitations of social capital and social support theories.

The Sociology of Mental Health

Our understanding of the sociology of mental health can be greatly attributed to the writings of the most influential classical sociological theorists, such as Durkheim, Marx, and Weber (Horwitz 2007; Morrison 2006). These theorists imply that stressors, and as a result, emotional distress, derive from “larger social processes of social integration, inequality, and cultural values as well as from the historical transformations in these processes” (Horwitz 2007:67). Durkheim emphasized the notion that social causes exist independently of individuals because they remain unchanged in intensity and environment while individuals change. Similarly, Marx’s views on stratification are fundamentally social because they emphasize relationships as opposed to individualism (Horwitz 2007; Lin 2001; Morrison 2006). Marx indicates that “dominance and dependence can only exist within interdependent relationships” (Horwitz 2007:68). Comparably, Weber highlights the theory that the principles of social action are not individualistic, but rather rely on social and cultural locus (Horwitz 2007; Morrison 2006). Durkheim, in particular, was vehemently intrigued by the psychological ramifications of societal living. Durkheim’s analysis of suicide, accredited to be the pioneering sociological study of mental health, explored the concept of the impact of collective societal living on mental health and distress (Horwitz 2007;
Morrison 2006; Turner 2003). Durkheim discovered the linkage between “fundamental social processes” and “empirical indicators of rates of suicide across a wide variety of social contexts” (Horwitz 2007:70). Further, Durkheim emphasized the notion that the probability of suicide depends upon people’s connections with one another and with social institutions (Morrison 2006; Turner 2003).

For Durkheim, mental health is affected by social integration, the attachment to society through formal links to community organizations and informal ties to family and friends (Fothergill et al. 2011), in two ways. First, it gratifies attachment needs by linking people to socially assigned ideals, which are the most influential origins of human satisfaction (Morrison 2006). How strongly these ideals and beliefs tie individuals to the collective state of mind is of extreme importance; the contents of the ideals are not germane. Second, mental health is affected by social integration through the regulation of innate human desires and needs (Morrison 2006). According to Durkheim, individuals are naturally driven to have unappeasable desires; however, means must be proportionate to needs in order for happiness to be achieved. Insatiable desires and needs can only be quelled by collaborative rules, as opposed to by the individual solely (Morrison 2006; Turner 2003). In addition, “[s]ocially integrated social settings contain just and equitable norms that regulate human instincts and lead to states of contentment” (Horwitz 2007:72). Nevertheless, distress is the result of the disintegration of norms and values, which is routinely caused by unexpected changes in social life. Further, Durkheim believed that social bonds that are strong and socially developed objectives that are realistic encourage good mental health. The key to the acquisition of good mental health, for Durkheim, is the emphasis on solid social institutions that unify individuals so that they belong to a collective group, as opposed to isolating individuals (Horwitz 2007; Allik 2004).
Durkheim provided a substantive foundation for modern sociological theorists studying the topic of mental health in society (Berkman et al. 2000). Elaborating and expanding upon Durkheim’s concepts, contemporary theorists in sociology have constructed further theoretical frameworks to explain the importance of mental health issues within the community, and more specifically, within the criminal justice system. Successful offender reintegration, particularly offenders experiencing mental health issues, relies greatly upon support from informal and formal social institutions (Hochstetler et al. 2010). One such theoretical framework frequently employed in the sociological literature, social capital (McKenzie et al. 2002; Lin 2001; Portes 1998; Bourdieu 1986; Hartwell 2004; Almedom 2004), will be outlined and discussed in the following section.

**Social Capital**

Capital is present in various forms, ranging from the general use of ‘capital’, financial capital, physical capital, human capital, cultural capital, and of course, social capital (McKenzie et al. 2002; Lin 2001; Coleman 1990; Turner 2003). The origin of the concept of social capital, recently recognized as an influential addition to the vast literature regarding the prevalence of mental health (McKenzie et al. 2002), is traced to Karl Marx in his study of the emergence of social capital from the social interactions between the bourgeoisie and labourers (Lin 2001; Portes 1998). As Lin (2001) summarizes, capital is captured by the bourgeoisie (capitalists) as part of the surplus value, and can be a product of a process. In addition, when the surplus value is produced and captured, capital is a part of an investment process. More importantly, the dominant class creates investments, and reaps the surplus value. Therefore, Marx’s theory focuses on the social interactions and relations between classes (Lin 2001). Another forerunner
in the introduction of social capital is de Tocqueville’s (1840; Ostrom and Ahn 2003; Turner 2003) comparative analysis of the British versus American relations and interactions. In addition, Jacobs’ (1961) publication analyzing communities and urban decay provides yet another unique example of social capital. Jacobs emphasizes the importance of taking advantage of the various forms of opportunities offered within a city. Further, these opportunities should be capitalized upon to encourage neighbourhood growth, success, and stability. In ‘The Death and Life of Great American Cities’, Jacobs (1961) states:

A city’s collection of opportunities of all kinds, and the fluidity with which these opportunities and choices can be used, is an asset—not a detriment—for encouraging city-neighborhood stability. However, this asset has to be capitalized upon. It is thrown away where districts are handicapped by sameness and are suitable, therefore to only a narrow range of incomes, tastes, and family circumstances. Neighborhood accommodations for fixed, bodiless, statistical people are accommodations for instability. The people in them, as statistics, may stay the same. But the people in them, as people, do not. Such places are forever way stations (p. 139-140).

Expanding upon the classical notions of social capital, contemporary theorists have widened the breadth of the theory by identifying multiple forms of capital. Bourdieu, a French sociologist and modern social capital theorist, defines the theory as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (1986:248). Bourdieu’s analysis of social capital is described as “the most theoretically refined among those that introduced the term in contemporary sociological discourse” (Portes 1998:3). Bourdieu focuses on the benefits reaped by individuals, the formation of social networks, as a consequence of participation in groups, and the creation of resources through socialization (Portes 1998; Turner 2003; Almedom 2005). Social capital, according to Bourdieu, is divided into two aspects: the social relationship that “allows individuals to claim access to resources possessed by their associates”, and the quality
and quantity of the resources (Portes 1998:4). Moreover, the sociologist is best recognized for his concept of cultural capital, which is chiefly disseminated through family (Reay 2004). Children acquire types of temperament, various manners of thought, and qualities of style from family, which are then “assigned a specific social value and status in accordance with what the dominant classes label as the most valued capital” (Reay 2004:58).

Following Bourdieu, Coleman (1990) states,

Social capital is defined by its function. It is not a single entity, but a variety of different entities having two characteristics in common: They all consist of some aspect of a social structure, and they facilitate certain actions of individuals who are within the structure. Like other forms of capital, social capital is productive, making possible the achievement of certain ends that would not be attainable in its absence (p. 302).

Coleman extended social capital to demonstrate how investment in training, education, and welfare could promote human capital (Turner 2003). Further, Putnam provides a frequently quoted, yet quite general definition of social capital (Halpern 2005; Turner 2003). This theorist defines social capital as “features of social life—networks, norms, and trust—that enable participants to act together more effectively to pursue shared objectives” (Putnam 1995:665). Putnam’s comparative analysis of the effectiveness of different regional governments in Italy concluded that the level of trust between strangers and the participation in associational life were the crucial factors in the effectiveness of the governments (Halpern 2005).

Despite the variation in definitions of social capital, most forms appear to contain three central elements. Comprised of a network; a cluster of norms, values and expectancies; and sanctions, the three elements are easily recognizable in most forms of social association (Halpern 2005; Turner 2003). Social network is composed of a combination of the social relationships, ranging from informal interactions to formal exchanges of material and emotional support. These relationships may not always be positive, however, and can be characterized by dislike and
contention (Halpern 2005). In addition, these networks, or connections, are categorized as horizontal and vertical, formal and informal, weak and strong, and bridging, bonding, and linking (Ferlander 2007; Adler and Kwon 2002; Almedom 2005). Horizontal networks are defined as voluntary associations that emphasize “equivalent status and power”, while vertical networks “link unequal agents in asymmetric relations of hierarchy and dependence” (Ferlander 2007:117-118). In addition to the direction of ties, or networks, the distinction between formal and informal connections is paramount. Formal connections, described as contacts between citizens and civil servants, “builds civic skills and provides access to formal support, such as informational support and support from agencies such as childcare and medical services” (Ferlander 2007:118). Moreover, informal connections, such as family, friends and neighbours, generally do not establish civil society but are nonetheless essential in providing emotional support and maintaining social networks (Ferlander 2007; Adler and Kwon 2002).

Networks can also be classified by their strength, particularly between strong and weak ties. Granovetter’s (1973) analysis of the linking of micro-macro networks emphasizes the importance of strong versus weak ties. Granovetter defines the strength of a tie as “a (probably linear) combination of the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie” (1973:1361). This sociologist further states that “[a]n initially unpopular innovation spread by those with few weak ties is more likely to be confined to a few cliques, thus being stillborn and never finding its way into a diffusion study” (Granovetter 1973:1367-1368). Moreover, Granovetter asserts that weak ties, for example acquaintances, are non-intimate and are not regularly maintained (Ferlander 2007). Ex-offenders with substance use issues, coupled with a mental health issue, tend to have weak ties (Hartwell 2004; Almedom 2005). In addition to the significance of strong and weak ties,
Narayan (1999) states that the distinction between bonding and bridging social capital is important. Bonding social capital occurs when social networks are comparable in terms of age, ethnicity, and education, while bridging social capital is based on “heterogeneous and outward-looking connections that include people across social groups” (Ferlander 2007:119). Strong ties are found to describe people who are emotionally comparable to oneself, while bonding ties refer to people similar to oneself in other aspects of life. Weak ties refer to people who are emotionally incomparable to oneself, while bridging and linking ties refer to people who are dissimilar to oneself (Ferlander 2007; Adler and Kwon 2002; Schneider 2007). Additionally, Woolcock (1998) supplements the notion of bonding and bridging social capital by adding the third facet of linking social capital. Whereas bonding and bridging social capital refers to horizontal ties, linking social capital makes reference to vertical ties; people are connected vertically up and down the social ladder (Woolcock 1998; Adler and Kwon 2002).

The second element present in social capital according to Coleman (1988) is social norms, which refer to the rules, values and expectations that represent the network members. Some norms contain a behavioural component while others are affective. Finally, the third element of sanctions refers to formal and informal maintenance of social norms. Direct or subtle communications of disapproval of an act that is in violation of a written or informal social norm are exchanged among members of a network. The sanction, however, is not always negative, and may be expressed positively (i.e., a praise, compliment, encouragement, etc.) (Halpern 2005; Coleman 1990). Along with social capital, social support theory, which also has roots in sociology and social psychology, is a prevalent theory in psychiatry and community mental health and is an important element of social integration.
Social Support

Shifting from the notion of social capital, social support theory is also widely linked to psychological health outcomes (Cohen and Wills 1985). Social support is grounded in the works of sociologists Simmel, Thomas and Znaniecki, Park, Burgess, and McKenzie (Vaux 1988). The foundation of contemporary interest in social support is attributed to three scholars, Caplan (1974), Cassel (1976), and Cobb (1976). Caplan (1974) hypothesized in his work in preventative psychiatry and community mental health that the influence of others in the course and outcome of crisis transitions experienced by an individual is paramount. Moreover, Caplan (1974) utilized the term “support system” to describe the importance of support stemming from family, friends, neighbourhood-based services, mutual-aid groups, and clergy. He also noted the importance of durability and reciprocity of these relationships (Caplan 1974). Further, Caplan also emphasized the importance of formal caregivers in “mobilizing, enhancing, creating, and collaborating with informal support systems” (Vaux 1988:7).

Along with Caplan, Cassel (1976) was intrigued by the ecological findings linking unpleasant urban conditions, such as crowding, and poor housing, with elevated rates of psychological and physical disorder. Cassel did not clearly define social support, however he viewed support as being provided by those most important to an individual, and as serving a protective function, such as “buffering” the individual from psychological repercussions of stressful events (Vaux 1988). In addition, Cassel identified the concept of stress and support sometimes meshing, and stressful experiences disrupting social ties; support is diminished, and further demands are added (Vaux 1988).

Finally, Cobb (1976), in his address to the American Psychosomatic Society, adopted a similar view as Cassel and Caplan regarding the importance of support in relation to
psychological health. In addition, Cobb provided a conceptual definition of social support, and asserts that “[s]ocial support is defined as information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations” (1976:300). Further, Cobb (1976) identifies two significant and related purposes of this definition: protection from unfavourable repercussions of stressful events and fulfilment of social needs. The three components of the definition reflect emotional support, found in close relationships; esteem support, revealed in public and “meeting needs for recognition and bolstering sense of self-worth”; and, belonging support, which provides a sense of belonging in society, and affiliation with a social group (Vaux 1988:7). Cobb’s (1976) major focus, however, was the notion of social support as a stress-buffer. He asserts that strong social support can protect people experiencing stressful life events from diverse psychological and physical afflictions.

Discussed frequently in mental health and psychological literature, four types of social support have been identified: as emotional (listening, esteem, trust), informational (suggestions, advice, information), instrumental (aid in money, time, labour), and appraisal (referring to self-evaluation, or the affirmation by others) (Listwan et al. 2010; Pettus-Davis et al. 2009; Vollmann et al. 2010; Wong et al. 2009; Langford et al. 1996). Each of the types of social support allow a reciprocal exchange of supportive action. Further, Pinkerton and Dolan (2007) added the element of ‘concrete support’ to the notion of social support. This form of support refers to practical acts of support between individuals, and is frequently left out or underestimated by professionals (Pinkerton and Dolan 2007). An important distinction between perceived social support (perceived to be available if needed), and received social support (reported to have been recently provided by others) must be made (Hartwell and Benson 2007; Hupcey 1998). Perceived social support is responsible for the positive impact on health, well being, and adjustment (Hartwell and
Benson 2007; Hupcey 1998). Hartwell and Benson further note that “measures of perceived and received support are not interchangeable and that the processes tapped by these two types of support are not identical” (2007:332).

Beyond the diverse types of social support, the variations in the quality of social support are identified as important. Three forms of support qualities identified in the literature include closeness (the extent to which support can be assumed and given due to mutual caring between partners, close family members, and friends); reciprocity (exchanging things equally with others, and ensuring that a person does not feel indebted to another); and, durability (the contact rates and length of time people have known each other) (Pinkerton and Dolan 2007; Gottlieb and Bergen 2010; Hupcey 1998). It is important that those who are deemed as reliable support members are easily accessible for help, have known the individual for a long time, and are not intrusive (Pinkerton and Dolan 2007).

In terms of social support and mental health, persons with stronger social supports have a tendency to experience fewer psychological problems (Williams et al. 1981; Maulik et al. 2010; Cohen and Willis 1985; Cummins 1988; Hirsch 1979; Wong et al. 2009). Tolsdorf’s (1976) study concluded that hospitalized schizophrenics had fewer social supports in their lives, and valued support much less than non-psychiatric patients. In addition, studies have shown that low levels of social support are related to mortality (Cohen and Wills 1985). Mental disorders have been linked to occur as a result of stressful life events. The presence of social support and social networks have the potential to reduce the impact of stress on the development of mental health issues; in other words, high social support buffers the effect of stress (Maulik et al. 2010; Cohen and Willis 1985; Cummins 1988; Vilhjalmsson 1993; Cohen 1992; Chakraborty et al. 2010; Cobb 1976). In addition, individuals suffering with depression may alienate potential sources of
social support, or discern a lack of social support when in fact adequate support is present (Aneshensel and Frerichs 1982; Vollmann et al. 2010).

Stress can be amplified for prisoners during the process of release from prison, particularly for those who suffer with a mental health issue. Although prisoners entering the prison system may already suffer with mental health issues, research also suggests that the prison environment is conducive to the development of further, or additional, mental problems (Listwan et al. 2010). Shinkfield and Graffam (2010) found that social support within and outside of prison has a positive effect on the mental health of prisoners. Moreover, with ex-offenders more vulnerable to re-arrest within the first 6 months after release, the importance of a pre-release plan is paramount in order to keep recently released offenders on track post-release (Shinkfield and Graffam 2010; Salisbury and Van Voorhis 2009). While social capital and social support theories have been widely examined in the literature, an integrated perspective best elucidates the challenges experienced by ex-offenders with mental health issues and concurrent disorders. Additionally, this theoretical framework helps to explain the manner in which a non-profit, community-based organization is responding to this populations needs.

**Social Capital and Social Support Theories: ‘Social Integration’**

The concepts of social capital, social networks and social support have been analyzed and employed by a plethora of sociological and social psychological theorists. An integrated theoretical framework, however, offers a theoretical perspective that is grounded in the sociological literature and is useful as a way to explain a non-profit, community-based organization’s role in the lives of their clients. Social capital, in collaboration with social support theory, provides a comprehensive perspective into the accessibility of resources during the
process of reintegration of ex-offenders with mental health issues and concurrent disorders, as well as how the attained resources can act as ‘buffers’ against further stress (Cohen and Wills 1985). Considering the diverse elements that construct both social capital and social support theory, borrowing concepts appropriately from each of these theories aids in demonstrating how an integrated theoretical approach is more suitable than either one on their own.

Noting the lack of clarity in the usage of the terms (social networks, social support, social ties, and social integration) in the literature in reference to the impact of social relationships on health, Hartwell and Benson (2007) created a framework to articulate this integrated approach. Appropriately entitled ‘social integration’, Hartwell and Benson “suggest that social integration is most clearly viewed as a “meta-construct” composed of distinct, but interrelated, concepts—in this case, social networks, social support, social engagement, and social capital” (2007:330). These concepts emphasize a unique way of thinking about social ties (between individuals, individuals and groups, and between groups) and their effects on individuals and groups. Fundamentally anchored by social networks, social integration uses social support and social engagement (the degree to which individuals participate in various relationships, activities, and social roles) as key elements (Hartwell and Benson 2007). Furthermore, each of these elements is influenced by social capital and has the potential to affect one another, as well as outcomes in health, adjustment, and mental health (Hartwell and Benson 2007).

Social integration, a form of structural social support, was employed by sociologists to explain how social ties can affect psychological well-being long before Hartwell and Benson’s (2007) meta-concept of the theory. This form of support refers to the existence of close personal relationships, the frequency of social activities, and participation in organizations (Kunovich and Hodson 1999). For instance, Kunovich and Hodson (1999) studied social integration’s buffer
effect on war-related distress. The researchers found mixed results, reporting that being a member of informal organizations, such as sport clubs, was beneficial for mental health. Meanwhile, being a member of some formal organizations, like church groups, was found to have a negative effect on mental health. Interestingly, the authors noted that formal organizations may act as a medium to revive and re-live the traumatic events. The informal organizations were removed from the political upheaval, and therefore provided more positive supports. Further, being a part of a collective tragedy did not fare well in terms of support for those involved. The authors found that family members and friends were unable to provide adequate support, since they too were experiencing psychological distress (Kunovich and Hodson 1999). Thus, as discussed in Kunovich and Hodson’s (1999) study, identifying the role that formal and informal organizations play in buffering psychological distress is important. Further, not relying on individuals also undergoing psychological distress may provide stronger support systems.

In contrast, although Hartwell and Benson (2007) identify their meta-concept of social integration to be comprehended at the aggregate and individual level, it functions more effectively at the aggregate level (Hartwell and Benson 2007). Further, these sociologists assert that social integration “permits researchers to examine social participation both based on and resulting in social arrangements and well-being” (Hartwell and Benson 2007:345). The meta-concept of social integration also allows the context and environment, as opposed to the individual characteristics or behaviour, to be analyzed. Subsequently, issues surrounding macro-level dynamics that influence and shape environments, as well as the availability of resources, can be addressed (Hartwell and Benson 2007).
Criticisms and Limitations of Social Capital and Social Support

Although concepts deriving from social capital and social support theory have contributed greatly to contemporary sociological theory, neither are unaccompanied by criticisms and limitations. Portes and Landolt (1996) identify multiple shortcomings of social capital, beginning with the concept that “[i]f social capital is a resource available through social networks, the resources that some individuals claim come at the expense of others” (p.19). Essentially the argument is that there is a finite amount of social capital available and therefore not everyone can benefit all of the time. Due to limited resources and availability, someone must ultimately receive less social capital in order to make room for others. In addition, Portes and Landolt (1996) assert that the sources of social capital are at times confused with the benefits obtained from them. These sociologists state that for social capital to achieve meaning, the quality of resources must be separate from the capacity to gain resources via social networks. When there is confusion between social capital and the benefits gained from it, then the terminology is transformed to mean that the “successful succeed” (Portes and Landolt 1996:2). Furthermore, only the positive effects of social participation are considered, without evaluating the negative implications. In contrast, Visher and Travis (2003) assert that family members can be a negative form of support. In these cases, family members cannot be referred to as reliable and positive supports, and therefore can hinder the individual’s advancement or well being.

In terms of social ties, Portes and Landolt (1996) state that strong ties that fortify a group can also exclude outsiders. These researchers employ the example of industries with strong social ties; no matter how qualified or skilled a newcomer may be, they are often unable to find a way into the industry (Portes and Landolt 1996). In addition, Lin (2000) asserts that “members in resource-poor networks share a relatively restricted variety of information and influence”
Thus, members of a disadvantaged group may experience a lack of social capital, due to the tendency to socialize with other members of the same group, also referred to as ‘homophily’ (Lin 2000).

Finally, Thoits (1982) contends that literature asserting that social support can buffer psychological and physical negative effects of stressful life events must be interpreted with caution. This sociologist argues that most studies do not adequately conceptualize or operationalize social support, which is an assertion identified in a vast amount of the social support literature (Langford et al. 1997; Tolsdorf 1976; Cummins 1988; Hupcey 1998; Vilhjalmsson 1993; Gottlieb and Bergen 2010; Cohen 1992; Williams et al. 2004). Thus, this study must proceed with caution when employing social support theory. A clear definition of social support is important, and this study will contribute to operationalizing the element of social support within social integration. Lastly, the buffering effect of social support on distress has been the focus of most researchers, while the main effect of social support upon distress has been neglected (Thoits 1982). Despite limitations, social support theory continues to have a strong influence on the sociological and psychological literatures and is a useful analytical framework.

**Conclusion**

In this chapter I have reviewed the academic literature relating to the topic of the prevalence of mental health issues and concurrent disorders in offenders. Further, I have outlined the common barriers to community reintegration experienced by this population. The role of community-based organizations and treatment for offenders with mental health issues and concurrent disorders was described as important, and can aid in reducing recidivism. In addition, I
demonstrated how the employment of an integrated theoretical framework is useful to understand and explain ways in which community-based services can be important sources of support for offenders with mental health issues and concurrent disorders. The following chapter will outline and discuss the methods and methodology employed to conduct our study.
Chapter Two: Methods and Methodology

Introduction

Guided by the principles of community based research (CBR) and community-engaged scholarship (CES), this study was conducted in partnership with the John Howard Society of Waterloo-Wellington (JHSWW). Community-engaged scholarship includes multiple facets of academia, including teaching (community-engaged learning and service learning), research (e.g. community-based participatory research), and service (i.e., outreach, community service) (Calleson, et al. 2005). In this case, I am using CES to refer to the community engaged research component. The Carnegie Foundation for the Advancement of Teaching defines academic community-engagement as the “collaboration between institutions of higher education and their larger communities (local, regional, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity” (Community Engagement Classification 2010). Further, Calleson et al. (2005) assert that the essential component of community-engaged scholarship is the process required in collaborating with communities. Community-engaged scholarship involves the researcher to be fully engaged in a mutually beneficial partnership with the community partner, which allows the needs of the community to guide the activities of the researcher (Maurana, et al. 2001; Israel et al. 1998). Maurana et al. (2001) note that “[c]lear goals, adequate preparation, appropriate methods, significant results, effective presentation and reflective critique are critical to community scholarship” (p. 211). Using these principles to work in partnership with a community-based, non-profit organization such as the JHSWW to conduct research the organization articulated as a need, fits with CBR and CES.
The JHSWW is a non-profit, charitable community-based organization whose mission is to provide “[e]ffective, just and humane responses to the causes and consequences of crime” (Jones n.d.). This mission is accomplished by providing a multitude of programs for youth and adults who have been involved, or are at risk of being involved, in the criminal justice system. The John Howard Society is a national organization that has individual organizations throughout Canada, which the JHSWW is a part of, and offers programming out of 19 locations in the province of Ontario alone. One such program, ‘Community Aftercare’ (Aftercare), is a “supportive counseling service that focuses on helping offenders to assess their needs, to access community resources and to develop a realistic plan of action to attain their goals” (John Howard Society of Waterloo-Wellington n.d.). The Aftercare program is used by offenders for support and aid in reconnecting with the community, which is known as reintegration.

