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The role of occupational therapy in corrections settings.

Rebecca Bradbury
Ithaca College

The Role of Occupational Therapy in Corrections Settings

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Rebecca Bradbury

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Abstract

Occupational therapy is a broad discipline, but one that aims to help people who experience a variety of impairments to function and manage their daily life. A large population of adults in America experience dysfunction in managing their daily life, and often receive inadequate support to improve. Nearly 2 million adults are incarcerated in the U.S. penal system. Most prisoners will eventually be released back into communities where they are responsible for maintaining their individual roles as productive members of society, but many struggle to do so. The purpose of this phenomenological study was to explore the role of occupational therapy in corrections settings. Four occupational therapists working with criminal populations were contacted and agreed to participate. The corrections settings represented in the sample included a Federal Medical Center with the Federal Bureau of Prisons, a state prison, and secure forensic units within a state psychiatric hospital. Three interviews were conducted with each participant to ascertain the lived experience of working as an occupational therapist in a correctional setting with a criminal population. Qualitative data analysis revealed three emergent themes representing the roles of each occupational therapist within corrections: safety and security, people are people, and advocacy. The findings of the study are novel in that this is a first reported attempt to obtain explicit details of the work of an occupational therapist in a variety of corrections settings. The implications of these findings suggest that there is justification for occupational therapy to establish corrections as a recognized area of practice.

Keywords: Incarceration, corrections, occupational therapy

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Dedication

For Mom and Dad.

Also, to my family and friends who make up the expansive support system that I am so lucky to have and for which I am eternally grateful.

Thank You.

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Chapter 1: Introduction

Background

The United States is the fourth largest country in the world with a national population of over 300 million (Central Intelligence Agency [CIA], 2014). China and India contain the leading population counts with over one billion people each (CIA, 2014). Despite having less than half the population of either China or India, America has the highest incarceration rate of any nation in the world (Deady, 2014; U.S. Department of Justice, 2013; Walmsley, 2013).

Nearly 1 in 35 American adults are currently associated with the correctional system, which includes being on probation or parole and being housed in jail or prison (Glaze & Kaeble, 2014). The variation in settings for correctional institutions makes the study of the U.S. penal system complex. Jails are typically run by local governments and house inmates with minor, short-term offenses (i.e., usually 12 months or less), people awaiting trial and sentencing, and inmates waiting for transfer to prison