Recognizing that mental health issues are common among Aftercare clients initiated the JHSWW’s interest in research. Furthermore, there is a dearth of literature addressing the prevalence of mental health issues amongst those served by a non-profit, community-justice organization, such as the JHSWW. Our study attempts to fill that gap through an examination of the prevalence of mental health and addictions issues in the JHSWW Aftercare program. This program was chosen because it is not funded or designated as a mental health and/or addictions program for offenders, yet based on agency experience this population frequently accesses services from the Aftercare program. Responding to the research needs of the JHSWW, the agency staff and I exchanged knowledge and resources to create a partnership for the purpose of research. Through discussion and collaboration with the staff of the JHSWW, and more specifically the Executive Director, three main research questions and their sub-questions were composed to be addressed by this study. These questions include:
1). What is the ‘typical’ profile of the clients accessing the Aftercare program?
   • What are the mental health issues of the JHWW Aftercare clients?
   • How do these issues intersect with other problems, such as substance abuse?
   • How do JHWW staff members view Aftercare clients?
   • What have been the experiences of JHWW staff members in working with Aftercare clients?

2). What barriers do Aftercare clients experience?
   • What are the experiences of Aftercare clients in accessing other community-based mental health and/or substance use resources available to the general public?
   • What are the barriers to Aftercare clients in accessing other community-based mental health and/or substance use resources available to the general public?
   • If Aftercare clients have experienced general barriers to community reintegration, what barriers have they encountered?

3). What is the role of the Aftercare program in Aftercare clients’ lives?
   • How does the JHWW address clients’ needs/barriers who are accessing the Aftercare program?
   • What is the role of non-profit organizations, specifically the JHWW, in providing care to people with mental health issues involved in the criminal justice system?
   • How can JHWW’s resources including staff expertise, programs, and services better address their clients’ mental health needs?
   • How do Aftercare clients see the program as contributing to the prevention of their recidivism?
   • How can non-profit, community-based organizations that serve clients with mental health issues involved in the criminal justice system be better supported?
This chapter outlines the methodology and methods of this community-engaged research. It will address the importance of researcher reflexivity, positionality, and discuss the research samples. The quantitative and qualitative methods employed to collect data are then summarized, and the chapter will conclude with an outline of the data analysis procedures.

**Community Based Research and Participatory Action Research**

In order to appropriately and effectively collect the type of data required by JHSWW, our study employed CBR principles in addition to some tenets of Participatory Action Research (PAR) methodology. Both CBR and PAR are research methodologies that fit well with CES. CBR creates and mobilizes knowledge for action by “communities, civil society, policy makers, and stakeholders in all of the key areas affecting the future social, economic, and environmental sustainability of Canada” (Community Based Research Canada 2008). Universities and colleges, in particular, are focusing on community-based research to promote knowledge sharing between students and community partners for a mutual benefit (Community Based Research Canada 2008). Similar to CBR and CES, PAR methodology also involves the researcher/student and community partner in a collaborative relationship. PAR differs from CES, however, as this methodology generally refers to a methodology in which those most affected by the research (in our case, JHSWW staff and Aftercare clients) are involved in every aspect of the study, from design to dissemination. Two primary objectives of PAR, described as empowerment through “consciousness-raising” and the production of “knowledge and action directly useful to a community”, highlight the promotion of change in the lives of the participants and those involved (Kidd and Kral 2005:187). Aligning only partially with these objectives, only the Executive Director and the Aftercare staff acted as both research partners and participants in this
study. I worked closely with the Aftercare staff to consult and discuss various aspects of the research, such as drafting the consent form, scripts, interview guide, and coding manual. The Aftercare clients, however, did not have any part in the consultation process, and acted solely as research participants\(^3\).

**The Importance of CBR**

Developed in the late 1960’s to reduce the distrust of the research participants and to help improve economic and social conditions, CBR provides a framework to respond to issues within a social context and promotes collaboration, education, and action as key concepts (Kidd and Kral 2005; Macaulay, et al. 1999; Park 1993; Israel et al. 1998). Additionally, this form of research emphasizes the importance of the relationship between researcher and community, the benefit reaped by the community as a direct result of the research, and the involvement of the community in the research as itself beneficial (Macaulay, et al. 1999; Ward and Wolf-Wendel 2000; Maurana et al. 2001; Calleson et al. 2005; Holland and Gelmon 1998; Community Based Research Canada 2008; Israel et al. 1998). With a long history in many disciplines, the strengths of this approach are also transferable to counseling and community mental health services (Kidd and Kral 2005; Israel et al. 1998). Kidd and Kral (2005) identify community based research approaches to have been used successfully with homeless persons, persons with disabilities, minorities, survivors of domestic violence, and in other health promotion contexts.

Focusing primarily on the exchange of knowledge, CBR requires a great deal of dedication and investment on the part of the student researcher and community research partner (Bushouse 2005; Israel et al. 1998). Similarly, the Aftercare staff faced the challenge of

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3 Aftercare clients were not included as research collaborators due to their sometimes transient lifestyles. Future research could involve clients as collaborators, however ample time must be allocated to allow this partnership to foster.
responding to the daily demands of their clients, all the while fitting in time for a research project. In addition, Kidd and Kral (2005) assert that a particular “attitude”, which includes openness to experience, respect, and genuineness, should be developed by the researcher to engage in this methodology. This frame of mind allows the researcher to more “readily hear and respond to requests by groups of people wanting to improve their lives, negotiate difference and commonality concerning goals and methods of a study and, in general, have in mind a framework for action that can be broadly applied” (Kidd and Kral 2005:188). The researcher must be prepared to be actively involved in the middle of the lives of the people, or group, involved and at times will experience frustration and confusion.

Acting as a dynamic process, the methods and modes of CBR are developed over time and are a result of the knowledge gained through the examination of experiences (Sandy and Holland 2006; Maurana et al. 2001; Calleson et al. 2005; Holland and Gelmon 1998; Community Based Research Canada 2008; Bushouse 2005; Minkler 2005; Israel et al. 1998). Further, CBR emphasizes the importance of defining what constitutes a ‘community’ within a study (O’Toole et al. 2003; Israel et al. 1998). In the context of the current study, the JHSWW ‘community’ is composed of various individuals in diverse roles, and it is a community within a community. These individuals are social workers, community service officers, counselors, program facilitators, and individuals involved in, or at risk of involvement in, the criminal justice system. Members of the Aftercare program ‘community’ are mainly clients and counselors. These Aftercare ‘community’ members are linked, regardless of differing social or economic statuses, by one commonality: participation in the Aftercare program. In addition, many Aftercare clients share similar experiences in the criminal justice system. Thus, this study’s ‘community’
members are bonded by diversity, barriers, and marginalization, making this population and study sample ideal for CBR.

Forming around the problem, CBR allows the student and community partner to learn how the participants “perceive problems and strengths, ways that they can know about each other and their community, and how change is experienced, as both active agents and those receiving the benefits of positive change” (Kidd and Kral 2005:189). Frequently, the first task of the researcher is to exchange dialogue and experiences with the group. I met with the Aftercare team and the Executive Director of the JHSWW in the very early stages of the study (Mid-January, 2010). This meeting laid the groundwork for the foundation of the study, influenced the direction of the research, and helped decide upon the most appropriate research methodology. The Executive Director and I met on several occasions from mid-January to March following this meeting to draft the study’s research questions. These questions were mainly formulated to respond to the needs of the agency, and to address the gaps in the sociological literature regarding mental health issues and concurrent disorders in a non-profit, community-justice client population. I then met with Aftercare staff on numerous occasions for consultations regarding the various forms and tools employed by this study. The consent form, script used by the staff to recruit client participants, telephone script, and interview guide were discussed at length with the Executive Director and Aftercare staff, and edited numerous times from late January to early June. The Aftercare staff and the Executive Director would provide feedback regarding the language used in the consent forms and scripts. This is consistent with the principles of CBR, as this methodology develops from unique challenges and involves reflection on the part of the student researcher and community partner (Park 1993; Kidd and Kral 2005; Bushouse 2005; Minkler 2005; Israel et al. 1998). Sharing their knowledge and experience in working with this
population was important for developing these tools. In addition, I learned more from the Aftercare staff about the Aftercare population, and the types of individuals that the program serves, than I would have conducting the research without their collaboration (e.g. the best language to use when conducting interviews with Aftercare clients).

The approach to produce knowledge in CBR varies from traditional surveys to storytelling, and qualitative research methods are best paired with this methodology due to the importance of understanding participants’ experiences (Israel et al. 2005). Similarly, the Aftercare staff, Executive Director, and I decided that interviews with both Aftercare clients and staff would be beneficial to elicit various experiences about mental health issues and concurrent disorders, and accessing services in the community. Further, the Aftercare team, Executive Director, and I recognized the importance of creating a tool to collect quantitative data to report relevant statistics, which is mostly unique for a CBR methodology. This tool, designed only by the Aftercare team and the Executive Director, was then used by the Aftercare staff to gather data relating to mental health issues and concurrent disorders. Thus, agency staff had a key role in the design of the study.

The adoption of CBR principles and some tenets of PAR methodology proved to be quite useful for engaging in a community-based research partnership. Examining the experiences of Aftercare clients with mental health issues and concurrent disorders receiving services from the JHSWW, and how the JHSWW can better address this population’s needs required constant collaboration with staff. Further aligning with CBR, developing a trusting relationship with the Aftercare staff was vital in order to facilitate an amicable and balanced research partnership and to promote knowledge sharing. Emphasizing the employment of qualitative research methods,
but not discrediting the use of quantitative methods, the methods used in this study align with the principles of CBR.

An important part of any CBR project is to remain reflexive (Israel et al. 1998). The following section will discuss my reflexivity, and positionality while conducting this study.

**Reflexivity and Positionality**

Described as “self-criticality among researchers” (Kidd and Kral 2005:187), reflexivity acknowledges that research commonly expresses the orientation, values, and personal qualities of the researcher (Wertz et al. 2011). The importance of dialectic movement between action and reflection between the researcher and the group/participant when employing a CBR methodology is further emphasized by reflexivity (Israel et al. 1998). Highlighted as part of the rigor of qualitative research, reflexivity involves transparency, self-disclosure, and social accountability on the part of the researcher (Wertz et al. 2011; Israel et al. 1998). The reflexive approach of CBR makes every research project employing this methodology a “custom job”, and can result in “vagueness and ambiguity when the need arises to describe methods” (Kidd and Kral 2005:187).

For instance, obtaining Research Ethics Board (REB) clearance from the university was a lengthy process. Since I was working in partnership with a community-based agency, with a sensitive issue and with a potentially risky population (e.g., ex-offenders, individuals involved in the criminal justice system, individuals with mental health issues and concurrent disorders), the REB required detailed information regarding every step of the study. This was initially challenging, as the study’s data collection methods mostly unfolded as the project progressed, like many other CBR projects (Israel et al. 1998). Following the first submission of the REB application, I reflected upon the information required by the REB with my advisors (who
included Mavis Morton, an Assistant Professor in the Department of Sociology and Anthropology and the Executive Director of the JHSWW, Joan Nandlal, who has a PhD in psychology, is an adjunct professor in the Department of Psychiatry at the University of Toronto, and became an adjunct professor at the University of Guelph in order to be able to act as a committee member for my Master’s thesis). This process involved lengthy discussions regarding the needs of the agency, in addition to how these needs can be appropriately and safely addressed. The main concerns of the REB were surrounding disclosure of incidental information by the participants, specifically regarding illegal activities or harm to themselves or others. If reportable information arose in the interviews, I was required to report it to an Aftercare staff who would then contact the appropriate authorities. In addition, the REB required in-depth information regarding the plan of action to reduce the psychological and social risks. Providing the participant with contact information for crisis hotlines and allowing the participant immediate access to an Aftercare staff member were ways to address these risks. The REB also had concerns regarding only verbally communicating the study’s information by the Aftercare worker to potential Aftercare client participants. The REB required that an information sheet be provided to the clients, in addition to the verbal communication. The Aftercare team was not in agreement with this request initially, as they had concerns surrounding the Aftercare clients’ reaction to receiving a more formal information sheet. The Aftercare team thought that this formality might deter the clients from participating, due to various reasons (e.g. authority issues, the clients feeling as though participation was mandatory, and the literacy capacity of some of the clients). Finally, the Aftercare team and I decided upon appropriate wording for the information sheet in order to clearly and effectively relay the study’s information to the clients, and to respond to the REB’s request. After several REB application edits and submissions, ethics
clearance was finally approved approximately three months after the initial submission. This process, however, demanded constant collaboration, reflection and change. Further, remaining conscious and aware of my position of privilege and my abilities to read while some of our participants cannot was important to be able to reflect upon this power imbalance.

Reflecting upon my positionality while conducting this research was important. Next to my respondents, I am a white, twenty-six year old, university educated, middle class, able-bodied, heterosexual woman who has never been in conflict with the criminal justice system. The majority of the research participants have been, at one point or another, involved in the criminal justice system and most come from marginalized backgrounds. Further, my career as a correctional officer provided a different insight and opinion of the criminal justice system that many individuals have not experienced. Many incarcerated offenders possess an “us vs. them” mentality in regards to correctional staff, and do not easily trust law enforcement officials. Moreover, persons employed at a non-profit, community-based organization that serves individuals involved in the criminal justice system may have their own beliefs and opinions regarding correctional facilities and those working within them. This caused me to proceed with caution at times when revealing my background. As a central tenet of CBR and PAR, the researcher must be “prepared to engage in what can be a very personal struggle with their own deeply embedded beliefs” (Kidd and Kral 2005:190). Thus, it was crucial throughout the research, analysis, and writing process of our study that I was aware of the power dynamics in which our research was embedded. My analysis of the challenges and experiences faced by the participants required examining the larger scope of the sociological issues revealed by the data. Thus, it was crucial that I put aside my previous experiences of working on the front-line with this population.
A related and important tenet encompassed by CBR is the importance of addressing power inequities (Israel et al. 1998). As a result, the researcher must note that “research participants are not powerless in the research relationship” (Grant et al. 2008:592). The first step towards sharing knowledge is recognizing and valuing various sources of knowledge. The CBR researcher can facilitate this by sharing his/her own knowledge and demystifying the research process (Grant et al. 2008). By sharing my previous experiences in the criminal justice field as a correctional officer, the Aftercare staff were able to conclude that I had prior encounters with marginalized populations. Further, existing power inequalities may be reinforced by the efforts to encourage participation. As a CBR researcher, it is important to understand a group’s interest in participating and level of commitment. The level of participation has an impact on the outcome or change that is the effect of CBR. Often, there is confusion about what is regarded as change, and it is important to keep in mind that social change is a slow process (Grant et al. 2008). The Aftercare staff and Executive Director were motivated and very committed to our study not only as research partners, but also as participants. Further, the social change that will hopefully come from our study will not be an immediate result. This change will come over time, and at a much later date, if at all. The JHSWW will be using the results of our study to potentially leverage additional funding for the Aftercare program, and promote knowledge advancement on the topic of mental health issues and concurrent disorders in the Aftercare population. Thus, the challenge of recognizing immediate social change in this study is a non-issue. Moreover, Grant et al. (2008) assert that credibility in CBR and PAR “means that the truth and knowledge of the community is both privileged and communicated” (p. 598). In short, does the research adequately reflect the community or group and the experiences of its members? (Grant et al. 2008). Remaining reflexive and focusing on the issues and needs identified by the JHSWW
allowed for a more authentic representation of the experiences shared by the organization and Aftercare clients.

Acknowledging that this research project is a learning opportunity for all (Grant et al. 2008), I experienced a great amount of knowledge sharing while conducting research at the JHSWW. Many of the staff members whom I had regular contact with were seasoned social workers and counselors, were very well versed in the criminal justice system, and had extensive firsthand experience working with individuals with mental health issues and concurrent disorders. Further, I worked closely with the Executive Director of the JHSWW, who was an important resource for questions regarding social psychology and community psychiatry, and the process of conducting community-engaged research. The Executive Director, in particular, was also a valuable resource in teaching me how to develop research questions, design research tools, and code and analyze data. In addition, the staff viewed our research as an opportunity to make their voices heard regarding the current state of community-based treatment for ex-offenders with mental health issues, and they were exceptionally welcoming. As such, they were involved in many of the stages of our study, including acting as participants. Thus, working towards a common objective, such as change, remaining transparent was relatively effortless.

**Data Collection**

Following the epistemological tenets of CBR, and noting that this methodology generally favors a qualitative approach, the decision to incorporate a mixed methods approach was agreed upon in collaboration with the JHSWW. Employing a mixed methods approach “allows a wider, or more complete, picture to emerge than that presented by single methods work alone” (Williamson 2005:9). Thus, the employment of quantitative methods integrated with semi-structured, in-
depth, individual interviews provides another avenue to gather rich data. Useful to elicit experiences and potential challenges encountered by participants, interviews can “add depth and meaning to numbers” (Kraska and Neuman 2008:459). Further, the use of quantitative information has the potential to add precision and clarity to words (Kraska and Neuman 2008). Considering the disadvantages of conducting a mixed methods study is also important. Differing from a mono-method approach, employing a mixed methods approach can be more costly and time consuming for the researcher. In addition, the researcher should be competent in various research approaches, and must be prepared for potential criticism by methodological pedants (Kraska and Neuman 2008).

**Quantitative Data Collection**

In order to effectively capture participants’ experiences, and to enhance reliability and validity, JHSWW staff and I decided that collecting quantitative data would be beneficial to the study. Quantitative data for the Aftercare program were collected primarily by JHSWW Aftercare program staff. Aligning with CBR, I first met with Aftercare staff in January 2011 to discuss the parameters of the study. Within these parameters, a specific tracking tool developed by Aftercare staff and the Executive Director to meet agency needs was developed⁴ (see Appendix ‘B’). The tool was developed based on evidence-based research and frameworks used in the mental health and concurrent disorders fields, and referred to definitions borrowed from the Centre for Addictions and Mental Health and other leading mental health organizations. The tool was employed to capture the prevalence of a substance use issue, mental health issue, developmental disorder, and/or an acquired brain injury within the Aftercare population. The tracking tool was distributed to Aftercare program staff at all three JHSWW sites and employed over a 4-month

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⁴ I did not participate in the development of this tool.
timeframe, from February 2011 to June 2011. I have chosen to only address the prevalence of mental health issues and concurrent disorders within this study, thus allowing for future research examining the prevalence of other disorders within this population.

All clients attending Aftercare programming within the 4-month timeframe were included in the sample, for a total of 61 individuals. Each client was assigned an identification code by the Aftercare staff, and if applicable, the appropriate category was selected on the tracking tool. The University of Guelph REB required detailed and in-depth information regarding the type of data collected by this study, in addition to the data collection methods. Thus, I submitted every consent form, script, interview guide, and data collection tool to the REB for approval. The tracking tool was developed by the JHWWW Aftercare staff and the Executive Director for the agency’s needs, and they permitted me to employ it for this study to collect quantitative data about mental health issues/mental illness and concurrent disorders in Aftercare clients. Upon approval from the University of Guelph REB, I reviewed the data collected by the tracking tool. Utilizing the tracking tool as a general guide, I developed a coding manual based on the information gathered during the first Aftercare meeting with staff and later from individual Aftercare staff members (see Appendix ‘C’). Informed by the mental health and criminal justice literature, in addition to the JHSWWW staff, the Aftercare database consists of 25 variables, such as age, mental health issues, involvement in the criminal justice system, and substance use issues, that were entered into an Excel file.
Qualitative Data Collection

Secondly, qualitative data were collected by conducting semi-structured, in-depth, individual interviews. Beneficial when discussing sensitive topics, such as mental health issues, individual interviews allow the researcher to form a rapport with the participant (Baribell and While 1994). The interview guide was created in collaboration with the Executive Director and the Aftercare staff, in order to address the prevalence of mental health issues and concurrent disorders in the Aftercare population, unearth this population’s experiences accessing community-based mental health services, how the Aftercare program can be improved, and address funding issues. Further, many of the questions were informed by the mental health literature, and were not intrusive. Given the sensitive nature of the topic, the questions were formulated to ease the participant into the subject of mental health. The aim of the Aftercare client interviews were to capture this population’s experiences within the criminal justice system, and more specifically, with community-based mental health services. The Aftercare population, which consists primarily of male ex-offenders, or individuals at risk of involvement in the criminal justice system, presents with complex needs. Many are at risk of homelessness, require aid in securing employment, and have a history of victimization. Further, the potential for marginalization within this population is relatively high, and the added stigma of a mental health issue and/or concurrent disorder is another burden. This population frequently requires multiple resources, usually in the form of community-based organizations, to attend to their needs.

The interviews, conducted with a total of 21 Aftercare participants, took place in private meeting rooms or offices at a JHSWW site from June 2011 to August 2011. Only Aftercare clients and program staff, all of whom are adults, were considered for interviews so the issue of parental consent and/or capacity to consent was a non-issue. The recruitment of Aftercare clients
to participate in an interview was done by JHSWW staff members. Due to the complexity and sometimes transient nature of the client base, purposive sampling was employed. Frequently used in field research or exploratory research, purposive sampling “…uses the judgment of an expert in selecting cases or it selects cases with a specific purpose in mind” (Kraska and Neuman 2008:228). Moreover, due to the complexity of the Aftercare population, Aftercare staff recruited clients who they regarded to be more open and willing to share their experiences with someone other than a professional. The Aftercare staff informed the clients about this study, and asked the clients to let them know if they were interested in participating. The REB was concerned that the clients would feel obligated to participate, since it was their counselor who was relaying the information about the study to them. This was avoided by requesting that the Aftercare staff have a casual conversation with the clients regarding the study, and provide them with an information sheet. Additionally, the REB expressed concerns regarding potential language barriers when interviewing Aftercare client participants. The JHSWW, however, did not have a history of language barriers (besides some occurrences of low literacy) in the Aftercare client base in the past, and thus not concerned about this occurring during the interviews. I did not encounter any language barriers (i.e., English not as a first language) when interviewing client participants.

Aftercare staff members provided clients individually with general information regarding the study (see Appendix ‘D’ for script for general research information). They then obtained verbal consent from clients who appeared interested in participating in our study for their contact information to be passed onto me. I contacted the clients via telephone or email from a JHSWW office to arrange a date and time for an interview (see Appendix ‘E’ for telephone script). Before commencing the interview, I gave a brief explanation of our study and reviewed the consent form with the client (see Appendix ‘F’ for consent form). Due to the nature of the Aftercare
population, a few of the clients struggled with low literacy. In order to avoid potential embarrassment for the client, I reviewed each section of the consent form with each client. Further, I made certain to review incidental findings (issues surrounding planned harm to themselves, to others, or participating in an unreported crime and my duty to report these findings to the JHSWW and the proper authorities) before the interview began (see Appendix ‘G’ for incidental findings script). Upon completion of these steps, I turned on the audio recording device and commenced the interview. The subject matter of our study is sensitive, and a few of the client participants disclosed past experiences with the criminal justice system. Researcher self-disclosure is frequently advised against by many methodologists (Sprague 2005), however at times can be suitable to empathize with the participant. In a few instances, it was appropriate to reveal my experience as a correctional officer to demonstrate my deeper understanding of the criminal justice system and incarceration. In these instances, the client participants recognized that I was not just a graduate student attempting to pry into their lives, but an individual attempting to further understand their experiences. A total of 14 clients participated in an individual interview, which varied in length ranging from 20 minutes to over one hour.

I recruited the participants for the staff interviews from all three of the JHSWW sites, and included a total of 7 current and past Aftercare staff and managers. Given that the Aftercare staff members were already aware of the study and I was working in constant collaboration with the Aftercare staff, recruitment was relatively easy. Before commencing the interview, I reviewed the consent forms with the staff participants (see Appendix ‘H’ for staff consent form). The staff interviews were conducted to supplement the information collected in the client

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5 Staff participants included any and all direct service staff who have worked in the Aftercare program and who are still employed at the JHSWW, as well as management/supervisory staff.
interviews and therefore employed a different interview guide than that used for the client interviews (see Appendix ‘I’ for client interview guide and Appendix ‘J’ for staff interview guide). The staff interviews delved deeper into the issue of funding and public policy, which aligned with the needs of the JHSWW. The client interviews remained on the topic of their experiences in the criminal justice system, and accessing community-based mental health services. Each semi-structured interview followed an open-ended design, and the ordering of the questions was modified as needed. Some of the participants, both client and staff, requested that a question be re-worded or re-framed in order to ensure clarity. At times, additional probing questions were used to avoid vagueness and to elicit lengthier responses. None of the participants declined to use the audio recording device, which was helpful to maintain a connection and eye contact with the participants during the interview. Further, the staff interviews were much longer than the client interviews, varying from 30 minutes to almost 2 hours. This may be indicative of the difference in educational level, background, ability to articulate their points, and needs, in comparison to the client participants.

Data Analysis

Employing both quantitative and qualitative methods in this research helped to minimize limitations and ensure validity. Further, analysis of the data occurred not only while coding but throughout the collection processes. Upon completion of the 4-month timeframe, I met with the Aftercare staff members to examine and discuss the results of the tracking sheets. Over the course of the 4 months an Aftercare database coding manual was developed in collaboration with JHSWW staff. The parameters, or variables, included in this coding manual derived from client information obtained by the mental health and criminal justice literature, reviewing the client’s
files, and meeting with the Aftercare staff. The variables include: client identification; gender; client’s current age; duration of service; referral source; previous involvement with Aftercare program; alcohol and/or drug use; suicide risk; client housing situation; see counselor at other agency; mental health/mental illness; developmental disorder; acquired brain injury; employment status; history of victimization; primary offence (secondary, tertiary, and fourth, if applicable); multiple charges; number of charges; previous criminal justice sector involvement; engage in self-harm; and, whether or not the client was interviewed (as only a subset of the Aftercare clients were interviewed).

The data from the tracking sheets were coded and the sample of clients included in the 4-month timeframe, which totaled 61, was entered into the database. Ranging in age from 18 years old to 67 years old, the sample was comprised of 52 males and 9 females from various cultural backgrounds. The data were analyzed by employing the most recent version of Statistical Package for the Social Sciences (SPSS 18) software. Frequency distributions which are “the distribution of cases into categories of one variable, that is, the number or percent of cases in each category” (Kraska and Neuman 2008:346) of the dataset were computed. Further, frequency distributions for those clients interviewed and not interviewed were also analyzed. The intra-rater reliability of the Aftercare dataset is 90 per cent.

Each in-depth, individual interview was transcribed verbatim from the audio recording device using ExpressScribe software. Qualitative data analysis, considered to be less standardized compared to quantitative analysis, has been widely criticized in the past in the social sciences. Kraska and Neuman (2008) report, in reference to qualitative analysis, that “even though its methods of data collection are discussed at length, its methods of analysis were unclear and not open to inspection” (p.466). Recently, however, qualitative researchers have
adopted an analytical approach that “seems as scientific as it does artistic” (Kraska and Neuman 2008:466). During the process of transcribing, emerging themes were noted which later facilitated the task of open coding.

By examining the data to condense them into preliminary analytic themes, or codes, open coding is the first step of data analysis (Kraska and Neuman 2008). This process “brings themes to the surface from deep inside the data” (Neuman 2000:422), and mostly originates from the research questions and concepts in the literature. I reviewed the printed transcripts, and notes were made alongside the initial themes that emerged during transcription. This list of themes serves to help to easily access the emerging themes, aid the researcher to find themes in future coding, and reorganize, sort, combine, extend, or discard the themes of the study (Neuman 2000). Employing an inductive approach, I remained open and without preconceived perceptions about other potential emerging themes. I coded the data by hand, assigning each main theme a distinct color. The client interviews were initially coded separately from the staff interviews, and upon the second stage of coding, axial coding, similarities between the groups emerged. During this stage, axial coding “not only stimulates thinking about linkages between concepts or themes but it also raises new questions” (Kraska and Neuman 2008:474). Looking for subcategories, or sub-themes, I focused more on the initial coded themes than the data. Moving towards identifying the axis of central concepts in analysis (Neuman 2000), I discarded some themes and examined others in more depth. Quotes from the respective color-coded main themes and their sub-themes were copied into separate documents, and the final step of selective coding was then completed. In this stage, “[r]esearchers look selectively for cases that illustrate themes and make comparisons and contrasts” (Neuman 2000:424). This step was important for comparing and contrasting the client and staff main themes. Further aligning with tenets of CBR, the emerging
themes were examined and discussed in collaboration with JHSWW staff throughout the coding process. I met with the Executive Director on numerous occasions from the beginning of December to mid-January to discuss the main themes and sub-themes of the data. Further, once these themes were outlined, I emailed the Aftercare team for their feedback. All of the team members, for the exception of one staff member, responded and provided additional ideas for sub-themes. Upon agreement of the main themes, the data were then ready for interpretation.

**Challenges**

Conducting community based research is not absent of challenges for both the community partner and the academic researcher (Flicker et al. 2007; Hamberger and Ambuel 2000; Davidson and Bowen 2011; Williams 2004). Traditionally, community based research partnerships tended to be one sided, with the academic researcher conducting what is referred to as “drive-by data collection” (Williams 2004; Davidson and Bowen 2011). In these cases, the academic researcher would access participants through collaboration with a community partner, but fail to carry through with helping to address the other needs identified by the community based agency/partner. Thus, the balance of power was shifted in favor of the academic researcher, at times leaving the community partner frustrated and disappointed (Williams 2004; Davidson and Bowen 2011).

Our study attempted to negotiate the imbalance of power traditionally encountered during community based research, and find reciprocity to foster more of a collaborative partnership. This was attempted by listening to the needs of the JHSWW Executive Director and staff members. Aware of their demanding and busy schedules, it was important to consider the time that the JHSWW staff contributed to acting both as research partners and participants.
Recognizing that direct service, as that provided by the JHSWW, is the priority of the agency, it was important that I remain patient and flexible when staff members were required to re-schedule a research meeting due to client demands. Further, the Executive Director, who has a strong research background and experience in community based collaborations, was regularly available to provide guidance and feedback regarding the direction of our study. Acting as Executive Director, participant, research partner, and committee member, I was fortunate to have a community partner with such a range of knowledge and an interest in mentoring.

Additionally, to ensure reciprocity, a contract was formulated between the University of Guelph and the JHSWW at the beginning of the partnership. This contract, which named the JHSWW as owners of the data, was important for building a trusting relationship and outlining expectations with the community partner (Davidson and Bowen 2011). Further, since our study involves sensitive data, it was imperative that data collection and analysis was conducted in the JHSWW offices. Although at times this seemed to be an inconvenience due to weather, other scheduling conflicts, etc., it was a necessary part of conducting this research. Finally, a summary report of our study’s results will be provided to the JHSWW to be used for future reference and funding proposals. Thus, the relationship fostered between myself, as the academic researcher, and the JHSWW, as the community partner, is one of mutual benefit. This reciprocal partnership appears to be still somewhat of an anomaly in the community based research literature (Flicker et al. 2007; Hamberger and Ambuel 2000; Davidson and Bowen 2011; Williams 2004).

Despite the challenges encountered while conducting this CES study, there were countless benefits that arose from collaborating with the JHSWW. For example, I secured a temporary, part-time position at the JHSWW, which provided me with valuable skills and
experience. This employment opportunity would not have been available to me if it were not for this study and the positive research partnership fostered between the JHSWW and myself.

**Conclusion**

In this chapter, I have demonstrated how principles of CBR, and some tenets of PAR methodologies, are appropriate and effective for engaging in a community-based partnership and study. Particularly practical when employing qualitative research methods, this methodology promotes knowledge sharing. Further, I outlined the significance of researcher reflexivity and reflected upon my own positionality, which is explicitly important when employing CBR methodology, partnering with a community-based organization, and dealing with a complex population. This chapter also reviewed the research samples, the methods of data collection, and the approaches employed to analyze the data. It concludes with a discussion of the challenges of conducting a CBR study. The following chapter will present the quantitative and qualitative results of this study.
Chapter Three: Results

Introduction

This chapter presents the quantitative and qualitative findings of this study. The findings of this study sought to address numerous research questions which were created in collaboration with the JHSWW to attend to the needs of the agency, and attempt to fill the gap in the sociological literature regarding the prevalence of mental health issues within the Aftercare population. Our research questions also sought to reveal the experiences faced by this population when accessing community-based mental health services. I first present the results of the quantitative analysis, specifically the frequency distributions for the most relevant variables. I analyzed a total of 25 variables, and I will present and discuss many of the preliminary descriptive statistics in this chapter. Further, many of the research questions posed in this study are addressed by the results of the qualitative analysis. These qualitative findings, which are presented in the form of themes and sub-themes of the semi-structured interviews, will also be examined.

Quantitative Findings

Table 1 demonstrates the frequencies of the analyzed data that help paint a picture of the profile of the clients accessing the Aftercare program at the JHSWW, the prevalence of mental health issues/mental illness among the Aftercare clients, and the prevalence of alcohol/substance use. These findings, in addition to some of the qualitative findings, help to respond to this study’s first research question, which addresses the ‘typical’ profile of the client accessing the Aftercare program. These data, which were obtained from the tracking sheet, reviewing Aftercare client files, and meeting with Aftercare staff, are important to examine to understand some of the issues faced by the Aftercare population.
Among the 61 Aftercare clients included in this study, 82.5 per cent were male, and 14.8 per cent were female. The age of the sample ranged from 18 to 67 years old. Clients’ housing situation varied greatly. A majority of the Aftercare sample (62.1 per cent) lived in somewhat stable living conditions, in an apartment alone, with a partner/roommate, or with their parents. One-third, 32.7 per cent, were living in a rooming house, shelter, or recovery house, or living in an apartment designated for an individual with a mental health issue, and 4.9 per cent were transitory or homeless. In terms of employment status, 47.5 per cent were receiving income assistance through the provincial or federal government, and 24.6 per cent were employed full-time or part-time. However, 22.9 per cent of the sample were unemployed.

The JHSWW serves individuals who have been involved, or at risk of involvement, in the criminal justice system. As expected, more than three quarters, 85.2 per cent, of the Aftercare sample were previously involved in the criminal justice system. Hence, 15 per cent of the sample were not formally involved in the criminal justice system, however were still accessing services from the Aftercare program. Further, 77 per cent had multiple charges. Violent offences, or offences committed against the person (i.e., assault, attempted murder, and murder), accounted for the largest portion of offences committed in the sample, representing 37.6 per cent. The next most prevalent kind of charges were related to theft, robbery, and/or weapons offences. These offences represented 21.6 per cent of the Aftercare sample. Following theft, robbery and/or weapons offences are sexual offences, which represent 13.1 per cent of the sample. Next, narcotics offences, representing 8.2 per cent, and ‘chronic criminality’, 4.9 per cent, represent a smaller portion of the sample. Finally, 1.6 per cent of the Aftercare sample’s

6 Race was not included in this study because it is not a variable tracked by JHSWW, nor was it relevant for this research.
7 ‘Chronic criminality’, a term developed by an Aftercare staff, refers to those clients who have various charges, and who have been involved in criminal activity for most of their lives. Arguably, a large number of the Aftercare clients could be categorized as ‘chronic criminals’, however a few stood out to be particularly deeply rooted in crime.
most recent charge, or offence, was breaching probation or parole. The ‘unknown’ and ‘not applicable’ categories were comprised of those clients for which the Aftercare staff were not aware of their criminal history\(^8\), or those clients who did not have a criminal charge.

In addition to their criminal justice involvement, 60.7 per cent of the Aftercare sample suffered with some form of mental health issue/mental illness\(^9\). Communicated to the Aftercare staff by the client, or measured by the Aftercare staff according to criteria used by the JHSWW, ‘mental health issues/mental illness’ represents a significant portion of the Aftercare sample. Comparably, Aftercare clients with an alcohol and/or substance\(^{10}\) use issue (concurrent disorder) also represents a large percentage of the sample, by 77 per cent. Further, 31.1 per cent of the sample reported a history of victimization\(^{11}\), and 18 per cent engaged in some form of self-harm. Both victimization and self-harm could be connected to current mental health and/or substance use issues. The findings further demonstrate that more than half (52.5 per cent) of the Aftercare sample relies solely on counseling provided by the JHSWW Aftercare staff. With only 34.4 per cent of the sample reporting that they access services from other community-

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\(^8\) The Aftercare staff are not always informed of a client’s previous criminal history, or current charge(s); it depends on what information is provided by the client and/or referral source.

\(^9\) As outlined by the JHSWW and based on one or more of the following: observable behaviour (including comments made, such as talking about something that isn’t real, reference to taking a particular medication, etc.) that would lead a reasonable person to conclude that there is a mental health issue/illness present, collateral information (e.g. third party information), or the client expresses that he or she has been diagnosed with a mental illness (schizophrenia, schizoaffective disorder, depression, bipolar, etc.) or experiences symptoms such as delusions or hallucinations that are obviously attributable to another cause.

\(^{10}\) As outlined by the JHSWW: Client is dealing with a substance use problem that could include the use of prohibited substances, abuse of prescription medications, use of legal substances but to such an extent that it negatively impacts on the individual’s life (e.g., daily use of marijuana, excessive consumption of alcoholic beverages)

\(^{11}\) Any indication of past victimization reported to the Aftercare staff. This may include bullying, pattern of physical and/or emotional harm by parent(s) and/or other family members, partner, friend, etc. A conservative approach was taken when defining ‘victimization’.
<table>
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<th><strong>Table 1: ‘Profile’ of Aftercare Clients (N=61)</strong></th>
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| **Gender** | Male- 82.5% (n=52)  
Female- 14.8% (n=9) |
| **Age** | 18-67 years old (M=39.49) |
| **Housing Situation** | Living in apartment/house alone, or with partner/roommates/parents- 62.1% (n=38)  
Living in rooming house, shelter, recovery house, or apartment designated for an individual with a mental health issue- 32.7% (n=20)  
Transitory/Homeless- 4.9% (n=3) |
| **Employment Status** | Social Assistance- 47.5% (n=29)  
Employed- 24.6% (n=15)  
Unemployed- 22.9% (n=14)  
Unknown- 3.3% (n=2)  
Pension- 1.6% (n=1) |
| **Primary Offence** | Violent Offences/Offences Against Person- 37.6% (n=23)  
Theft/Robbery/Weapons- 21.6% (n=16)  
Sexual Offences- 13.1% (n=8)  
Narcotics- 8.2% (n=5)  
‘Chronic Criminality’- 4.9% (n=3)  
Breach of Probation/Parole- 1.6% (n=1)  
Unknown/Not Applicable- 8.2% (n=5) |
| **Multiple Charges** | Yes- 77% (n=47)  
No- 8.2% (n=5)  
Unknown/Not Applicable- 14.8% (n=9) |
| **Previous Criminal Justice System Involvement** | Yes- 85.2% (n=52)  
No- 13.1% (n=8)  
Unknown- 1.6% (n=1) |
| **Mental Health Issues/Mental Illness** | Yes- 60.7% (n=37)  
Unknown- 39.3% (n=24) |
| **Alcohol and/or Substance Use** | Yes- 77% (n=47)  
Unknown- 23% (n=14) |
| **History of Victimization** | Yes- 31.1% (n=19)  
Unknown- 68.9% (n=42) |
| **Engage in Self-Harm** | Yes- 18% (n=11)  
Unknown- 82% (n=50) |
| **Access Counselor Outside of JHSWW** | Yes- 34.4% (n=21)  
No- 52.5% (n=32)  
Unknown- 13.1% (n=8) |
| **Previous Aftercare Involvement at JHSWW** | Yes- 24.6% (n=15)  
No- 59% (n=36)  
Unknown- 16.4% (n=10) |
| **Duration of Service in Aftercare** | Less Than 3 Months- 23% (n=14)  
3 Months to Under One Year- 29.5% (n=18)  
1 Year and Greater- 47.5% (n=29) |
based organizations or counseling services\textsuperscript{12}, this is an important finding. The question of why so many of the Aftercare clients do not access other counseling services outside of the JHSWW will be attended to in the qualitative findings. In addition, almost a quarter (24.6 per cent) of the Aftercare sample had been previously involved in the Aftercare program\textsuperscript{13}, and 47.5 per cent have been accessing the program for one year or longer.

\textit{Qualitative Findings}

The qualitative findings of this study are the result of 21 semi-structured, in-depth interviews with 14 Aftercare clients and 7 staff. Consistent with the assertion that qualitative methods are ideally used when employing a CBR methodology (Israel et al. 2005), these interviews were important to make sense of the quantitative findings, and provide a deeper understanding of the experiences of the research participants. Using a thematic analysis, the findings from the Aftercare client interviews were analyzed separately from the staff interviews. Some of the themes and sub-themes overlap; while others pertain specifically to either the client or staff interviews. Since the interviews were analyzed employing an inductive approach, not all of the research questions were addressed by the themes or sub-themes. The main themes identified include: identifying the interconnection between substance use, mental health issues, and the criminal justice system, the barriers to community reintegration, self-sufficiency and positive reintegration, and challenges for the Aftercare program. The following section will present and discuss these main themes, along with their sub-themes.

\textsuperscript{12} Refers to mental health counselors, substance abuse counselors, emotional support, etc. Not referring to medical doctors who are providing regular medical care to the client.
\textsuperscript{13} Referring to if the client was involved with the Aftercare program in the past, left for a period of time (one year or more), then returned and was still in the program at the time of our study.
**Interconnection Between Substance Use, Mental Health Issues and the Criminal Justice System**

The study identified various reasons for the Aftercare clients’ involvement in the criminal justice system. These reasons revealed by staff and client participants show an interconnection between substance use, mental health issues, and involvement in the criminal justice system.

Additionally, this interconnection helps to supplement the quantitative findings addressing our study’s first research question, which sought to identify the ‘typical’ profile of the clients accessing the Aftercare program. The data of this qualitative theme reveals that most Aftercare clients also perceive alcohol and/or substance use and mental health issues/mental illness to be contributing factors to their involvement in the criminal justice system. Interestingly, the sub-theme of alcohol and/or substance use was common in the client interviews, while mental health issues/mental illness were found in mainly the staff participant interviews. These sub-themes will be discussed in more detail in the following section.

**Alcohol and/or Substance Use**

Many of the participants shared their stories about how or why they became involved in the criminal justice system. Many of the reasons varied, but most involved alcohol and/or substance use. As client participant, Jackie\(^\text{14}\), shared:

> And then I fell apart, eighteen {years old}, I fell apart again. Quit school, went on the pub crawls, you know, the fun stuff, right, but I’m an addict, addicts don’t do those things, they can’t. Because I get on my, I get my keys out and I put them in the ignition, I got five impairs, six now, but my last one was ten years ago, so we’re hoping that says something to the judge, I’ve got to get through this, eh. And this one’s going to be tough for me, because when you go to jail, you do alcohol, you do drugs, you do everything...

Like client participant Jackie’s past with addiction, client participant Maurice shared a similar experience, and also expressed his difficulties staying sober:

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\(^{14}\) The names used are pseudonyms
I haven’t been like horribly bad or nothing like that, but when I was a kid I got in trouble, I got an impaired when I was nineteen {years old} and then I didn’t get in trouble for years, and then when I really started drinking a lot and drugging a lot, I started getting into more and more trouble. Right, so at first I got, I basically did a home invasion, which I did my time for, and I just assaulted fourteen people, and I got charged and I was looking at seven to ten years, I was really going to change my life. I got away because of a technicality, I ended up getting two years, one on house arrest, and one in, well, because I cut the bracelet off and ran away, so when they came and got me, I did the rest of the time in jail, right, so I got out and I stayed good for a little because I wanted to get away from the booze and drugs, and then I got back into ‘er again, right...

In many instances, participants with alcohol or substance addictions commit crime to support their habits. Client participant, Oliver, elaborated:

I prided myself as an addict, that I didn’t have a criminal record, and I didn’t until I was twenty-nine years old, that’s a lie, but it isn’t a lie, because, not to go off on a tangent, I promised my mother, although I have our issues, that I’d quit doing crime when I was eighteen {years old}. Well, good ole manipulative addict, bending the wheels, I had {did} a few criminal things, but with highway traffic, but they aren’t classified as criminal, but that was technically my first criminal charge, and I prided myself on not having that, and my addiction brought me so low that I committed a crime in order to support my habit.

This participant viewed himself foremost as an addict, even after committing ‘smaller’ traffic offences. Once he had to resort to other criminal activities to support his addiction, he accepted the ‘criminal’ label.

Much like alcohol and/or substance abuse, a mental health issue/mental illness was also identified as a reason for involvement in the criminal justice system. This sub-theme was mainly identified by the staff participants, unlike many of the other themes. This sub-theme will be discussed in the following section.

Mental Health Issues/Mental Illness

The research identified the lack of social or coping skills, coupled with the possibility of abusing or failing to take their medication as the reason why individuals with mental health issues may
become involved in the criminal justice system. Although most of the Aftercare client participants did not specifically relate their mental health issues to their involvement in the criminal justice system, the staff participants made this connection explicit. Staff participant, Toby, explained:

When I’ve had contact with the police, I’ve probably been better able to talk my way out of it, so I appear stable, I can interact appropriately with authority, and so I was raised with those skills. So I’ve broken the law, like I think most people have in some way, but someone who may struggle with mental health issues, or other issues as well, like haven’t been given some of those skills. I think they’re going to be charged, and they’re going to be identified on the street by police officers as well, so, you might have your folks walking down the street, talking to yourself, you know, I mean it’s scary. And people get scared by that, they might call the police, you know, someone’s acting strangely, so you’re just more identified, and you may put yourself maybe in more risky situations. I mean I don’t think it’s always mental health anyway, anyone can put themselves in more risky situations {laughs}, but you know, I think you’re more identified, and the police just have more contact with you when you have mental health issues, and you’re less able to deal with that. Yeah, and I think you might be also be put in situations where the police are called more often than the situations that I put myself into, for example.

Further, staff participant Cindy stated that many Aftercare clients with mental health issues come in contact with police, or the criminal justice system, due to abusing or failing to properly take their prescribed medication:

[D]id they take their medication? That’s a factor, a lot of times we, and I know you hear this all the time in mental health, they feel like they’ve been cured, or, because they stop taking their medication, then they get into trouble. So I had a client who has anxiety, very high anxiety, and he abuses his medication. That’s another factor, he takes it when he feels like it, and when he, you know, and he tells me he abuses his medication, like it’s just for me to say, he comes and he tells me that. He’s out of medication and it’s the third week, the doctor only gives him every month, so he’s taken too much, so then he’s got a week of a little bit of challenge because he has no medication, so he comes in to tell me he abuses it.

All of the staff participants agreed that individuals with mental health issues generally come in contact with the criminal justice system more frequently than clients without mental health issues. Further, the staff participants commonly reported that the symptoms that sometimes
accompany a mental illness may bring the individual to the attention of the police. Although they may not be criminally responsible they are now known to the criminal justice system.

Mental health issues/mental illness was explicitly revealed by the staff participants to be a common reason for criminal justice system involvement for many of the Aftercare clients. Whether the client participants had the capacity to relate their involvement in the criminal justice system, and their criminal behaviour, to their mental health issue is uncertain. Mental health issues/mental illness, however, was identified as presenting barriers to community reintegration by both the staff and client participants. The following section will outline and discuss the various barriers to community reintegration revealed in the study.

**Barriers to Community Reintegration**

The research identified mental health issues/mental illness as one of the barriers to community reintegration. The majority (12) of the client participants expressed having suffered in the past, or currently suffering, with some form of mental health issue. Moreover, the mental health issues have directly or indirectly contributed to their experience or lack of experience with community reintegration. One of the client participants was never incarcerated, but was at risk of becoming involved with the criminal justice system. Even that participant expressed concerns relating to mental health issues and how it has affected their life. Due to their mental health issues, some of the participants revealed that completing daily tasks were more challenging. In addition, their mental health issues prevented them from accessing various community services, such as mental health counseling, that would aid in their process of community reintegration. Issues such as stigma (both ‘mental health’ and ‘offender’), history of victimization, and complex needs (i.e., alcohol/substance use and concurrent disorders) were prevalent in the interviews.
In addition to mental health issues/mental illness, this research identified other general barriers to community reintegration such as criminal history, diminished welfare state/lack of available services, and lack of social support/social capital. These findings, in addition to those mentioned above, help to respond to our study’s second research question, which sought to reveal the barriers faced by Aftercare clients. The following section will address the sub-theme of stigma, which was identified by both the client and staff participants.

**Stigma**

Many of the participants expressed having experienced some form of stigma. This stigma was predominantly directly related to their offender label, or the offender label and mental health issue (double stigma). Staff participant Cynthia described the challenges of dealing with the ‘offender’ stigma in the Aftercare population:

> [H]aving to live with the stigma attached to their specific offence, because people knew about it, their families and friends knew about it, or just people in general knew about it. Some of them were on the sex offender registry, and where ever they lived people in their neighborhood knew...

Further, some of the client participants expressed frustration relating to judgment by others. They revealed that because of their appearance the community treated them differently. For instance, client participant Jake shared his encounter while attending an appointment at his psychiatrist’s office:

> {Makes reference to tattoos on arms} I walk in there, and I’m judged right away. Right away. And everyone I’ve went to see, I’ve told [Name of Aftercare Worker], I’m not a prejudice person, I used to be, but every doctor that I go see is an [Ethnicity] doctor, and they’re telling me, there’s nothing wrong, we can’t give you nothing, well f**k man, I got my whole medical file at my house, and I’ve seen {a} forensic psychiatrist. They had me on all these medications, lithium, and all this stuff, ‘cause I’m bi-polar. You know, he doesn’t want to put me on nothing, nothing.

He stated further:
I had another psychiatrist call me a scruffy old man full of tattoos. And I had mental health bring it up to the doctor, say look man, what’s wrong with you? We were going to have it retracted but I let that slide ‘cause I was working on a lot of things then.

Another client participant, Jackie, expressed frustration with the demographics of the region. The chances of someone recognizing her in the hospital, if she happened to be admitted for her mental health issues, was a concern:

It’s very frustrating, it’s also frustrating for me to get help in [Name of City in Southern Ontario] because I work here now, so when I, I checked myself into the psych hospital for two days in [Name of City in Ontario] after my Mom did that {referring to when her Mom stole from her}, I couldn’t do it here, because I checked someone in the day before {referring to someone with her job}, like, I couldn’t be sharing a room with a client.

Similarly, client participant Jake further alluded to the stigma that he feels when talking about attending a mental health service:

Because like I won’t go to that mental health downtown, because it’s just downtown, and everybody sees you going in there, and I’ve got that much of a hang up, I know what people are thinking, they are crazy, I don’t know right...

Further, client participant Maurice also expressed difficulties with accessing mental health services because of stigma:

[It’s] not so much the people inside, it’s more of the people outside, and in my life, it shouldn’t matter, but that’s something that I’m working on, right, is my self-esteem and stuff, right, but the thing is it shouldn’t, I should be able to walk in anywhere I want...

Meanwhile, client participant Rose shared her experience of feeling stigmatized as a ‘mental health patient’ when attempting to access services:

A lack of workers, a lack of care, the receptionist was so rude to me, she goes ‘sit there, and just wait until I’m done on the phone’. Oh that’s going to make me feel really good, thanks a lot, you know, because I’m a mental case, you don’t want to treat me like a human being?

This statement clearly highlights the internalization of the ‘mentally ill’ label that is experienced by so many of the participants.
Much like the client participants, the staff participants also expressed the common concern of stigma that is experienced by the Aftercare client population during the process of community reintegration. Particularly, the double stigma of suffering with a mental health issue and carrying the offender label appeared to be an issue. The staff participants expressed concern regarding the affect that the stigma of suffering with a mental health issue, along with the offender label, had on obtaining housing. When asked if Aftercare clients who are experiencing mental issues face further barriers during the process of community reintegration compared to the general offender population, staff participant Mary responded:

I think where those with mental health issues may have some additional issues might be that, you know, they would have both the ex-con or that background, plus the challenges of, ok, you know accessing housing or accessing whatever and if there’s some sort of history there that might make it problematic for somebody else to agree to rent to them or something like that, right, if it is disclosed. So, do I think that they have more challenges in community reintegration? I think yes...

Further, some participants identified the “odd” behaviour of clients with mental health issues to limiting their chances of obtaining housing. Staff participant Bob stated:

Yeah, yeah, because they get denied housing because they just, you know, present kind of odd, and people don’t want to rent to them. They, as I was saying earlier, they will be, you know, denied services at agencies because of the way that they present hostile and aggressive, and that freaks people out, so they just say you’re not allowed here, you’re banned, we don’t want to deal with that. I have an issue with that...

Much like the barrier of obtaining housing for Aftercare clients with mental health issues, securing employment seems to be another common difficulty for this population. Staff participant Toby elaborated:

I mean, you’re looking at folks, not only struggling with basic stuff, like anybody would after coming out of incarceration, but you have further barriers for getting employment, if, you know, if you’re not able to be at work every day, because you’re struggling {with} mental health issues, yeah, and it may impact how you’re able to interact with people, and so workplaces may not like how you interact with people. You know, depending on what the mental health issue is, I mean, I guess you have less resources if you’re not able to find employment, and you may find yourselves again in risky situations...
In addition to stigma as a barrier to community reintegration, the study revealed that a history of victimization can have an effect on experiences of community reintegration and involvement. The following section will elaborate on this sub-theme.

**History of Victimization**

Our study also identified a history of victimization as a common barrier to community reintegration. Many of the participants expressed a prior experience with various forms of victimization, such as abuse or traumatizing experiences, at some point in their lives. This victimization could be a contributing factor to their current mental health issue and potentially their criminal justice system involvement. Client participant Oliver shared his experience:

> I was never taught certain things growing up, so how can I expect to have them? You know, like my parents grew up without these skills, my parents were never raised properly, I grew up in a very, multi-generations of dysfunction, physical abuse, mental abuse, sexual abuse, you name it, it’s in my family. My parents didn’t have it to give to me, my Dad’s acknowledged {that} he shouldn’t have had kids, so how can I expect him to pass it on to me? {referring to passing on the knowledge of how to properly raise children}

Further, some of the participants related their past experiences and victimization to their current addiction issues. For instance, client participant Maurice stated:

> ...[T]he first time I drank was one, two {years old}, you know, my Father’s an alcoholic too, he’s twenty years sober now, but I myself, am thirty years old, so ten years of it we’d be partying and you know what I mean. One time they all had their coffee cups on the counter, and I knew it was something, I thought it was booze, and I went around drank them all, poured it into one, drank it all, but it was mushrooms...it was my Uncle that had the mushrooms, right, and just, you know, one thing after another I guess, seeing it normalized in my life, turned into me doing it, but then with this little bit of jail, and doing this and that it made me think I was invincible, you know, I could sell cocaine, what are the cops going to do?

Similarly, the staff participants also identified a history of victimization to be highly prevalent in the Aftercare population. Staff participant Bob stated that a history of victimization is “almost
always” relevant to Aftercare clients, and staff participant Cynthia asserted that it is relevant “probably a hundred percent of the time”. When speaking about prior traumatic experiences, staff participant Blanche elaborated:

Oh, they’re rolled into virtually every relationship we have. Yeah, I mean prison itself is a trauma, don’t let anyone tell you otherwise, but the reality is that most of them have been traumatized long before they got to prison, either through family violence, or their relationships in schools, their relationships with their communities. I mean of course there are healthy middle class people that find themselves in jail, that’s not the majority of the population.

Further, staff participant Bob added that prior traumatic experiences, or victimization, could be an explanation for current criminal behaviour, and possibly mental health issues and/or substance use:

...[B]ut as far as those long term, chronic traumas that they have, those are a significant factor in today’s behaviour for them. Anger and rage that has, you know, never been resolved, because being victimized they have this anger, rage, that they displace and project onto society. So that’s a big factor, a lot of incredibly low self esteem and depression, because of poor family of origin, a lot of negativity and put downs, early sexualization is another huge one that we see with people that are sex offenders, they were just exposed to sex at way too young of an age, there was no innocence, no time for that, they were victimized and then they recapitulate that and end up, you know, victimizing people when they get older. It’s the traumas of the past {that} are a significant factor today in terms of rage, and depression and self-medication with substances.

It is beyond the scope of our study to conclude whether past victimization or trauma induced or contributed to a mental health issue within the Aftercare participants or contributed to their involvement in the criminal justice system. The staff participants, however, commonly agree that a history of victimization can at times be a barrier to both community reintegration and well being for many of the Aftercare clients. Additionally, our study also revealed complex needs as a barrier to community reintegration and involvement for the Aftercare population. This sub-theme is discussed in the following section.
Complex Needs

Another barrier to community reintegration identified by the study is complex needs. Arguably, most individuals involved in the criminal justice system present with various needs, however the Aftercare population presents with a varying degree of complex needs. More specifically, these complex needs are mostly due to a broad range of mental health issues and concurrent disorders, and are continuously evolving. Staff participants commonly estimated that approximately 80 per cent of the Aftercare client population suffers from some form of mental health issue. Moreover, they estimated that 70 per cent of the Aftercare client-base as dealing with a concurrent disorder.

Staff participant Bob provided a description of the types of mental health issues present in the Aftercare client population:

I would say a good significant number, if not most of them, there are those that are not, but primarily most of them have something, at least an anxiety disorder of some kind, a G.A.D {Generalized Anxiety Disorder}, right. They may have that I would say nine out of ten of them have a mental health issue of some kind. Although, that goes in degrees of severity. Some quite severe, others mild, others it seems mild, but it wasn’t, it was worse. And they, and they fool you all the time. You work with a client and you say this person’s not getting it, and they have limited cognitive capacities and such and the next time you see them, wow, you know, they don’t even seem like the same person. Something’s happened in the meantime, changed their meds or they’re off their meds, or whatever it may be. So, a client doesn’t present the same every session, right....

Client participant Jake, suffering with concurrent disorders, shared his mental health issues, “I’m diagnosed bi-polar, I’m diagnosed with personality disorder, I have severe anxiety, I suffer from panic attacks, I’m PTSD {Post Traumatic Stress Disorder}, and I’m on no medication”.

Similarly, client participant Rose, also dealing with addiction and mental health issues, described how her drug use has affected her life:

I was a whirlwind drunk, I was a drug addict, I did crack cocaine, I’ve put needles in my arms, I tried to kill somebody... I have to wear depends at night, because I have, well drugs effected my insides, quite a bit. I’ve had, oh geez, at least twenty overdoses, one, two, two DOA’s {Dead On Arrival}, yeah, I’ve been trying to commit suicide since I was fifteen years old, that’s a long time I’m forty-seven {years old} now, I’ve got the scars to
show it, and I’ve got the scars up here \textit{points to head} to show it. I have two children, both children I don’t know what happened, but I get to a certain age, and I forget they exist...

In order to help keep the symptoms of her mental health issues at bay, client participant Rose said that she is prescribed 900 milligrams per day of Seroquel, a drug used to treat symptoms of bipolar disorder, schizophrenia, and other major depressive disorders. For a recovering drug addict, this presents new barriers to recovery and reintegration.

The research also identified mental health issues and/or concurrent disorders as negatively affecting the process of community reintegration for the client participants. For instance, client participant Jake stated:

I have a hard time getting outside, I have anxieties, it takes me like, it takes me days sometimes just to get me outside that door. I’m so, I don’t know what I’m frightened of, it’s just, I dunno, it’s just, wow, and I’m out four years now, it’s still like this. And I have lots of suicidal thoughts in my head, right, and I’m just hanging on, hanging on, hoping for this program \textit{referring to the Aftercare program}...

Moreover, the study also revealed that mental health issues pose indirect barriers to community reintegration. For example, client participant Greg said that his anxiety has gotten so bad that he does not drive anymore. In addition, other participants directly related their mental health issues to further involvement in criminal activities. Client participant Diana shared her experience:

I had just been diagnosed with bipolar, and I had a manic episode in November, in which I totally disassociated from stuff. I went into a store and I repeated the behaviour \textit{referring to stealing} but it wasn’t like any other, like it was totally robotic...

Staff participant Cindy explained how mental health issues could be a barrier for Aftercare clients:

Yeah, because they might not be able to advocate for themselves. They might not be able to communicate what they don’t know, because they’re having issues and they don’t realize it’s because they’re maybe feeling anxiety, and made people probably think they’re impatient, but they’re not impatient, they’re feeling anxiety because they’re not getting the support they need, you know what I mean? So they’re, it’s an absolute barrier, absolutely, I wouldn’t doubt that for a second.
In addition to the many barriers to community reintegration experienced by offenders, Aftercare clients and staff agreed that mental health issues and/or concurrent disorders pose different challenges. The presence of a mental health issue may hinder a client’s ability to properly communicate their needs, and hold them captive in their own thoughts. An anxiety disorder may make exiting the house to perform daily tasks challenging, while a manic state may provoke criminal tendencies. Regardless of the mental health issue or concurrent disorder, Aftercare staff must work beyond the typical community reintegration barriers commonly experienced by most offenders, and consider the additional barriers encountered by the Aftercare clients. Additionally, another barrier to community reintegration revealed in our study is possession of a criminal record and/or criminal history. This barrier will be discussed in the following section.

**Criminal Record and Criminal History**

A common barrier to community reintegration identified by our study is the effect that having a criminal record and criminal history has on community re-entry. Many of the participants expressed frustration and hardships due to the criminal history that follows them into their daily lives. This criminal history creates various barriers when attempting to secure a job, and accessing mental health, health care, and other community-based services. Client participant Rose shared her experiences with attempting to access community-based mental health services:

Yeah, the offender puts the label on your head, immediately. Oh is this for court issues? I’m like, well yeah, it is. What do you want me to say, no? Yes it is, it’s a court issue here. And here’s what I’m doing. Well I can’t see you this week, but call me next week. I call her, I don’t have time this week, but I’ll see you next, do you know what that does to somebody like me? The stress factor alone is enough to drive me insane. I’m waiting for a phone to ring...
This participant relates her offender status, or criminal history, to the reasoning behind her mental health worker avoiding her requests. Similarly, client participant Ned described the challenges associated with securing a bed in a drug treatment centre, and the consequence of possessing a criminal record:

They pick and choose, because they want their numbers, they want their success rates to be, you know, high, so what they’ll do is if, you know, you’re a first offender, or, you know, they pick and choose exactly who they want to go there, because there’s so many beds available for people coming from an institution. Ok, so they pick and choose who they want to go there, because if they pick someone that’s going to re-offend...So, when I go for these type of programs, they look on my record, and say, no, this guy’s going to re-offend...I’ve never, ever made a parole in my life...but at that time if I had’ve been given the help that I was given now, way back when, I probably wouldn’t be in half the trouble that I was in, you know what I mean?

The study also found that Aftercare clients have difficulties accessing services at the hospital. More specifically, staff participant Bob revealed that many of the available health care services are not adequately equipped to deal with this population. Due to this, many of the clients go without proper services and turn to the JHSWW, and the Aftercare program, for aid:

...[T]he outpatient services, those places are not designed to work with people who have problems with the criminal justice system, or present as aggressive and violent, or potentially violent. They’re not, I mean, I don’t have problems with violence with clients, but they’re scary to some people, and because of that they get short shrift, they don’t get service, and so it’s us or nobody...

As indicated by this staff participant, the Aftercare clients are frequently turned away from services because of their involvement in the criminal justice system, leaving only the JHSWW, and the Aftercare program as an option for community services. This limitation of services can create further barriers to community reintegration and involvement for this population, and hinder a successful reintegrative experience.
Further, the participants indicated difficulties in moving forward with their lives on a personal level due to the consequences of possessing a criminal record, and frequently, their institutionalization. Client participant Jake shared his struggles due to institutionalization:

Especially with my kind of record and [Name of Aftercare Worker] knows I have a bad record, and I’m struggling still, I’ve been in institutions since the time I was nine {years old}, I got thirty-five years in the penitentiary and I’m only fifty-two {years old}, I mean it’s a struggle out here for me...

Much like the client participants, the staff participants also identified institutionalization as a contributing factor to difficulties in community reintegration. Staff participant Doris explained:

Like, some of the things that happen to these people are just, oh my God, can’t comprehend what it must be like to be in there, to get stabbed because you won’t give up your peanut butter. And it’s only one of those little hotel-sized packages of peanut butter, but got stabbed because he wouldn’t give it up. You know, when things like that happen to you in there, you’re going to have a harder time adjusting when you get out. Some of the folks, too, that have been in there a long time have, well they’ve become institutionalized, and can’t cope. One guy did nothing but eat, because he could eat what he wanted, when he wanted, and he ate, and ate, and ate, and ate, almost ate himself to death, like, yeah. Gained huge amounts of weight, because he said he never got real food in there, and he seemed to be making up for lost time, and just ate, and ate, and ate, and ate...

Many of the participants also reported a change in their relationships with family and friends due to their incarceration and/or criminal record. Thus, the consequences of possessing a criminal record, or having a history of criminal justice system involvement, seem to carry over into various aspects of the participants’ lives. The participants experienced daily living barriers, such as how to follow a healthy diet due to the effects of institutionalization, and social service barriers, as a consequence of their criminal history. These challenges prove to be sizable hurdles to overcome. In addition to possessing a criminal record and/or criminal history, the research also indicated that a diminished welfare state, and a lack of available services was a barrier to successful community re-entry. The following section will elaborate on this sub-theme.
**Diminished Welfare State/Lack of Available Services**

This study also identified a diminished welfare state, and in turn, a lack of available services, as a common barrier to community reintegration. While many participants had attempted to access services such as Alcoholics and Narcotics Anonymous, few were attending mental health counseling. A few participants tried various other mental health counseling services, but were not satisfied with the results. Most, however, reported that there was a lack of free of charge mental health counseling services that could address their needs in a timely manner. The participants agreed that the wait-lists for the mental health organizations were simply too long (i.e., 6 months to 2 years), and waiting was not an option. Client participant Rose shared her experience:

> Yeah, I tried, and I tried, and I tried to get into [Name of Mental Health Agency], I mean, I have psychological problems, I’m probably one of the rarest medication cases you’ll find, you know. And, I went everywhere, and it was a three year waiting list, it was a six year waiting list, it was a two year waiting list, and I got court tomorrow, type deal...and nobody could help me...

Client participant Oliver also stated that getting into a treatment service was quite demanding, which presented a barrier to sobriety for him:

> Well actually, well before I came to JHSWW, I had phoned [Name of Counseling Service], and I found [Name of Counseling Service], and [Name of Counseling Service] it was like jumping through flaming hula hoops to try and get there, and I didn’t have the monetary means to be able to do it either. [Name of Counseling Service], I didn’t need help two months down the road, I needed help now, and I’ve been to [Name of Counseling Service] in the past, and even this time I looked into it and they wanted me to fill out all these forms and backwards, sideways, and in between, and you know, as an addict, I wanted help and I wanted it right now. I realize that now, but back then, I don’t want to be jumping through hoops you know, and I realize it now that I’ve been clean for 10 months, but back then, you can’t tell an addict to wait, it just doesn’t happen, and a lot of time it was half measures. So, you know it’s just, whatever, I give up...

Further, the participants also reported that there are few, if any besides JHSWW, community-based organizations that serve individuals with complex needs like the Aftercare population.
This shortage of services is mostly due to a lack of understanding of this population’s issues and needs, particularly related to their involvement with the criminal justice system and ‘offender’ status. Staff participant Bob elaborated:

Well, most of the other counseling services in town, and not to disparage them at all, but they’re not familiar with the individual dynamics of the people that get involved with the criminal justice system. You know, the people who come here, the clients who come here typically, not all, but most are fairly multi-problem, you know, they have the psychological or psychiatric issues, the substance issues, you know, there’s been a lot of damage done over the years, physically, emotionally, spiritually to them, they’ve been victimized themselves, they victimize people. So that difference is that the other agencies are just not equipped to cope with these people, and are intimidated by these people, and will often just will terminate early with the clients because they are intimidated by how they present even, they look scary, or they talk scary, you know, it’s really alien to a lot of the people that are doing counseling here in the area, or they have their issues around sexual offending that they can’t handle...

Client participant Ned also expressed frustration with attempting to access services to address his criminality and mental health issues. He added:

I’ve asked, I’ve had problems with, I’m a habitual thief, you know, what can I do about it, and stuff like that. And, basically there’s nobody that you can see, if you have a stealing problem, like a psychiatrist, you can’t find a psychiatrist, or you can’t find a group that deals with people that have, you know, OCD, and when I say OCD, I mean impulsive, obsessive compulsive disorders, there’s nobody actually, even if you go to [Name of Counseling Services], [Name of Counseling Services], that understand OCD. But yeah, when I talk to, say [Name of Aftercare Worker], [Aftercare Worker]’s talked to so many people, and [Aftercare Worker]’s, you know, counseled so many people that [Aftercare Worker] understands that. But if I try to make an appointment with [Name of Counseling Services], like I did that about two weeks ago, I needed help with some counseling, and I go in and see this guy that he’s just out of university, and so he doesn’t really have a lot of experience with people, he’s got book experience and everything like that, which is great, and everything, but he says the best thing to do is every morning when you get up, just sit back and breathe. And I’m thinking, well if that’s the case, if it that easy, you know, like come on, so my thought right there, just closes down, this guy doesn’t have a clue...

Thus, the participants identified the JHSWW as their main, or sole, resource for counseling.

When asked if they tried to access other counseling services, most replied “no”. Further,
although the JHSWW is not officially recognized as a mental health service\textsuperscript{15}, the participants reported otherwise. All of the participants related their psychological well being to the counseling services provided by the Aftercare staff, and many stated that they would refer an individual suffering with mental health issues to the JHSWW. For instance, client participant Maurice shared:

\begin{quote}
I can kind of see where I need that, like you know, if I’m having some troubles with like anxiety or something, I know who to go to, right. Well usually I’ll come here first, but I mean, eventually if I’m having troubles with a sore foot, I go to the doctor, right, if I’m having troubles fitting in this world, I come here, and [Name of Aftercare Worker] usually kind of sheds a light on something that I missed.
\end{quote}

Further differing from other counseling services, the participants voiced their appreciation for being able to come back to the JHSWW for services whenever they chose. Unlike many other counseling services, a client’s file remains open until the client feels that he/she is ready to move on. Sometimes this process is lengthy, and many participants have been attending services at the JHSWW for a few years. The participants stated that other counseling services in the area have a prescribed timeframe for service, which may not be beneficial for this particular population.

While the study found that a diminished welfare state, and as a result a lack of available services, posed challenges to community re-entry for the Aftercare clients, a lack of social support and social capital was also prevalent in the research. This sub-theme will be discussed in greater detail in the following section.

\textit{Lack of Social Support/Social Capital}

Another barrier to community reintegration identified by the research was a lack of social support/social capital (social connections or relations that have positive and productive benefits).

\textsuperscript{15}The JHSWW does not receive mental health funding, nor is the agency regarded as a mental health service by the mental health sector.
The lack of social support can be challenging for a newly released offender, and frequently hinders successful reintegration. Social support can come from various sources, most commonly family and friends. As staff participant Cindy stated, “[f]amilies are vital. I have a few clients who have come out who have phenomenal family support. They’re different people. They’re different people than the people who don’t have the family support”. Many of the participants reported losing the support of much of their family and friends during the period of their incarceration, and others were lacking social supports even prior to incarceration. For instance, client participant Jake stated:

   No, I had nothing, I was thrown out on the street, I was just finished my five year sentence and do what you want. And that’s basically what I did, I never had no Mom, never had no Dad, they both died when I was in prison, I had two brothers died when I was in prison, so I was just a basket case, right, I got right involved with the same things when I got into drugs, heavy into it, heavy into it...

Some participants that had social supports available before incarceration indicated that their prison term created friction within their family, and as a result, some lost contact with their family and friends. Client participant Toby stated, “…but my family’s very shattered, very broken, so as much as I have to live with my part in some of the relationships, a lot of them are out of my control. So I got out with nothing, I didn’t even talk to any family members at all in my ten months {that I was} incarcerated....”

   Without the appropriate social supports in place, the participants indicated difficulties in attempting to create bonds and relationships with others. Many found it difficult to make new friends that were not involved in the criminal justice system, therefore making it easier to fall back into the ‘wrong crowd’, or negative networks. As staff participant Blanche stated:

   [T]hey’re finding themselves hanging out with the old crowd again, and the temptation to get re-engaged and what to do about that, because gosh darn it, we’re social creatures, and when we have a relationship with a collection of people, relationships
take time, and it’s lonely when you don’t have them. And it’s, to my mind, pretty understandable that they would gravitate back towards old friends. Particularly because it’s a place where they’re accepted in a community that generally doesn’t accept them, and is hostile to them by virtue of the fact that they have a criminal record, and so they find themselves sometimes gravitating back to the bosom of old friends who in the past were not a good influence, and they’re torn between that need for social contact and knowing, hopefully, knowing that this isn’t necessarily a good environment for them.

Meanwhile, a lack of social support/social capital may have even greater repercussions for those participants suffering with mental health issues and/or concurrent disorders. As staff participant Mary indicated, the presence of a mental health issue may limit a client’s ability to form social supports or build social capital:

[D]o I think that they have more challenges in community reintegration? I think yes, another one would be around the social supports and the naturally occurring social supports. Depending again on what the mental health issue is, they may be more or less able to engage and develop their own appropriate network, right. I guess the reason why I’m repeating the question is, you know, what extent do people coming out of that system have a mental health issue, just you know, as a function by having been there, and then that’s now a contributor to dealing with and trying to, you know, find housing, find some volunteer work, find all of those things. So yeah, I do think it’s more challenging...

Although various challenges and barriers to community reintegration were revealed in the study, the research also found positive experiences of community reintegration.

**Self-Sufficiency and Positive Community Reintegration**

Unlike the concerns outlined above, this research also unearthed experiences of positive community reintegration. More specifically, the participants related the JHSWW, and the Aftercare program, to their newfound self-sufficiency and change in thinking and behaviour. Within the interviews, many of the participants directly linked their participation in the Aftercare program with the reduction of their criminal behaviour\(^{16}\), or recidivism. In addition, the participants discussed the various forms of social support and social capital that, by virtue of

\(^{16}\) The effect of the Aftercare program on the reduction in criminal behaviour, or recidivism, was not included in the quantitative data collection.
their involvement, the Aftercare program provided. These findings (in part) help respond to our study’s third research question, which addresses the role of the Aftercare program in Aftercare clients’ lives.

**Change of Thinking/Behaviour**

The research identified various ways in which clients perceived that the Aftercare program had changed their thinking and behaviour. Some expressed changes in knowing right from wrong, and thinking things through before they react. For example, client participant Phil stated that the Aftercare program “give{s} people a chance to refocus and then get a chance to see the different light, we’ll say, like for me for instance, it gave me a chance to stop and think before reacting, which I never did before”. Others indicated that the Aftercare program allowed them to be more aware of who they are as individuals, and find their way in the world. For instance, client participant Joe stated that his involvement in the Aftercare program has been “helping me get more awareness of myself, of what I’m doing, and what I shouldn’t be doing, and what’s right and what’s wrong”. Further, client participant Colin reported a similar experience:

> [B]ecause I’m going through so much personal discovery. Like before I was arrested I was a person {who} was extremely terrified of myself, of knowing who I was, of acceptance, like I had no self-esteem, self-respect, and just from coming here, you know, or that hour a week, I grow so much because I have so much to reflect on when I leave here, and because I’m personally growing, I’m more confident doing everything else in my life.

Other participants reported that the Aftercare program changed their outlook on life, and had even prevented them from committing suicide. For example, client participant Maurice stated that the Aftercare program has “just turned my whole attitude and outlook upon life around and now I can see it for what it really is, and what really means something, you know..” Meanwhile, client participant Jesse accredits the Aftercare program to saving his life. He stated, “...I don’t
think I’d be here. I would’ve committed suicide a long time ago. So you could say [Name of Aftercare Worker] is actually keeping me alive. There are some rough weeks, yeah, but like I say coming here at least once a week kind of pulls me over somehow”.

Further, many participants attributed their sobriety, and subsequent change of thinking, to their participation in the Aftercare program. For instance, client participant Kyle stated:

I can say it’s just changed my life, in one particular way that jumps out, actually two ways, first of all, it helped my sobriety, it helped me in that way, it gave me tools to live. I’m now, and will continue to be, hopefully, a respectful, responsible member of society. And I take it very seriously, I contribute to society in a lot of ways, it’s kind of hard to talk about myself in a bragging way, but there’s a lot of stuff that I do now that are good for me, and that are good for society and people around me. Second of all, which was really important, I thought, was it helped me, [Name of Aftercare Worker] helped me, have an understanding of the justice system...

Indeed, the Aftercare program was identified to function as a “life-line” for nearly all of the participants. Further, they expressed a great amount of gratitude to the JHSWW, and to the Aftercare staff for offering the program. Many participants directly related their newfound happiness to the work that the Aftercare staff do, and thanked them for their kindness and respect.

In addition to changing the participants’ way of thinking, our study also revealed a relationship between participation in the Aftercare program and a general reduction in criminal behaviour and recidivism. The following section will examine this sub-theme in greater detail.

**Criminal Behaviour and Recidivism**

The study’s interviews also identified a relationship between participation in the Aftercare program and a reduction in recidivism. The majority of the participants agreed that their participation in the Aftercare program was a positive contribution to their change in criminal behaviour, and ultimately reduced the rate of recidivism. Many of the participants explicitly
correlated their ability to stay out of the criminal justice system with the Aftercare program, much like client participant Ned, who stated, “...if I didn’t have JHSWW, [Name of Aftercare Worker] to talk to and stuff like that, I would’ve been in jail again, like, probably a month after I was released. You know, just out of anger, and hate, and frustration, and not knowing where to turn...” Further, client participant Oliver also stated,

And if I wouldn’t have got help, not only from [Name of Aftercare Worker], but from my probation officer, I’m pretty sure that I would be still committing crimes because I got out of jail with seven dollars in my pocket and a backpack full of clothes, and not one person in my family wanted anything to do with me.

Other participants reported that the Aftercare program helped with their mental health issues, which in turn prevented further criminal activity. Client participant Phil elaborated:

Well the JHSWW {Aftercare} program helped me out through a situation, quite a bit, because it gave me a different hindsight, I guess. I’m extremely ADHD {Attention Deficit Hyperactivity Disorder}, and borderline Tourette's, so I have an issue with authority, and I have an issue of control, we’ll say, so I have quite the violent crime issues, because I don’t tolerate bullshit. And then I pop a gasket and then I just start swinging, right, it’s not necessarily what I want to do it’s something that I couldn’t control, say, before because of my short circuiting, and I’m learning now to step away and walk away instead of getting in to it, because I don’t want to be incarcerated again; [Name of Correctional Institution in Southwest Ontario] {is} just a f**king zoo.

Many of the participants relied heavily on the advice and counseling that the Aftercare staff provided. This advice was either interpreted as a voice of reason or logic, or as a form of acceptance and understanding. For instance, client participant Jackie stated:

My logic doesn’t always exist when it comes to people I love, so I remember at maybe fourteen months sober and I was working with drug addicts and sex trade workers and I was going to [Name of City in Ontario] hanging out in crack houses, and that was where my family was so it made sense to me, and [Name of Aftercare Worker] pointed out you could lose your job, you could be charged, because I was never charged, you could lose it all, for a conversation with someone and I need that stuff pointed out to me. Yeah, so any kind of further involvement, any kind of involvement at all {in the criminal justice system}. 
In addition, many of the participants expressed gratitude for the acceptance and support that the Aftercare staff demonstrated. This support helped many of the participants cope with their situations, and ultimately, aid in reducing their recidivism. For example, client participant Diana revealed:

...[I]t {the Aftercare program} gives you the strength, I mean you have to find the strength within you, but when somebody believes in you, when you’ve come from a background where not very many people believed in you and there’s been abuse, and all of that, I don’t believe if I hadn’t of had, you know, the connection with [Name of Aftercare Worker] and {the} Aftercare program that I definitely would be able to go through what I’m going through now.

Further, client participant Colin referred to the Aftercare program as a positive reinforcement to preventing further criminal justice system involvement. He stated, “[i]t’s that constant positive reinforcement, it’s that constant, what’s the word, just like, a constant reminder of like all the good things {that} I’m doing. Every week I get reminded that I’m doing something really good in my life, and for me, that’s all that I need, is that acceptance”.

Other participants referred to the Aftercare program as a healthy alternative to drinking or abusing substances. For these participants, their alcohol and/or substance abuse were negative influences that lead them to the criminal justice system. For client participant Jesse, who was incarcerated for drinking and driving, the Aftercare program has prevented him from further offences. He stated, “I haven’t touched the booze for eight, nine months, going on nine months”. This was a milestone for him. Further, client participant Rose shared that she looks “more forward to coming to this society {JHWW} than I do to picking up a beer”. Finally, when asked if participation in the Aftercare program helped prevent further involvement in the criminal justice system, client participant Maurice responded:

Absolutely. I’m still sitting here, I’m still sober, three years later and I don’t do nothing, you know what I mean, I’m not one of those people that sit here and tell you this and
that, and then go home and break the law, I don’t do anything, like that kind of stuff. I’ve gone back to that format in my brain, and now that I’ve rebooted it, like and I’ve got it with good things inside my mind, and good intentions and good stuff. I don’t, it’s not even in my mind, you know, we’re {referring to he and his wife} broke, we’re broke, that’s it, you know, there’s no, oh, well you know that guy I seen across the street, there’s a TV going in his..., you know, those thoughts are gone, and I notice it most when I actually have dealings with my old friends.

The participants agreed that the counseling approach employed by the Aftercare staff was successful in helping to prevent involvement in the criminal justice system. Whether it was a voice of reason, giving the participants something to look forward to, or allowing the participants to see that a crime-free life can be great, the Aftercare program played an important role in the participants’ lives.

In addition to the effect of the Aftercare program on criminal behaviour and recidivism, the study also revealed an increase in social support and social capital. This sub-theme differs from the barrier of lack of social support and social capital as the participants identified the Aftercare program as a positive way to network and build relationships.

**Social Support/Social Capital**

Another sub-theme identified by our study was the social support and social capital gained by virtue of involvement in the Aftercare program. The majority of the participants identified, particularly, networking to be a benefit of participating in the Aftercare program. Further, the Aftercare staff would refer the participants to other community-based organizations, or resources, if they thought that the participants required further aid. This helped to provide social support to the participants, and potentially built social capital by allowing the participants to better themselves through accessing these resources.
The Aftercare program provided various forms of social support for the participants primarily in the form of micro-level, or daily, support. This support was indicated to have been in forms of writing reference letters, helping to secure employment, or aid in filling out forms.

Staff participant Cindy described the supportive role of the Aftercare workers:

I see my position as a supportive role for people who’ve been incarcerated and need to get themselves back on track, so the first thing I think is very important is I’m a listener, so that they actually have something to tell me, that they want to tell me. I’m not judgmental, so that they feel that I’m not going to judge what they’ve done, and then I’m supportive in the sense that I can help direct them to where they need to be going, which includes housing, includes employment, includes healthy choices, all those types of general life skills that sometimes they’ve missed because they weren’t parented perhaps in a way that was beneficial, or maybe they were parented and weren’t ready to listen, or ready to live that way, so when they’re ready, and I do have clients who aren’t ready, but the clients who are ready, I’m there, this is what we’ll do to help you. And if they’re not ready, I like to let them know what options are, so that when they are ready they know that they do have support, and they do know they have a community of support, which unfortunately people don’t know about, so that would be a big part of it...

One of the many forms of support demonstrated by the Aftercare staff included providing aid in writing resumes for job interviews. Client participant Jackie shared firsthand experience of how the Aftercare program has benefited her:

Well, when I applied for my job, [Name of Aftercare Worker], well [Aftercare Worker] was a reference, but also like helped me write {a resume}. I got a job based on lived experience and it’s very hard to write out your lived experience and be proud of it. It’s really hard to say, like, this is what I was, this is what I did, and this is how I know I can help, and to have your counselor sit down and put that all out with you. So it showed the value of [Aftercare Worker] work in me, and the value of me coming out, and the support to go and do more things.

Further, client participant Jake also shared how the Aftercare program has been a form of social support:

...[Aftercare Worker] does everything for like, everything I need, letters done, or just trying to help me investigate things, helping me to try and track down the money that they took from me when they put it in an account, when I was abused as a child by the priest and all that, right, trying to help me get that money back, writing letters to the Attorney Generals and stuff like that...
Other participants, like client participant Diana, indicated that the Aftercare staff would help “in filling out forms to help to get O.D. {Ontario Disability Support Program}, or disability...”

The participants also identified networking to be an important form of social support, and in turn social capital, offered by the Aftercare program. Many participants indicated that their involvement with the JHSWW, and the Aftercare program, helped them to build confidence and learn how to engage with others to form new bonds. As client participant Phil revealed, “it gave people a chance to meet other people that have the same type of interests, and what have you”. In addition, the participants stated that their participation in the Aftercare program granted them access to other community-based services. In other words, the program became a gateway to other services in the area. If need be, Aftercare staff would refer the participants to other resources that they otherwise may not be able to access in a timely manner. Staff participant Bob elaborated:

Well, sometimes we act as the sort of caseworker that brokers them to those services so they may not have accessed those services yet because it’s a primary place to attend that and then get brokered and referred, and because they don’t know where these places are. If they’re familiar with the community and have been around the block a bit, then yeah, they may already be hooked up with other services but someone coming out of incarceration maybe, you know, has never lived in this area or they didn’t need to access those services in the past until they got incarcerated then when they come here they don’t know, so that’s what my job is to broker them to those services that are going to be useful for that particular client.

Further, client participant Maurice stated, “...I met [Name of Aftercare Worker] and I’ve met some other resources and from those resources I met more, you know, people and resources, and it just kind of spider webbed...” Client participant Rose also shared that the Aftercare staff “allow me to do volunteer work, they send me to outlets where I can get other sources of, like [Name of Aftercare Worker] got me in [Name of Mental Health Service], no waiting list, no crap”. Many of the participants revealed that the Aftercare staff have all of the contacts for the necessary
resources, and that they do not hesitate to use them. For example, client participant Jake stated that the Aftercare staff “know all the contacts, they know all the people, that’s why I came to [Name of Aftercare Worker], and [Aftercare Worker]’s lined me up with everything...”

In sum, all participants made reference to the JHSWW and their participation in the Aftercare program, as a source of social support. This support supplemented already existing support from family or friends, or acted as a sole source of support for many participants. Further, the participants gained social capital by virtue of their involvement in the program, which allowed them to access employment opportunities and other community resources.

While the Aftercare program provided various positive experiences of community reintegration and contributed to the reduction of recidivism for many participants, the program also experienced hardships. The staff participants identified various factors affecting the Aftercare program, and their subsequent implications. These findings help to further address our study’s third research question.

Challenges for the Aftercare Program

Our study identified a number of concerns that threatened Aftercare’s program delivery, specifically a shift in the Aftercare client-base and a lack of adequate funding for the program.

Change in Client-Base

Staff participants expressed concern with the change in client-base over the years, including increases in clients suffering with mental health issues, clients presenting with concurrent disorders, and women accessing the Aftercare program. Further, the increase of clients
presenting with complex needs accessing the program was linked to decreased support within correctional facilities. Staff participant Mary elaborated:

...[T]he system has more community supports, you know, now than it did say twenty, thirty years ago. People still present with some really complex issues, so a part of the answer to your question is also a function of what support are they getting on the inside? And what policy decisions are made that changed that? You know, so we could be getting people who have as complex, or more complex needs than we were, you know, twenty years ago, which might seem ironic because we have so much more in terms of community support, but the flip side is, maybe there was more by way of social workers in the system in prisons twenty years ago than there is now, and because of cutbacks they’ve scaled back how many they’re going to have, and each of the ones they have is now seeing proportionately more clients so they’re not as intense as they used to be, you know, so those factors also impact on change in clientele...

Another change in the Aftercare client-base expressed by the staff participants was a noted increase in the amount of younger individuals and females accessing the program. Staff participant Bob stated:

Well, I would say that there’s more young people and more females than we used to have. The typical Aftercare client was a guy probably around twenty-six, twenty-seven years of age, used to being incarcerated, have been incarcerated a number of times, so males around that age cohort were the more typical ones. Now it’s all over the map, like all ages, and male and female, a lot more younger people now.

The increase in women and younger individuals accessing the Aftercare program\textsuperscript{17} presents new and additional issues for the Aftercare staff. For instance, these populations, especially women, are more likely to self-harm compared to the male population. Thus, these additional issues may not have been typically experienced by the Aftercare staff in the past.

Despite the centrality of the Aftercare program in integrating its clients into the community, reducing their chances for recidivism, and assisting them with their mental health and substance use issues, the program does not have a strong funding structure. This sub-theme is addressed in greater detail in the following section.

\textsuperscript{17} This profile of the clients accessing the Aftercare program is different from the profile identified by the quantitative results. This may be due to not as many women accessing the program during the timeline of our study.
Funding and Implications

Our study identified funding challenges and implications related to the change in client-base. These challenges are mainly due to the lack of acknowledgement by funders and the government that the Aftercare program provides a mental health service. As a result of the increase of individuals with mental health issues accessing the Aftercare program, the service delivery is affected. The staff participants expressed extreme gratitude to local United Ways\(^\text{18}\) for funding the Aftercare program, however the government does not supplement this funding. Staff participant Bob elaborated:

There’s no government money put into it, you know, I really have an issue with that because they put all kinds of money into prisons and police and all the stuff at the back end to react to crime, yet in terms of preventing the crime, nothing, no money. If it wasn’t for United Way we’d have to roll up shop on the Aftercare program. They funded it all these years, right, you know JHS \{John Howard Society\} was started for Aftercare, by the police chief of Toronto in the late forties \{1940’s\}, the police chief, who realized that the police aren’t there to prevent crime, they’re there to react to crime, you know, and that’s the irony of it all is like we’re always seen as these sort of con lovers, bleeding hearts, and we should just, you know, just get tough, and instead we’re wasting resources. We just spend it all on prisons, we’re not wasting any of your resources because we don’t get a dime from the government, even though we save society millions of dollars, we get nothing, and if it wasn’t for United Way we wouldn’t even have Aftercare.

Further, the participants expressed a need for more funding for the Aftercare program, particularly since the change in client-base demands more resources. For instance, staff participant Blanche stated:

I’d love to have more expertise available to us, I would love to be funded such that we could have, that we could either pay for assessments, or have someone on staff that could do the assessments. That would be brilliant, but our current funding for Aftercare in [Name of City in Southwestern Ontario] is a whopping, gosh, it’s eight hours a week. So that works out to about twelve thousand dollars a year, to serve all of our clients, so it’s really, pretty inadequate, and we certainly can’t afford a whole bunch of expertise, and that’s the worst of it is that we know that we don’t know everything, we know that what we do is well intentioned and as informed as we try and be. We know that it’s inadequate, we’re just at a loss as to how to, we know how to do better, we just can’t

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\(^{18}\) The United Way is an organization dedicated to mobilizing communities and raising funds to help create social change.
pay for it. So, that's the ongoing struggle.

Further, staff participant Mary added that the funding for the Aftercare program is “...at the seams, it’s pushing on the seam...” Additionally, many of the staff participants experienced the implications of a lack of sufficient funding for the Aftercare program firsthand. The implications ranged from reducing the frequency and length of Aftercare sessions, to an increase in the wait-time to see an Aftercare staff. Staff participant Bob responded:

...[T]here’s only really higher risk people that I can see weekly now, or suicide risks, or risk to really act out, or some sexual acting out. I try to see those people a lot more often. There’s others that I would see every week if I was part of a team in which I had a colleague that was doing the same thing as me, same amount of hours, then I could potentially do that, right. So I’ve had to modify how often I can see the clients, and unfortunately, too, I’ve had to make people wait a long time to see me, and that’s not good. Now the ones coming out of prison, I prioritize and, you know, I’ll know when they’re coming out, so I’ll give them an appointment for like the next day, right, not that day before going in to pick them up, but for the next day. So I prioritize those ones, so there’s a lot of balancing and juggling and figuring out, and shortened appointments, too, which I don’t like to do, but it’s a reality, right, I used to go with the old typical fifty minute hour, and now it’s half an hour, forty minutes, sometimes still the hour, right, depends on what’s going on that day. But, recently I’ve been squeezing in half hour, half hour, half hour, you know, it’s not long enough, you need the fifty minutes, for the most part, right...

Other staff participants acknowledged that the client centered care, which is an important aspect of the JHSWW’s and Aftercare program’s services, has been affected as a result of insufficient funding. Staff participant Mary elaborated:

You’re spreading out the frequency of their {sessions}, and they’re having to just sort of accept that that’s what it is, right. So at point though is them saying, I would really like if I could come back next week, and you’re saying, I can’t see you again for three weeks, at what point are you starting to compromise on client centered care? Right, because it’s not driven by the client, it’s driven by how much time, and of course you can’t ask the workers to, you know, essentially add four hours a week to their work week without additional resources or whatever, right. And also, too, even if you had the funding for the specific workers to add additional hours, just given the nature of the population there’s also merit to saying, you know, do you expand and expand and have other people help out with it, because you don’t want staff to get burnt out, right, they’re listening sometimes to some intense stuff when they, when they speak to the clients, right.
Similarly, client participants expressed the need for increased support in the Aftercare program. As a result of the lack of sufficient funding, and an over-subscription to the program, the participants noticed the changes. Many stated that their sessions were shortened, and that the time between appointments had increased. The client participants suggested hiring more counselors to accommodate the influx of clients, and to relieve the stress on the current Aftercare staff. They recognized that these requests were in vain, however, as the current funding simply does not allow it.

Finally, funding for the Aftercare program is also susceptible to changes in government policy. Many of the participants stated that the current policies may indirectly impact the funding of the Aftercare program by affecting the general public. For instance, staff participant Doris elaborated:

> Aftercare program is not government funded, it’s only United Way, but government policies impact the amount of money that folks have to donate to United Way, and stuff like that. Government policy impacts how many people are going to be incarcerated and prosecuted, and you know, find their way into the Aftercare program. So, government policy impacts the whole criminal justice system, really.

Further, when asked if the current public policy enables or supports the provision of Aftercare services, the response was a resounding “no” amongst the staff participants. The participants identified the current policies to be in favor of a “tough on crime” approach, as opposed to being proactive. This was identified to directly impact the Aftercare program, as indicated by staff participant Toby:

> Well, the government’s own website says that programs like ours are effective in deterring people from committing future offences, so their own website says our services are effective, and generally what they do, they haven’t studied our specific one, but programs like ours. And yeah, but the current public policy obviously is more of sort of tough on crime, and talking fifteen seconds about folks who are offenders when it takes a little bit more than fifteen seconds to understand an offender, why they do that.
So it’s kind of an easy way out, and looking at the different, the current, I mean the legislation that they hope to pass {referring to Bill C-10}, you know, have all been shown from the States {U.S.A} to be ineffective at reducing crime.

Thus, all of the participants agreed that funding is a concern with the Aftercare program, and that it is not sufficiently funded for the current client demand. This lack of funding has had implications for both the Aftercare client-base and the staff. Further, the Aftercare staff have had to adapt to the increase of clients with mental health issues and concurrent disorders, in addition to the ‘typical’ issues experienced by individuals involved in the criminal justice system. This adaptation is demonstrated by shortened appointments; longer wait times in comparison to previous years, and heavier caseloads. In short, the lack of funding, and subsequently resources, comes at the expense of the Aftercare clients and staff. In contrast, however, the participants indicated that regardless of how busy the Aftercare staff may be, they always make time to speak to a client. They stated that this ethic sets the JHSWW apart from other counseling services in the area.

**Conclusion**

In sum, the quantitative findings revealed that the ‘typical’ Aftercare client is male, with a mean age of 39 years old, residing in fairly stable living conditions but probably receiving some form of social assistance for income. Previously involved in the criminal justice system, and possessing multiple charges, the ‘typical’ client was familiar with the court system. Presenting with a mental health issue, substance use issue, or concurrent disorder, the JHSWW and Aftercare program is the only counseling service accessed by the client. Moreover, the client has more than likely been accessing services at the JHSWW for longer than one year. Thus, the ‘typical’ Aftercare client presents with very complex issues and needs. Further, the qualitative
data provided information that helps to explain the quantitative data, i.e. the reasons for criminal justice system involvement, which the participants identified as issues with alcohol and/or substance use, and mental health issues. The study also identified barriers to community reintegration which include stigma, difficulties accessing mental health and substance use treatment, history of victimization, possessing a criminal record and a lack of social support and social capital. Due to these barriers, the data revealed that the Aftercare clients were turning to the JHSWW and Aftercare program for aid, and many were using the agency as their sole form of support. Further, as a result of the increase of individuals suffering with a mental health issue and/or concurrent disorder accessing services from the JHSWW, the data revealed factors affecting the Aftercare program’s service delivery. Both the client and staff participants voiced concerns regarding the lack of funding for the Aftercare program and the subsequent change in the “client centered care” approach. The next chapter will offer a synthesis of our current study’s findings, Social Integration theory and current relevant academic literature.
Chapter Four: Discussion

Introduction

In this chapter, I will relate the quantitative findings and qualitative themes that were revealed in my analysis of the prevalence of mental health issues and concurrent disorders within the Aftercare client population to the literature and theory discussed in Chapter One. Our study sought to address various research questions and respond to the JHSWW’s needs in order to address the prevalence of mental health issues and concurrent disorders within the Aftercare population. It also sought to reveal clients’ experiences accessing community-based mental health services, as well as their experiences of community reintegration. Although the prevalence of mental health issues and concurrent disorders within the offender population has been extensively researched, there is a lack of sociological research addressing the prevalence of mental health issues and concurrent disorders within clients accessing a non-profit, community-based organization. Further, little is discussed in the sociological literature regarding the challenges and issues faced by these community-based organizations when providing services to this population. This study addresses this gap in the sociological literature by demonstrating that there is a high prevalence of mental health issues and concurrent disorders within the Aftercare population. Additionally, the findings indicate that due to the high demand of services from individuals presenting with complex needs, the JHSWW is facing a lack of adequate funding to provide the required support and counseling for this population. The barriers to community reintegration experienced by this population revealed in this study will also supplement the literature in various disciplines.

I will first discuss the results of the quantitative data and some of the qualitative data that define the profile of the ‘typical’ Aftercare client, in order to provide an illustration of the
complexity of the needs of this population and to address our study’s first research question. I will then address the qualitative themes in relation to the literature and theory previously outlined in Chapter One. This data will also help respond to our study’s second and third research questions. Next, I will discuss the research and policy implications of this study and conclude with this study’s research limitations and recommendations for future research.

Profile of Aftercare Clients

Data presented in Chapter Three reveal a portrait of the ‘typical’ Aftercare client, which helps to respond to our study’s first research question. Data demonstrate that over three quarters of the Aftercare client population were men, which is consistent with correctional statistics (Calverley 2010). Also prevalent in the data was the rate of mental health issues and previous involvement in the criminal justice system, which represented over one half of the client sample. These findings are aligned with previous research addressing the rising prevalence of mental health issues within the criminal justice system, and the difficulties this population encounters with becoming entrenched in the system (Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001; Allodi et al. 1977; Hodgins and Cote 1990; Motiuk and Porporino 1991; Arboleda-Florez et al. 1995; Wormith and McKeague 1996; Corrado et al. 2000; Brink et al. 2001; Gretton and Clift 2011; Constantine et al. 2010; Prins 2011; Prins and Draper 2009). Further aligned with the literature, the quantitative data revealed a high prevalence of substance use within the Aftercare clients, representing over half of the sample. This finding is not surprising since research shows that the likelihood of substance use is almost tripled when a mental health issue is present (Brems and Johnson 1997).
Further, the qualitative data supplements the quantitative findings by demonstrating an interconnection between substance use, mental health issues, and involvement in the criminal justice system. The client participants related substance use issues to their involvement in the criminal justice system, while the staff participants related the clients’ mental health issues to their involvement in criminal activity. These interconnections reaffirm and provide more depth to the portrait of the ‘typical’ Aftercare client identified by the quantitative data by demonstrating a relationship between mental health issues, substance use and involvement in the criminal justice system. This relationship helps to denote the degree and range of issues and needs the Aftercare clients are presenting with, and the complexity of counseling and support that they require.

These findings can also be connected to the literature addressing the continuity of care for offenders with concurrent disorders. The literature reports that concurrent disorder offenders respond more effectively to programs that do not address mental health issues or substance use issues alone, but rather as an integrated approach (Brems and Johnson 1997; Prins and Draper 2009). The quantitative data in our study demonstrated that just over half of the sample only accessed services from the JHSWW. Thus, the high prevalence of concurrent disorders might be explained by the ideal accessibility of these clients to the services provided by the JHSWW, and more specifically, the Aftercare program.

The findings uncovered in the quantitative data also help to supplement the qualitative themes. The qualitative findings provided a more in-depth interpretation of some of the quantitative results. These findings and their relation to the literature and theory will be discussed in the following section.
Reintegration Barriers and the Role of the JHSWW: Social Integration

The psychological and criminological literature has revealed higher arrest rates and involvement in the criminal justice system in individuals with mental health issues and concurrent disorders (Hartwell et al. 2010; Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001). Our participants’ responses mostly echoed these findings in the literature, but whether these client participants were aware and conscious of the effect of their mental issue on their involvement in the criminal justice system is uncertain. Many, however, did relate their substance use to their involvement in the criminal justice system. Some revealed the need to commit crimes to support their substance use habit. Similar to the findings reported by Watson et al. (2004), the staff participants revealed that many of the Aftercare clients inadvertently come to the attention of the police due to their actions and behaviour, and thus begins a cycle of arrest and “criminalization of the mentally ill” (Lamb and Weinberger, 2005; Brink et al. 2001).

Barriers to Community Reintegration

Due to the criminalization of these individuals, the study’s data revealed various barriers to community reintegration experienced by the Aftercare clients. These barriers, which help to address our study’s second research question, mostly included additional challenges upon community re-entry or general, daily difficulties experienced by the clients due to their mental health issue and/or concurrent disorder. The participants identified stigma as a significant barrier to reintegration. Stigma can come in various forms, and presenting as an offender with a mental health issue can create double stigma for the individual. This stigma was determined to affect the participants’ chances of obtaining housing, which is similarly identified in the literature as a significant barrier to reintegration for this population (Griffiths et al. 2007; Baldry et al. 2003;
Solomon et al. 2001). Due to the “odd” behaviour demonstrated by these individuals, coupled with the criminal history, the staff participants revealed difficulties for their clients when accessing suitable housing. Also consistent with the literature (Gillis et al. 2005; Tschopp et al. 2007; Draine et al. 2002), the stigma associated with possessing an ‘offender’ and ‘mental health issue’ label was revealed to hinder employment opportunities for the participants. Whether this stigma was due to the combination of the ‘offender’ and ‘mental health issue’ labels, or if one is stigmatized more than the other was not specifically indicated. Tschopp et al.’s (2007) study revealed, however, that “criminal history can be less stigmatizing than mental illness” (p. 185). Beyond the various issues ex-offenders face following incarceration, the staff participants reported that additional challenges of suffering with mental health issues can affect an individual’s ability to obtain a job or properly perform their tasks at work.

Beyond the tangible barriers such as difficulties accessing housing and obtaining employment associated with the stigma of being involved in the criminal justice system and suffering with a mental health issue, the client participants identified challenges accessing mental health treatment due to the stigma attached to their ‘offender’ status and possessing a criminal record and/or history. Although the literature highlights the importance of continuity of care for this population (Griffiths et al. 2007; Conklin et al. 2000; Wolff 2005), this continuity is difficult to achieve if mental health organizations do not welcome individuals involved in the criminal justice system. Our study found that a lengthy criminal record is a barrier for one participant with a concurrent disorder attempting to access services from a designated drug treatment facility specifically mandated to provide services to recently incarcerated offenders, due to the augmented possibility of re-offending. This finding, which appears to be absent in the literature, defeats the purpose of mandated post-release treatment and counseling services and fails to
respond to the federal and provincial (Ontario) strategies regarding continuity of care (Brink et al. 2001; Laishes 2002; Correctional Services of Canada 2010; Ministry of Health and Long-Term Care 2006). The staff participants, in particular, report that many of their clients had been turned away from other community-based mental health, outpatients, and counseling services due to their hostile or aggressive behaviour. This finding is consistent with the literature, as Lamb et al. (2004) report that many community-based mental health organizations will not treat this population because of intimidation or the possibility of violence. This leaves minimal treatment and counseling options for this population, and as a result requires the JHSWW and the Aftercare program to fill this void.

Further, the continuity of care model is primarily designed for those ex-offenders with mental health issues and concurrent disorders who have been previously incarcerated (Griffiths et al. 2007). This continuity of care approach only takes into consideration those individuals who have been a part of the formal court or criminal justice system (traditional court system or Mental Health Courts), and not those who are at risk of involvement in the criminal justice system. The implications of this are that since not all of our study’s participants had been formally charged, or had been incarcerated, they would not be eligible for the programs and services mandated to be provided for ex-offenders suffering with mental health issues and/or concurrent disorders upon release from incarceration. One of our study’s participants had not been formally charged or directly involved in the criminal justice system. Additionally, the Aftercare workers reported that there are other Aftercare clients who were at risk of involvement in the criminal justice system who had approached the JHSWW and the Aftercare program requesting counseling and guidance. These individuals, however, were involved in high risk activities and were placing themselves in potentially dangerous situations. These situations could
lead to their arrest, and subsequently incarceration. Thus, the JHSWW and Aftercare program provided services to these individuals, following their mandate of attempting to provide services to everyone who requests it.

**State of Community-Based Mental Health Services**

In addition to the barriers to community reintegration discussed above, this study also shed light upon the diminished welfare state and the impact this is having on community-based mental health services. Similar to the findings in the literature (Lamb et al. 2004; Lamb and Weinberger 2005; Baillargeon et al. 2010b; Kubiak et al. 2011; Wolff 2005), the participants identified a lack of community-based services that serve individuals with mental health issues or concurrent disorders involved, or at risk of involvement, in the criminal justice system. As a result, our study reported long wait times for community-based mental health treatment, and an overall absence of community-based mental health services that are able to respond to this population’s complex needs (‘ex-offender’, mental health, concurrent disorder, barriers to reintegration, etc).

Our data are similar to findings reported by Baillargeon et al. (2010b), who found that “services that are provided by mainstream community-based mental health centers may be largely ineffective in meeting the distinct treatment needs of a substantial portion of mentally ill returning prisoners, including those with co-occurring substance use disorders and a history of treatment resistance” (p. 368).

Thus, these mental health and concurrent disorder community-based treatment services are replaced by services offered by the JHSWW and the Aftercare program. The JHSWW, specifically the Aftercare program, however, is not officially recognized as a ‘mental health’ service. The participants stated otherwise, and most relied solely on the JHSWW and Aftercare
program for counseling. This occurrence is also most likely linked to this population’s propensity to attend treatment for mental health issues and substance use issues in the same location. As indicated by Prins and Draper (2009), “[i]ntegrated mental health and substance use services, in which specific treatment strategies and therapeutic techniques are combined to address mental illnesses and substance use disorders in a single contact or series of contacts over time” (p. vii), have been shown to greatly improve outcomes for individuals with mental health issues. An integrated treatment model, such as that offered by the Aftercare program, provides services to respond to the complex needs of individuals with mental health issues and/or concurrent disorders who are involved in the criminal justice system. The findings of our study indicate that these services are vital to this population to overcome the various, and sometimes very complex, barriers to social integration.

The Aftercare Program’s Role: Effect on Recidivism, Social Support, and Social Capital

Although social support and social capital theories have been employed in the sociological literature to help conceptualize mental health and its effects on socialization (McKenzie et al. 2002; Cohen and Wills 1985), an integrated theoretical approach provides a more suitable framework to understand the complex role of the JHSWW in the Aftercare clients’ lives. The ‘meta-concept’ of social integration (Hartwell and Benson 2007), which is anchored by social networks, uses social support and social capital as key, interrelated elements. Each of these elements can affect one another, and functions more effectively at the aggregate level (Hartwell and Benson 2007). The combination of social support and social capital as an integrated framework, which is somewhat of a complex perspective, is required to adequately conceptualize the complex issues surrounding the prevalence of mental health issues and concurrent disorders.
within the Aftercare client population, and how the JHSWW responds to these issues. The barriers that this population faces when attempting to access community-based mental health services, such as stigma and an overall lack of available treatment services, as well as during the general process of community reintegration (e.g. employment, housing, etc.), are far from straightforward. Aside from overcoming the ‘offender status’ stigma, this population must also deal with the challenges associated with suffering with a mental health issue or concurrent disorder. Without the combination of all of the elements of social support and social capital (‘social integration’), successful reintegration would be difficult to achieve.

The data from our study demonstrate a lack of social support and social capital experienced by Aftercare clients upon re-entry into the community, which is consistent with the literature discussing the barriers to community reintegration (Griffiths et al. 2007; Jacoby and Kozie-Peak 1997; Visher and Travis 2003; McCoy et al. 2004; Baillargeon et al. 2010b; Graffam et al. 2004; Solomon et al. 2001). The sociological literature has critiqued the lack of conceptualization and operationalization of social support (Thoits 1982). This study has contributed to the operationalization of this theory, and social integration, by defining social support as the needs identified by the participants and showing ways in which social integration occurs. This is important, as social support is a key element in social integration. How social support is defined by the Aftercare clients may vary from other definitions in other populations. These needs, which vary from an increase in tangible, concrete supports to greater community-based mental health services for this population, are issues related to social structure, social process and social conflict. It is the collection, or combination of the lack of stable housing, access to employment, stigma, access to community-based mental health and substance use
services, and positive social supports that result in this population relying on the JHSWW for aid.

Many of the participants identified losing support from family and friends, which are vital elements of social support, upon their incarceration which acted as a barrier to successful community reintegration. Further, our data revealed that Aftercare clients with mental health issues and concurrent disorders may face greater challenges when attempting to create bonds and acquire supports as they may be less likely to be able to fully develop a positive, functioning network. As a result, these individuals frequent the same circles of ‘support’ (or, lack thereof) and/or negative influences as prior to their incarceration, which, as reported in the literature, may affect their recidivism (McCoy et al. 2004; Visher and Travis 2003). Visher and Travis (2003) report that “[p]ositive peer relationships, and probably new relationships, in the period after release are undoubtedly an important component of the identity transformation that must occur for former prisoners to avoid returning to the lifestyle that resulted in their incarceration” (p. 98).

Our data show that this population’s rate of recidivism, however, is positively affected by the clients’ participation in the Aftercare program. Our study revealed that the Aftercare program helped to change the participants’ thinking and behaviour. By providing a sort of “life-line” to the clients, the Aftercare program is identified to help with suicidal ideations, promote sobriety, provide tools for coping, and provide a newfound self-awareness. This self-awareness initiated reflection upon the Aftercare clients’ actions and behaviours, which in turn lead to a more positive way of living. As a result, many of the participants agreed that the Aftercare program helped to reduce or cease their criminal behaviour, and thus, recidivism. The findings in our study support the research identified in the literature asserting that community-based treatment models can aid in reducing recidivism in offenders with mental health issues (Conklin et al.
2000; Laishes 2002; Lurigio 2001; Hammett et al. 2001; Wolff 2005), and most of the participants accredit the tools acquired through the Aftercare program (e.g. learning to cope with their mental health issues, guidance for securing employment, self-esteem building, and prosocial skill development) to allowing them to positively move forward in their lives.

The Aftercare program further aided in the reduction of recidivism in the Aftercare clients by providing various forms of social support and building social capital. This important process, which is providing a combination of these two elements that are lacking in the Aftercare client population, is an ideal demonstration of the effectiveness of social integration. Research states that those ex-offenders with positive family and social supports are more likely to experience positive community reintegration, and are less likely to abscond from parole (Nelson et al. 1999, as cited in Visher and Travis 2003). Ex-offenders with mental health issues, however, are identified to not fare as well with formal community supports, and frequently return to the criminal justice system (Hartwell and Benson 2007). Although the JHSWW, and the Aftercare program, may be considered to be a formal community institution, or support, our study suggests that distinguishing between formal and informal supports misses an important complexity regarding the diverse, individual relationships that are created within the community of the formal support. Our data revealed that the Aftercare program acted as a strong tie for the clients, and that many participants did not recidivate due to this positive support. Strong social supports are identified in the literature to have a positive effect on psychological issues (Williams et al. 1981; Maulik et al. 2010; Cohen and Willis 1985; Cummins 1988; Hirsch 1979; Wong et al. 2009), and high social support can buffer the effect of stress (Maulik et al. 2010; Cohen and Willis 1985; Cummins 1988; Vilhjalmsson 1993; Cohen 1992; Chakraborty et al. 2010; Cobb 1976). Many of the participants reported a lack of familial or social support, but alluded to the
JHSWW and the Aftercare program as a replacement to these important missing elements. The JHSWW, and Aftercare workers, provide a supportive figure that is removed from the negative circle, or network, that the client may be a part of. The workers understand the difficulties and challenges associated with being involved in the criminal justice system, and can act as a buffer against further distress by being a reliable support. Our study also revealed that the Aftercare workers provide the Aftercare clients with tools to work through their symptoms associated with their mental health issue. Additionally, the Aftercare program provided micro-level support, such as building life skills, that resulted in a greater, macro-level effect (coping mechanisms and skills that can be used in the future) on their lives.

The macro-level effect is achieved via the support obtained from the Aftercare workers, which demonstrates examples of all four types of social support, identified in the literature as emotional, informational, instrumental, and appraisal (Listwan et al. 2010; Pettus-Davis et al. 2009; Vollmann et al. 2010; Wong et al. 2009; Langford et al. 1996). Each type plays an integral role in helping to elucidate social support encompassed within social integration. The Aftercare clients receive emotional support through the Aftercare program via the Aftercare workers, who listen to their clients’ needs and concerns. Informational support is gained again from the Aftercare workers, who provide suggestions for problem solving and give advice. Instrumental and concrete support, a more tangible form of support, was acquired through writing reference letters and helping with drafting resumes with the clients. Finally, appraisal support is generated through the Aftercare workers’ reassurance of the client’s self-worth and providing encouragement. Further, the support provided to the Aftercare clients by virtue of involvement in the Aftercare program satisfy the numerous qualities of social support that are identified in the literature as closeness, reciprocity, and durability (Pinkerton and Dolan 2007; Gottlieb and
Although the staff at the JHSWW and the Aftercare workers are not necessarily regarded as ‘friends’ to the Aftercare clients, closeness is formed due to the support provided by the Aftercare workers. This closeness is the worker-client relationship and bond that is formed. In the absence of informal social supports, Aftercare clients may identify their workers as key figures of social support. Reciprocity, too, may not be an equal exchange of items or support, however the Aftercare client is not indebted to the Aftercare worker. This relationship is one of respect and growth, and does not demand a tangible return on the client’s part. Since this study identified almost half of the participants have been involved in the Aftercare program for longer than one year, the worker-client support shows durability.

Although many of the clients attend the Aftercare program for approximately one hour per week, or sometimes less regularly, the client relies on the JHSWW and Aftercare program to be an available, consistent, and reliable support, which is similarly identified as an important aspect of positive social support in the literature (Pinkerton and Dolan 2007). Further, the support offered by the JHSWW and Aftercare program is a perceived form of social support (support which is perceived to be available if needed). The Aftercare clients may not always require the support of the workers, however they are able to obtain it when needed. This form of support, identified in the literature as having a positive impact on health and well-being (Hartwell and Benson 2007; Hupcey 1998), is as vital as the actual supporting act itself, as it reassures the client that their needs and issues are important and that someone is available to address them at any time.

In addition to the Aftercare program’s role of providing various forms of social support for the Aftercare clients, the data from this study demonstrate that participation in the Aftercare program also increases social capital, another important element of social integration. The study identified the creation of both horizontal and vertical networks for the Aftercare clients.
Horizontal networks, which emphasize equality in power and status between individuals (Ferlander 2007), were revealed to be formed by the opportunities for the Aftercare clients to meet others similar to themselves through their involvement with the program. The tools and support that the Aftercare program provided for the clients allowed them to build the confidence to network and meet new people in the community. Meanwhile, vertical networks, which facilitate links with individuals or institutions of unequal social statuses (Ferlander 2007), were established by the “brokering” of clients to other community-based services or institutions. This research found that the JHWW, and more particularly the Aftercare program, acted as a liaison or “gateway” to resources that the client would not be able to necessarily access without their involvement and connection with the agency. The knowledge, resources, and connections that the Aftercare workers have with other community resources is, within itself, building social capital for the Aftercare clients through the ability to access structural supports (e.g. employment, housing, etc). Also referred to in the literature as ‘formal connections’ (Ferlander 2007), this form of contact provides access to informational support which facilitates an increase of social capital.

*Social Integration and its Effect on the Aftercare Program*

The needs of the Aftercare clients provide a basis for the approach used by the Aftercare workers, a “client centered approach”, and the complexity of this population’s needs have introduced challenges, such as adequate funding, for the JHWW. As Hartwell and Benson (2007) assert, social integration focuses on the environment, or macro-level issues, as opposed to individual behaviour. Thus, participation in the Aftercare program by individuals involved, or at risk of involvement, in the criminal justice system can be predicted by the availability (or lack
thereof) of other community-based resources for this population. As a result, the JHSWW is faced with funding concerns in order to provide the breadth of services required to respond to the influx of individuals with mental health issues and concurrent disorders accessing the Aftercare program, and to adequately address this population’s complex needs. This has caused the JHSWW to adopt a more entrepreneurial model, which may have service repercussions for the clients. In short, our study has revealed that the JHSWW’s “client centered care” approach has been affected by the increase of individuals with mental health issues and concurrent disorders accessing the Aftercare program, and subsequently, the lack of sufficient funding. The Aftercare clients have experienced shortened sessions, and longer wait times in between meetings with Aftercare workers than in previous years.

Our data found that more funding was required to adequately and efficiently respond to the needs of the Aftercare population, and that current public policy does not enable or support the provision of Aftercare services, contrary to the mandate reported in the literature (Griffiths et al. 2007; Correctional Services of Canada 2010; Laishes 2002; Brink et al. 2001). Although the literature does recognize the importance of allocating funding to community-based organizations to ensure that they are well equipped to deal with the mental health issues, concurrent disorders, and other challenges faced by this population during the process of community reintegration (Trueman 2003), our study revealed a seeming disconnect between the recommendations of scholars and researchers, current public policies, and the plan of action.

**Conclusion**

Consistent with the literature, the current study revealed that individuals with mental health issues and concurrent disorders tend to become entrenched in the criminal justice system
(Hartwell et al. 2010; Baillargeon et al. 2010; Lurigio 2001; Wolff 2005; Hammett et al. 2001; Freudenberg 2001), mostly due to inadequate community-based services available for this population. Due to this, the criminal justice system has experienced a drastic increase in the number of individuals with mental health issues and concurrent disorders incarcerated in provincial and federal correctional institutions (Ontario Ministry of Community Safety and Correctional Services 2008; Correctional Services of Canada 2010). Upon release from these institutions, this population requires community-based mental health and concurrent disorder treatment, in addition to services that can also attend to their other reintegration needs, such as accessing stable housing, and employment. There is currently a need, however, for more community-based treatment services for ex-offenders with mental health issues and concurrent disorders (Lamb et al. 2004; Lamb and Weinberger 2005; Baillargeon et al. 2010b; Kubiak et al. 2011; Wolff 2005).

Similarly, our study revealed challenges faced by this population when attempting to access these services, regardless of the current “continuity of care” strategy outlined by the federal correctional system (Griffiths et al. 2007; Conklin et al. 2000; Wolff 2005). Our study’s data suggest that ‘offender’ and ‘mental health issue’ stigma provided barriers for this population when attempting to access community-based treatment services, and that long wait times coupled with an overall lack of available services hindered their successful reintegration. Further, the current study found that this population generally lacks social support, in addition to social capital, mainly due to their criminal history. As a result of the combination of an absence of available community-based treatment services that serve this potentially “intimidating” population and a lack of social support, the data revealed that the JHWW, more specifically the Aftercare program, is the only form of reliable aid for many of these individuals. Due to the
increase of this population accessing services from the JHSWW and the Aftercare program, the agency has experienced funding concerns that may have negative implications for the future of the Aftercare program.

Our study’s findings have significant implications for mental health policy, community-based research, and the sociological literature.

Implications
As discussed above, this study revealed a high prevalence of mental health issues and concurrent disorders within the Aftercare client population. Further, this population relies on the support provided by the JHSWW and Aftercare program for aid during the process of community reintegration and with coping with mental health issues and concurrent disorders. The study also found that the Aftercare program is experiencing a lack of adequate funding to adequately address this population’s needs, which have service delivery repercussions for the clients. So, what does this all mean?

Community-Based Mental Health System and Public Policy Implications
Foremost, the findings of our study have important implications for the non-profit, community-based mental health sector, particularly for organizations treating individuals involved in the criminal justice system. In 2010, the House of Commons released the Mental Health and Drug and Alcohol Addiction in the Federal Correctional System report. A number of recommendations were outlined within this report, including highlighting the importance of developing partnerships with mental health services within the community to provide a continuity of care to released offenders (p. 29). This partnership, however, is difficult to establish since the JHSWW
is not officially regarded as a mental health organization. Social integration helps to elucidate the complex role of the JHSWW and Aftercare program in the lives of individuals with mental health issues and concurrent disorders involved in the criminal justice system, and how the organization provides support for the complex issues that this population presents with. Further, our study helps to demonstrate the extent that this population relies on the JHSWW and the Aftercare program, including mental health and substance use support. Thus, the data of our study provide the basis for the JHSWW to be recognized as a community-based justice organization that is also a part of the mental health system. Upon acknowledgement of the Aftercare program’s positive role in the lives of individuals with mental health issues and concurrent disorders involved, and at risk of involvement, in the criminal justice system, the JHSWW may have access to federal and provincial funding in order to adequately support the delivery of the Aftercare program.

Further, the Mental Health Commission of Canada (2012) has recently released a report titled *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. This strategy briefly touches on the state of mental health issues within the offender population in Canada, and offers recommendations to help remedy the over-representation of this population in the criminal justice system. One such recommendation promotes the increase of the use of the “civil” mental health system to provide support and treatment to this population (p. 38). Thus, it appears that organizations involved in the mental health system are attempting to respond to the demands and needs of offenders suffering with mental health issues. As our current study’s findings indicate, however, the implementation of these recommendations has yet to be seen by the Aftercare clients. Mental health and public policy researchers should be looking to studies conducted with community-based mental health and justice-based organizations, like the
JHSWW, to evaluate the best plan of action to move forward with policy changes to improve the accessibility of individuals involved in the criminal justice system to community-based mental health and concurrent disorder services. Without disregarding the importance of adequate mental health and concurrent disorder treatment for offenders during incarceration, further collaboration and communication with community-based counseling and treatment services for this population post-release must be emphasized. An important advancement in public policy could include collaboration between CSC and the JHSWW in providing services to these individuals upon release. Developing a partnership with the federal government may allow the opportunity for additional funding to be provided to non-profit organizations and programs like Aftercare, and as a result, lower the risk of recidivism for this population. Subsequently, these individuals will not be relying on the treatment services available during incarceration as an alternative to the lack of community-based services, and the criminal justice system will experience a decrease in offenders passing through correctional facilities. In addition, policy makers must consider those individuals involved in the criminal justice system suffering with mental health issues and concurrent disorders who fall by the wayside; these individuals frequently access community-based organizations for aid and support. Thus, these organizations, such as the JHSWW, require additional funding to ensure adequate and effective treatment delivery to benefit both the individual and society at large.

**Community Engaged Scholarship Implications**

This CES employed a CBR framework to effectively respond to the needs of the JHSWW, which were to address the prevalence of mental health issues and concurrent disorders within the Aftercare client population. Further, the JHSWW sought to reveal the experiences of this
population while attempting to access community-based mental health services. Conducting the research in partnership with the staff from the JHSWW provided a more in-depth understanding of the issues that the agency is facing when providing services to individuals with mental health issues and concurrent disorders who are involved, or at risk of involvement, in the criminal justice system. Adopting a CBR methodology also provides a ‘real world’ experience, and promotes useful skill building for those involved, particularly the student researcher.

Additionally, this study has established a basis for a relationship upon which future community-university partnering can build. This can have positive implications for the University of Guelph, the department of Sociology and Anthropology, and the department of Political Science. Conducting CES has not been extensively explored by Masters’ students from these departments in the past, however this research provides a foundation and strong rationale for future community-university collaborative and engaged research endeavors.

**Sociological Literature Implications**

Finally, our study supplements the sociological literature regarding the barriers to reintegration experienced by individuals with mental health issues and concurrent disorders who are involved, and at risk of involvement, in the criminal justice system. Although this topic is not entirely new, the data of our research provide new insight into the experiences of this population when attempting to access community-based mental health and concurrent disorder services. Our study’s findings show that this population experiences difficulties due to a lack of available community-based services to serve these individuals. Additionally, our study also contributes to the social support, social capital, and social integration literature by further defining ‘social support’, and by helping to operationalize social integration. The data of our study reveal that
‘formal supports’, such as the JHSWW and the Aftercare program, may in fact provide a positive form of support for the Aftercare clients. Further, the Aftercare program was identified to provide a replacement to the lack of support from family and friends frequently experienced by offenders during community reintegration (Griffiths et al. 2007; Jacoby and Kozie-Peak 1997; Visher and Travis 2003; McCoy et al. 2004; Baillargeon et al. 2010b; Graffam et al. 2004; Solomon et al. 2001).

In addition to helping to operationalize the meta-concept of social integration, the structural barriers and issues, such as employment and housing, revealed in our study further supplements the sociological literature. Although these barriers to reintegration have been previously identified in the literature (Graffam et al. 2004; Baillargeon et al. 2010; Draine et al. 2005; Visher and Travis 2003; Mallik-Kane and Visher 2008), our study employs an interdisciplinary approach, using criminological, psychological, and sociological literature, to demonstrate the challenges experienced by ex-offenders with mental health issues and concurrent disorders when attempting to access community-based resources to help overcome the barriers to reintegration. Additionally, our study demonstrates how community-based organizations can address power inequalities frequently experienced by this population through the ‘brokering’ of clients to other resources and services. Thus, the community-based organization acts as an effective intermediary. In short, our study has significant implications for the sociological literature by revealing the role that non-profit, community-based organizations play in addressing the various barriers to reintegration, including complexities surrounding mental health issues and concurrent disorders, for individuals involved, or at risk of involvement, in the criminal justice system.
Limitations

Despite our study’s findings which support JHSWW policies, services, public policy and the academic literature, it is not absent of limitations. Foremost, the sample size for the quantitative data collection (n=61) is small. This number, however, was the total number of Aftercare clients who were participating in the Aftercare program within the study’s timeline. Further, a purposive sampling method was employed to recruit participants for the in-depth interviews. The Aftercare workers expressed concern regarding the ability of some of the Aftercare clients to participate in an interview with a graduate student from outside of the JHSWW. These concerns were mainly surrounding the clients’ comfort with speaking to someone else, other than an Aftercare worker, regarding their experiences and challenges that they may have faced in the community. Thus, information regarding the study was provided only to those Aftercare clients who the Aftercare workers thought would be more comfortable and willing to speak to an ‘outsider’. Therefore, the qualitative sample may not be truly indicative and representative of the Aftercare population, and the breadth of challenges this population faces with accessing community-based mental health services.

Other limitations of the study include challenges experienced with using CES and CBR. It was difficult to meet with the Aftercare staff all together to discuss the steps of the study, and to collaborate with them. Given their busy schedules, and having to travel between JHSWW agency sites, not every aspect of this study was reviewed with each Aftercare worker. More input from the staff as the research progressed would have been ideal. The Executive Director, and the primary Aftercare worker from one of the sites, however, were available on a regular basis. Further, because I worked out of a particular JHSWW site on a regular, daily basis, I formed a relationship with a few of the staff members. At times, some of the best information regarding
mental health issues in the criminal justice system and in the Aftercare population was obtained during casual interactions and conversations with the staff. When possible, I tried to document the comments and points after the conversation, however that was not always possible.

**Future Research**

Despite the limitations discussed above, the findings of the study are important given the increase of individuals with mental health issues and concurrent disorders in the criminal justice system, and accessing services from non-profit, community-based organizations such as the JHSWW. Future research could build upon the finding of a lack of continuity of care for offenders with mental health issues during the process of community reintegration. Future studies could follow federally or provincially incarcerated offenders post-release to evaluate the experiences of this population when attempting to access community-based mental health services, how long they can stay with these services, whether these services attended to all of their needs, and whether the ex-offenders were required to access other services in order to adequately address all of their needs. This may help establish future data for the federal and provincial governments to evaluate the effectiveness of their institutional mental health treatment, and continuity of care within the community.

Further, the qualitative findings of this study report that the Aftercare program has a positive effect on the Aftercare clients’ rate of recidivism, and even prevented criminal justice system involvement (for the one participant who was at risk of involvement in the criminal justice system). Conducting a longitudinal study following Aftercare clients in John Howard Societies across Ontario through their journey of the process of reintegration and accessing services could provide more reliable results regarding the affect of the participation in the
Aftercare program on the rates of recidivism. Additionally, a comparative analysis of the various Aftercare programs provided by John Howard Societies throughout the province could identify inconsistencies or weaknesses within the program, and evaluate how the program could be improved.

Finally, future research could be conducted by employing the tracking sheets used in this study to collect information regarding the prevalence of mental health issues and/or concurrent disorders within the Aftercare population. These tracking sheets also included the prevalence of developmental disorders and acquired brain injury within the Aftercare study sample. The prevalence of developmental disorders and acquired brain injuries within a non-profit, community justice based organization’s client-base (specifically Aftercare clients) also appears to be absent from the sociological literature. Future research could also focus on gender, geographical location, and race in relation to the data collected by the tracking sheets. In sum, the findings of our study allow for various important implications and future research endeavors.
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Appendix ‘A’

Research Questions

1. What is the ‘typical’ profile of the clients accessing the Aftercare program?
   a. What are the mental health issues of the JHSWW Aftercare clients?
   b. How do these issues intersect with other problems, such as substance abuse?
   c. How do JHSWW staff members view Aftercare clients? What have been the experiences of JHSWW staff members in working with Aftercare clients?

2. What barriers do Aftercare clients experience?
   a. What are the experiences of Aftercare clients in accessing other community-based mental health and/or substance use resources available to the general public?
   b. What are the barriers to Aftercare clients in accessing other community-based mental health and/or substance use resources available to the general public?
   c. If Aftercare clients have experienced general barriers to community reintegration, what barriers have they encountered?

3. What is the role of the Aftercare program in Aftercare clients’ lives?
   a. How does the JHSWW address clients’ needs/barriers who are accessing the Aftercare program?
   b. What is the role of non-profit organizations, specifically the JHSWW, in providing care to people with mental health issues involved in the criminal justice system?
   c. How can JHSWW’s resources including staff expertise, programs, and services better address their clients’ mental health needs?
   d. How do Aftercare clients see the program as contributing to the prevention of their recidivism?
   e. How can non-profit, community-based organizations that serve clients with mental health issues involved in the criminal justice system be better supported?
Appendix ‘B’

JHSWW Aftercare Program Data Collection Tool for Tracking Mental Health Issues, Substance Use Problems, Developmental Challenges, and Acquired Brain Injuries Among Clients

*To be for all Aftercare clients served by JHSWW between February 15, 2011 through to and including June 15, 2011. Clients who require assistance with only pardons applications are not included in this data collection.

Client ID #:

Date form completed:

Staff initials:

Please check all that apply:

___ Client is dealing with a mental health issue/mental illness based one or more of the following: observable behaviour (including comments made such as talking about something that isn’t real, reference to taking a particular medication, etc.) that would lead a reasonable person to conclude that there is a mental health issue/illness present, collateral information (e.g., third party information), or the client expresses that he or she has been diagnosed with a mental illness (schizophrenia, schizoaffective disorder, depression, bipolar) or experiences symptoms such as delusions or hallucinations that are not obviously attributable to another cause

___ Client is dealing with a substance use problem that could include use of prohibited substances, abuse of prescription medications, use of legal substances but to such an extent that it negatively impacts on the individual’s life (e.g., daily use of marijuana, excessive consumption of alcoholic beverages).

___ Client is dealing with a developmental disorder such as but not limited to ADHD or a learning disability, Fetal Alcohol Spectrum Disorder, autism, Asperger’s Syndrome. These are neurological disorders that result in impaired functional, social and communication skills.

___ Client is dealing with Acquired Brain Injury that affects cognitive and/or motor functioning.

Notes:
Appendix ‘C’

Aftercare Database Coding Manual
Prevalence of Mental Health Issues and Substance Use Issues within Aftercare Clients

Clients participating in ‘Aftercare’ programming, using the ‘Aftercare Tracking Tool’, which was used for a 4-month time period, starting Feb. 15th, 2011 and ending June 15th, 2011. This tracking sheet captured whether the client presented with a mental health issue, developmental disorder, substance use issue, or an acquired brain injury. Information to create this database was taken from the ‘Aftercare tracking Tool’, as well as from the primary Aftercare worker(s).

<table>
<thead>
<tr>
<th>Variable (Column # in Database)</th>
<th>Variable Title</th>
<th>Variable Label</th>
<th>Variable Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Client Identification</td>
<td></td>
<td>Each client will be identified by a number, starting with K-1 or C-001. These numbers are found on the client’s tracking tool sheet.</td>
</tr>
<tr>
<td>Q2</td>
<td>Gender, male or female</td>
<td>1=male; 2=female; 777= Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Client’s gender</td>
</tr>
<tr>
<td>Q3</td>
<td>Client’s current age</td>
<td>18, 19, 20, 21, etc. 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Client’s current age is identified by (Aftercare Worker); refer to date written on back of tracking tool sheets.</td>
</tr>
<tr>
<td>Q4</td>
<td>Duration of Service</td>
<td>1=Less than 3 Months; 2=3 Months to Under One Year; 3=One Year and Greater; 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Determined by how long client has been involved with the Aftercare program. This time line was provided (Aftercare workers), referring to date that tracking tools were discussed. (i.e. As of June 15, 2011, when tracking sheet was reviewed with Aftercare worker, client has been involved in program for 3 years).</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Q5</td>
<td>Grouped Referral Source</td>
<td>1=Community Partner; 2=Self; 3=Other JHS Program/Staff; 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Who referred the client? Crown, Police, Family (not the client themselves), the client themselves, other community-based agency, etc.</td>
</tr>
<tr>
<td>Q6</td>
<td>Previous Involvement with Aftercare Program</td>
<td>1=Yes; 2=No; 777=Unknown (Not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Has the client previously been involved with Aftercare? Referring to if client was involved with Aftercare years before, left for a period of time (one year or more), then returned, and is currently still in the program.</td>
</tr>
<tr>
<td>Q7</td>
<td>Alcohol and/or drug use</td>
<td>1=Yes; 2=No; 3=Third party report: partner/friend; 777=Unknown (Not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Client is dealing with a substance use problem that could include use of prohibited substances, abuse of prescription medications, use of legal substances but to such an extent that it negatively impacts on the individual’s life (e.g., daily use of marijuana, excessive consumption of alcoholic beverages.)</td>
</tr>
<tr>
<td>Q8</td>
<td>Suicide Risk</td>
<td>1=On suicide watch; 2=Previous Suicide Attempt(s); 3=Suicide Ideation/threat; 777=Unknown (not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Is the client a suicide risk? : Is client on suicide watch, has had a previous suicide attempt(s), or suicide ideation/threat; taken from information indicated by Aftercare worker. If client has attempted suicide AND has suicidal ideations/threats, then code for the suicide attempt.</td>
</tr>
<tr>
<td>Q9</td>
<td>If yes, when?</td>
<td>Ex., has client attempted suicide within 2 weeks to one month prior to date of commencing Aftercare program?</td>
<td></td>
</tr>
<tr>
<td>----</td>
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<td>-----------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>1=within past 2 weeks-1 month; 2= Within 3 Months to 6 Months; 3=Within 6 Months to 8 Months; 777= Unknown (i.e., not indicated on any documentation in file when attempt/ideation/threat occurred); 999=Information Missing</td>
<td>Ex., has client attempted suicide within 2 weeks to one month prior to date of commencing Aftercare program?</td>
<td></td>
</tr>
<tr>
<td>Q10</td>
<td>Client Housing Situation</td>
<td>&quot;What is the client’s housing situation as of the date of ‘tracking tool’ implementation? (Feb. 15, 2011)&quot;</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1=Living Alone and Paying Market Rent; 2=Living Alone and Cost of Housing Subsidized; 3= Partner is Paying Cost of Housing or Subsidizes Client’s Share of Rent/Mortgage; 4=Living in Parental Home; 5=Relative Other than Parent Pays Housing Cost; 6=Living in a Recovery House; 7=Living in An Apartment through a Mental Health Agency; 8=Transitory; 9=Partner Pays Cost of Housing or Subsidizes Client’s Share of Rent/Mortgage and Children are in the Home; 10=Living in Own Home; 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q11</th>
<th>See Counselor At Other Agency</th>
<th>&quot;Does the client see a counselor outside of JHSWW?: Refers to mental health counselors, substance abuse counselors, emotional support, etc. Not referring to medical doctors who are providing regular medical care to client.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1=Yes; 2=No; 777=Unknown (i.e.: not indicated on any documentation in file); 888= Not Applicable; 999=Information Missing</td>
<td></td>
</tr>
<tr>
<td>Q12 MH/MI</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Does the Client have a Mental health issue? : Client is dealing with a mental issue/mental illness based on one or more of the following: observable behaviour (including comments made such as talking about something that isn’t real, reference to taking a particular medication, etc.) that would lead a reasonable person to conclude that there is a mental health issue/illness present, collateral information (e.g., third party information), or the client expresses that he or she has been diagnosed with a mental illness (schizophrenia, schizoaffective disorder, depression, bipolar, etc) or experiences symptoms such as delusions or hallucinations that are not obviously attributable to another cause.</td>
</tr>
<tr>
<td>Q13 D.D.</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Does the Client have a developmental disorder? : Client is dealing with a developmental disorder such as, but not limited to, ADHA or a learning disability, Fetal Alcohol Spectrum Disorder, Autism, Asperger’s Syndrome. These are neurological disorders that result in impaired functional, social, and communication skills.</td>
</tr>
<tr>
<td>Q14 Acquired Brain Injury</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
<td>Does the Client have an acquired Brain Injury? : Client is dealing with Acquired Brain Injury that affects cognitive and/or motor functioning.</td>
</tr>
<tr>
<td>Q15</td>
<td>Employment status upon date of tracking tool implementation</td>
<td>1=Unemployed; 2=working part-time; 3=working full time; 4=Attending college/university/training course; 5= Ontario Works; 6=O.D.S.P; 7=Sporadic; 8=Retired; 9=Actively seeking employment; 10=Canada Pension Plan; 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q16</td>
<td>History of Victimization</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888= Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q17</td>
<td>Crime (primary offence)</td>
<td>Primary offence that client was charged with.</td>
</tr>
<tr>
<td>-----</td>
<td>-------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Theft under $5000;</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Theft over $5000;</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Assault;</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Assault w/ weapon;</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Drug Possession;</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mischief Under;</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Mischief over;</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Possession under $5000;</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Possession over $5000;</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Forcible Entry;</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Uttering Threats;</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>FTC Bail Conditions;</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Forcible Confinement;</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Breach of Probation;</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Breach Undertaking;</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Breach Recognizance;</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Break &amp; Enter;</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Weapons Dangerous;</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Disobey Court Order;</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Obstruct Justice;</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Mischief;</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Carrying a concealed weapon;</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Criminal harassment;</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Break, Enter &amp; Theft;</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Attempt Assault w/ Weapon;</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Assault Causing Bodily Harm;</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Armed Robbery;</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Importing Narcotics;</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Aggravated Assault;</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Criminal Harassment;</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Sexual Assault;</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Attempted Robbery;</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Impaired Driving;</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Assault Police;</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Luring; 36=Chronic Criminality;</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Stalking;</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Murder; 39=Fraud;</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Sexual Interference;</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Possession of Child Pornography;</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Attempted Murder;</td>
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</tr>
<tr>
<td>43</td>
<td>Robbery;</td>
<td></td>
</tr>
<tr>
<td>777</td>
<td>Unknown (i.e. not indicated on any documentation in file);</td>
<td></td>
</tr>
<tr>
<td>888</td>
<td>Not Applicable;</td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>Q18 Crime (Secondary Offence)</td>
<td>Secondary offence that client was charged with.</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1=Theft under $5000; 2=Theft over $5000; 3=Assault; 4= Assalt w/ weapon; 5= Drug Possession; 6= Mischief Under; 7= Mischief over; 8= Possession under $5000; 9= Possession over $5000; 10= Forcible Entry; 11= Uttering Threats; 12= FTC Bail Conditions; 13= Forcible Confinement; 14= Breach of Probation; 15= Breach Undertaking; 16= Breach Recognizance; 17= Break &amp; Enter; 18= Weapons Dangerous; 19= Disobey Court Order; 20= Obstruct Justice; 21= Mischief; 22= Carrying a concealed weapon; 23= Criminal harassment; 24= Break, Enter &amp; Theft; 25= Attempt Assault w/ Weapon; 26= Assault Causing Bodily Harm; 27= Armed Robbery; 28= Importing Narcotics; 29= Aggravated Assault; 30= Criminal Harassment; 31= Sexual Assault; 32= Attempted Robbery; 33= Impaired Driving; 34= Assault Police; 35= Luring; 36= Chronic Criminality; 37= Stalking; 38= Murder; 39= Fraud; 40= Sexual Interference; 41= Possession of Child Pornography; 42= Attempted Murder; 43= Robbery; 777= Unknown (i.e. not indicated on any documentation in file); 888= Not Applicable; 999= Information</td>
<td></td>
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</tr>
<tr>
<td>Q19</td>
<td>Crime (Tertiary Offence)</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Theft under $5000;</td>
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<tr>
<td>2</td>
<td>Theft over $5000;</td>
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<tr>
<td>3</td>
<td>Assault;</td>
<td></td>
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<td>4</td>
<td>Assault w/ weapon;</td>
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</tr>
<tr>
<td>5</td>
<td>Drug Possession;</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mischief Under;</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Mischief over;</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Possession under $5000;</td>
<td></td>
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<tr>
<td>9</td>
<td>Possession over $5000;</td>
<td></td>
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<tr>
<td>10</td>
<td>Forcible Entry;</td>
<td></td>
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<tr>
<td>11</td>
<td>Uttering Threats;</td>
<td></td>
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<tr>
<td>12</td>
<td>FTC Bail Conditions;</td>
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<tr>
<td>13</td>
<td>Forcible Confinement;</td>
<td></td>
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<tr>
<td>14</td>
<td>Breach of Probation;</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Breach Undertaking;</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Breach Recognizance;</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Break &amp; Enter;</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Weapons Dangerous;</td>
<td></td>
</tr>
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<td>19</td>
<td>Disobey Court Order;</td>
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<td>20</td>
<td>Obstruct Justice;</td>
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<tr>
<td>21</td>
<td>Mischief;</td>
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</tr>
<tr>
<td>22</td>
<td>Carrying a concealed weapon;</td>
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</tr>
<tr>
<td>23</td>
<td>Criminal harassment;</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Break, Enter &amp; Theft;</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Attempt Assault w/ Weapon;</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Assault Causing Bodily Harm;</td>
<td></td>
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<td>27</td>
<td>Armed Robbery;</td>
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<td>28</td>
<td>Importing Narcotics;</td>
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<td>Aggravated Assault;</td>
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<td>Criminal Harassment;</td>
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<td>31</td>
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<td>Impaired Driving;</td>
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<td>34</td>
<td>Assault Police;</td>
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</tr>
<tr>
<td>35</td>
<td>Luring;</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Chronic Criminality;</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Stalking;</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Murder;</td>
<td></td>
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<tr>
<td>39</td>
<td>Fraud;</td>
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</tr>
<tr>
<td>40</td>
<td>Sexual Interference;</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Possession of Child Pornography;</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Attempted Murder;</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Robbery;</td>
<td></td>
</tr>
<tr>
<td>777</td>
<td>Unknown (i.e. not indicated on any documentation in file);</td>
<td></td>
</tr>
<tr>
<td>888</td>
<td>Not Applicable;</td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>Q20</td>
<td>Crime (Fourth Offence)</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1=Theft under $5000; 2=Theft over $5000; 3=Assault; 4=Assault w/ weapon; 5=Drug Possession; 6=Mischief Under; 7=Mischief over; 8=Possession under $5000; 9=Possession over $5000; 10=Forcible Entry; 11=Uttering Threats; 12=FTC Bail Conditions; 13=Forcible Confinement; 14=Breach of Probation; 15=Breach Undertaking; 16=Breach Recognizance; 17=Break &amp; Enter; 18=Weapons Dangerous; 19=Disobey Court Order; 20=Obstruct Justice; 21=Mischief; 22=Carrying a concealed weapon; 23=criminal harassment; 24=Break, Enter &amp; Theft; 25=Attempt Assault w/ Weapon; 26=Assault Causing Bodily Harm; 27=Armed Robbery; 28=Importing Narcotics; 29=Aggravated Assault; 30=Criminal Harassment; 31=Sexual Assault; 32=Attempted Robbery; 33=Impaired Driving; 34=Assault Police; 35=Luring; 36=Chronic Criminality; 37=Stalking; 38=Murder; 39=Fraud; 40=Sexual Interference; 41=Possession of Child Pornography; 42=Attempted Murder; 43=Robbery; 777=Unknown (i.e. not indicated on any documentation in file); 888=Not Applicable; 999=Information</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
<td>Code</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Q21</td>
<td>Multiple Charges</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q22</td>
<td>Number of charges</td>
<td>1; 2; 3; 4; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q23</td>
<td>Previous Criminal Justice Sector Involvement</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q24</td>
<td>Self-Harm</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not Applicable; 999=Information Missing</td>
</tr>
<tr>
<td>Q25</td>
<td>Interview</td>
<td>1=Yes; 2=No; 777=Unknown (i.e., not indicated on any documentation in file); 888=Not applicable; 999=Information Missing</td>
</tr>
</tbody>
</table>
Appendix ‘D’

Script for ‘Community Aftercare’ Worker to Communicate General Research Information to Client

I would just like to tell you about a research project that is going to be conducted here at the JHSWW, that is a collaboration with the University of Guelph. The research is focusing on clients experiencing mental health issues who are using JHSWW’s services. This research project will help JHSWW understand the needs of this client population, and will help us adapt our services to better serve clients’ needs.

If you choose to participate in this research, your participation or lack of participation will not impact any of the services that you receive from JHSWW. Also, any information that collected is completely confidential, and you can choose to withdraw from the project at any time without any consequences.

If you have any questions, or are interested in participating, you can let me (the primary worker) know and I will put you in touch with the researcher.
Appendix ‘E’

Telephone Script for Calling Potential Participants

Hello, it’s Ashley calling from the John Howard Society. I am calling regarding the interview that [Name of ‘Aftercare’ worker] told you about (if client does not recall hearing about the interview, remind them what it is for. “Interview that is being conducted by a University of Guelph Master’s student, in collaboration with the JHSWW, for Community Aftercare clients”)

I was wondering if you are still interested in participating in an interview? Just to let you know as well that your participation is completely voluntary, and you can withdraw at any time. (If client says ‘yes, I am interested’, then ask them what days work best for them, then tell them what times are available; if client says no, then thank them, and cross their name off the list).

Once date/time is set up, write next to client’s name on the list. Put list back in envelope, to be locked up.
Appendix ‘F’

CONSENT TO PARTICIPATE IN RESEARCH

"Tools to Live": Using Community-Engaged Scholarship to Assess the Role of a Canadian Non-Profit Organization in Serving Persons with Mental Health Issues and Concurrent Disorders

You are asked to participate in a research study conducted by Ashley MacInnis (Graduate student) and Dr. Mavis Morton from the Sociology department at the University of Guelph, and Dr. Joan Nandial from the John Howard Society Waterloo-Wellington. The results of the study will contribute to a Master’s thesis, and to help the John Howard Society of Waterloo-Wellington maintain an effective program and support the agency in applying for additional funding.

If you have any questions or concerns about the research, please feel free to contact Dr. Joan Nandial (519) 743-6071 Ext. 211, or Dr. Mavis Morton (519) 824-4120, Ext. 52576

PURPOSE OF THE STUDY

The University of Guelph and the John Howard Society of Waterloo-Wellington is doing a study with ‘Community Aftercare’ clients to collect information about the needs of clients using the ‘Community Aftercare’ program. The purpose of the study is to find out how the program helps people, and whether there is a need for more programs like it. Also, the study will identify the benefits of the programs to help the agency obtain more resources to continue to meet and support client’s needs.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

We are asking you to participate in a research interview that will last approximately 30-60 minutes. The interview will focus on the types of services you are receiving and the ways in which they are helpful. Your views will be audio recorded to ensure that we correctly note your responses.

You will also be asked to participate in a focus group with four other ‘Community Aftercare’ clients. You will be discussing issues around community-based mental health services. This will take about 45 minutes. The focus groups will occur at the Kitchener JHSSWW office. The focus group will be videotaped and later transcribed.

POTENTIAL RISKS AND DISCOMFORTS

Participating in this research involves few risks. There is a possibility that some questions may make you uncomfortable, but please remember that you are not obligated to answer any question. Your answers will be kept private and confidential by the researchers. The main benefit of participation is the knowledge that you are contributing to the development of services that help people who have been involved in the criminal justice system.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Your opinions are very important. The general purpose of the study is to find out about your experience with the
‘Community Aftercare’ program. Your participation in this study will help the John Howard Society of Waterloo-Wellington maintain a helpful program and support the agency in applying for additional funding for the program.

The scientific community/society would potentially benefit from this research by adapting programs and services to address the mental health needs of clients who have been involved with the criminal justice system.

PAYMENT FOR PARTICIPATION

The participant will not receive any payment for their participation.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. All information collected will be treated as confidential, kept in a secure location for up to seven years in a locked office at the John Howard Society of Waterloo-Wellington. Only members of the research team will have access to the data. As an additional precaution, consent forms will be stored separately from collected data. In reporting results, your answers will be combined with those of all the other people we will interview. If something you say in the interview is used, it will be reported in such a way that no one will be able to identify you. We will maintain the privacy of your answers by never using your name in reports written based on this evaluation. JHSWW will own the data collected from this research project.

INCIDENTAL FINDINGS

Upon the incident of disclosing any information that may be understood as planned harm to yourself or others, I am obligated to report such information to the appropriate authorities. While there is no obligation to report criminal activity, this researcher might be subpoenaed, so you should not discuss any illegal activities that you were involved in. Also, I will have a duty to report any suspicious or suspected child abuse to the appropriate authorities.

PARTICIPATION AND WITHDRAWAL

You do not have to participate. Participating in this study is voluntary. You may refuse to answer any question. You may stop the interview at any time. If you choose not to participate or withdraw, it will not affect your involvement with the John Howard Society of Waterloo-Wellington.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics
University of Guelph
437 University Centre
Guelph, ON N1G 2W1
Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236

SIGNATURE OF RESEARCH PARTICIPANT

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I have read the information provided for the study "Tools to Live": Using Community-Engaged Scholarship to Assess the Role of a Canadian Non-Profit Organization in Serving Persons with Mental Health Issues and Concurrent Disorders as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant (please print)

______________________________________
Signature of Participant

Date

SIGNATURE OF WITNESS

Name of Witness (please print)

______________________________________
Signature of Witness

Date
Appendix ‘G’

Script to be used by researcher when communicating to participant about “Incidental Findings Procedure”:

Thank you for your participation in this research. I have to inform you that if you were to tell me anything in the interview regarding any serious unreported illegal activities, or any planned harm to yourself or others I am obligated to report it to the appropriate authorities. Do you understand? Please be aware of this requirement while we are conducting the interview. *(Be certain that client acknowledges that they comprehend)*

Do you have any questions?

Thanks again for your time, and we’ll get started when you are ready.
CONSENT TO PARTICIPATE IN RESEARCH

"Tools to Live": Using Community-Engaged Scholarship to Assess the Role of a Canadian Non-Profit Organization in Serving Persons with Mental Health Issues and Concurrent Disorders

You are asked to participate in a research study conducted by Ashley MacInnis (Graduate student) and Dr. Mavis Morton from the Sociology department at the University of Guelph, and Dr. Joan Nandlal from the John Howard Society Waterloo-Wellington. The results of the study will contribute to a Master’s thesis, and to help the John Howard Society of Waterloo-Wellington maintain an effective program and support the agency in applying for additional funding.

If you have any questions or concerns about the research, please feel free to contact Dr. Joan Nandlal (519) 743-6071 Ext. 211, or Dr. Mavis Morton (519) 824-4120, Ext. 52576

PURPOSE OF THE STUDY

The University of Guelph and the John Howard Society of Waterloo-Wellington is doing a study with ‘Community Aftercare’ clients and staff to collect information about the needs of clients using the ‘Community Aftercare’ program. The purpose of the study is to find out how the program helps people, and whether there is a need for more programs like it. Also, the study will identify the benefits of the programs to help the agency obtain more resources to continue to meet and support client's needs.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

We are asking you to participate in a research interview that will last approximately 30-60 minutes. The interview will focus on the types of services that are being provided in the ‘Community Aftercare’ program, mental health issues within ‘Community Aftercare’ clientele, funding, and public policies. Your views will be audio recorded to ensure that we correctly note your responses.

You will also be asked to participate in a focus group with three other ‘Community Aftercare’ staff. You will be discussing issues around community-based mental health services. This will take about 45 minutes. The focus groups will occur at the Kitchener JHSWW office. The focus group will be videotaped and later transcribed.

POTENTIAL RISKS AND DISCOMFORTS

Participating in this research involves few risks. There is a possibility that some questions may make you uncomfortable, but please remember that you are not obligated to answer any question. Your answers will be kept private and confidential by the researchers. The main benefit of participation is the knowledge that you are contributing to the development of services that help people who have been involved in the criminal justice system.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY
Your opinions are very important. The general purpose of the study is to find out about your experience with the ‘Community Aftercare’ program. Your participation in this study will help the John Howard Society of Waterloo-Wellington maintain a helpful program and support the agency in applying for additional funding for the program.

The scientific community/society would potentially benefit from this research by adapting programs and services to address the mental health needs of clients who have been involved with the criminal justice system.

PAYMENT FOR PARTICIPATION

The participant will not receive any payment for their participation.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. All information collected will be treated as confidential, kept in a secure location for up to seven years in a locked office at the John Howard Society of Waterloo-Wellington. Only members of the research team will have access to the data. As an additional precaution, consent forms will be stored separately from collected data. In reporting results, your answers will be combined with those of all the other people we will interview. If something you say in the interview is used, it will be reported in a such a way that no one will be able to identify you. We will maintain the privacy of your answers by never using your name in reports written based on this evaluation. JHSWW will own the data collected from this research project.

PARTICIPATION AND WITHDRAWAL

You do not have to participate. Participating in this study is voluntary. You may refuse to answer any question. You may stop the interview at any time. If you choose not to participate or withdraw, it will not affect your involvement with the John Howard Society of Waterloo-Wellington.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided for the study "Tools to Live": Using Community-Engaged Scholarship to Assess the Role of a Canadian Non-Profit Organization in Serving Persons with Mental Health Issues and Concurrent Disorders as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____________________________________
Name of Participant (please print)

__________________________________________
Signature of Participant                      Date

SIGNATURE OF WITNESS

Name of Witness (please print)

__________________________________________
Signature of Witness                          Date
Appendix ‘I’

Client Interview Guide

The University of Guelph and the John Howard Society of Waterloo-Wellington is doing a study with ‘Community Aftercare’ clients to collect information about the needs of clients using the ‘Community Aftercare’ program. The purpose of the study is to find out how the program helps people, and whether there is a need for more programs like it. Also, the study will identify the benefits of the programs to help the agency obtain more resources to continue to meet and support client’s needs.

**Theme: General Context**

- How long have you been involved with the John Howard Society?
- When did you start the Community Aftercare program?
- How did you hear about the John Howard Society? How did you become involved with the John Howard Society?
- Who referred you to the John Howard Society?
- Before you became involved with the John Howard Society, what sort of support or assistance did you receive from other agencies?

**Theme: Benefits of the ‘Community Aftercare’ Program**

- Are there advantages/benefits or positive/good things about coming to the John Howard Society?
- If so, can you give me a specific example of something that the program has helped you with? *Prompt: If not why not?*
- Has this program helped with leaving jail and reconnecting with the community? *Prompt: If so how? If not, why not?*
- Has your life improved, due to your involvement with the ‘Community Aftercare’ program? *Prompt: If so, how? If not why not?*
- Can you tell me about a time when you have been faced with a situation or a problem and [Name of ‘Aftercare’ worker], or another JHSWW worker was able to say or do something to help you?
- Describe the situation. Prompt: what happened?. Can you give me details about what you were thinking or doing and how JHSWW helped?

- Has being a part of this program helped prevent you from being further involved with the criminal justice system? Prompt: If so how? If not why not?

**Theme: Mental Health Services and/or Addictions Services from other Agencies**

- Have you tried to get help from other support services locally? (Prompt: Such as ______________________) How has that been? Did you experience any problems? Prompts: If yes, can you tell me about them? If not, what did you find helpful about the other services/supports? Why? If no help from other agency, what are reasons?

- Has being with JHSWW helped you get support from other agencies/supports? Prompts: If so how? If not why not? Did you ask JHSWW to help? If now why not?

- How easy is it to access or use services/programs at the JHSWW?

- How quickly can you speak to someone?

- How easy/hard is it to see someone face to face?

- Is there anything that the JHSWW could do differently to make getting help from them easier?

**Theme: Benefits of Mental Health Services in Community Aftercare Programming**

- If someone is just coming out of prison, and they need some help with mental health services, where would you advise them to go?

- If a person was struggling with a mental health issue, how might JHSWW be able to help?

- What help/support/services might you want from JHSWW that isn’t available now?

- If JHS could help people with mental health issues, do you think this might help keep people out of jail or away from the criminal justice system? Prompt: Why or why not?

**Other Feedback**

- If you were the director of the programs here at JHSWW what changes would you make and why?
- Is there any other feedback that you would like to share that could be helpful in developing programs at JHSWW?

**General Prompts**

- Earlier you mentioned X, let’s go back to that.
- Please tell me more about that.
- Can you tell me more about that?
- I’m not sure what you mean...can you tell me more about that?
- Can you describe that for me?
- Can you give me an example of what you mean when you say X?
Appendix ‘J’

Staff Interview Guide

The purpose of these interviews is to get some complimentary information to provide context to the ‘Community Aftercare’ client interviews. There’s no right or wrong answer, and I would like to hear your perspective as a Community Aftercare worker. You are not obligated to answer any questions.

I would like to start off with some questions about you, in order to better understand the context of your responses, and to find out more about you and your work here at JHSWW.

Theme one: About you

- How long have you worked as a part of the Community Aftercare team at JHSWW?

- How long have you worked in the social services sector?

- Have you always worked with individuals involved in the criminal justice system? If not, prompt: what is your previous work experience?

- So you say that you have worked in Community Aftercare for X years, how many clients would you say that you have served within the Community Aftercare program over that time? If interviewee is uncertain, prompt: An approx. number, in percentage.

I’d like to move on to the approach that you take when working with clients, and the client population that you serve...

Theme two: Approach to Working with Clients

- What is the purpose of the Community Aftercare program?

- Where do the majority of referrals come from? Prompt: Why do you think clients come to JHSWW? When they come to the program, is it your sense that they typically try to access other services? Why or why not?

- Can you tell me about the work that you do, and your duties?

- What kind of counseling approach do you (in the context of ‘you’ being a part of the Community Aftercare team) take with working with Community Aftercare clients? Prompt: How does using this form of counseling approach help with dealing with this clientele? How may it differ from other counseling services? Why or why not?

- How frequently do you need to work with Community Aftercare clients, in general? Prompt: How many days/times per week, over how long? Why?
- What are some typical issues that the Community Aftercare clientele need help dealing with?  
  Prompt: What others?

- Has the Community Aftercare clientele changed since you started working at JHSWW?  
  Prompt: Why or why not? How have you had to change your counseling approach, due to the changing clientele? Can you tell me more about this client population?

- In a given year, what percentage of the clients you see in Community Aftercare have returned to JHSWW, as opposed to going to other counseling services? Prompt: new intakes vs. percentage of clients continuing counseling during a year.

- Why do they return? Prompt: If most clients are ongoing, how has the duration (over time) and intensity (frequency) of the counseling changed?

- At what point do you think that a client’s file is closed?

  Moving on from the approach taken when working with this client population, I’d like to know more about mental health issues in the Community Aftercare clientele...

**Theme Three: Mental Health Issues in Aftercare Clients**

- How are you able to tell if a Community Aftercare client is presenting with a mental health issue? Prompt: How do these clients present? What’s the approx. percentage of Community Aftercare clients who are experiencing mental health issues in your caseload? What’s the approx. percentage of Community Aftercare clients who are experiencing a concurrent disorder (mental health and substance use issues)?

- How are you able to tell if an Community Aftercare client is presenting with both a dual diagnosis (mental health issue and developmental disorder)? Prompt: What’s the approx. percentage of Community Aftercare clients who are experiencing both mental health issues and developmental disorders in your caseload?

- What is the current practice for dealing with a Community Aftercare client when he/she presents with a mental health issue? Prompt: Are you satisfied with the current process/practice/mandate for working with Community Aftercare clients who present with mental health issues? How can this practice be changed/improved?

- How often are previous life experiences (such as history of victimization, early trauma) relevant to Community Aftercare clients? Please indicate on a scale: most of the time, some of the time, rarely, almost never, or never. Prompt: Can you explain how/why this answer is relevant?

- How do you think incarceration affects a prisoner/client who is dealing with mental health issues?
- To what extent is the criminal justice system helping individuals with mental health issues within provincial and federal correctional facilities? Prompt: How can the Federal and Provincial systems be compared, in terms of mental health services while incarcerated?

- What do you think is the primary reason, or reasons, that Community Aftercare clients who are experiencing mental health issues might have involvement with the law and the criminal justice system?

- Do Community Aftercare clients who are experiencing mental health issues face further barriers during the process of community reintegration, compared to the general offender population? Prompt: If so why and how?

- If interviewee thinks that the program is not satisfactory, ask: How can the Community Aftercare program be changed to better serve those clients presenting with a mental health issue?

Now that I have a better understanding of the prevalence of mental health issues found within the Community Aftercare client population, I’d like to move on to the topic of funding and public policy...

**Theme Four: Funding and Public Policy**

- How is the Community Aftercare program funded?

- Is the Community Aftercare program sufficiently funded? Prompt: Why or why not?

- If answered no to previous question- What are the implications for insufficient funding for the Community Aftercare program?

- What are you doing to manage/address the lack of funding and subsequent implications of insufficient funding?

- Does government policy impact funding for the JHSWW Community Aftercare program? Prompt: If so how and why?

- Does current public policy enable/support the provision of Community Aftercare services or not? Prompt: Why do you think that?

- Have public policies changed since you started working at JHSWW? Prompt: If so, how? What concerns do you have right now regarding policies?

- Are there funding/program challenges beyond government ones that impact the Community Aftercare program? Prompt: If so what are they?

**Closing Questions**
- Can the Community Aftercare program be changed/improved in the future? Prompt: If so, how and why?

- Is there any other feedback that you would like to share that could be helpful in enhancing the Community Aftercare program at JHSWW?

-Is there anything else that you would like to add or clarify to what you’ve said already?

Thank you!

N. B.: Not all prompts will be used for every interviewee. The prompts will be used as needed, depending on the nature of the interview/interviewee.

**General Prompts**

- Earlier you mentioned X, let’s go back to that.
- Please tell me more about that.
- Can you tell me more about that?
- I’m not sure what you mean...can you tell me more about that?
- Can you describe that for me?
- Can you give me an example of what you mean when you say X?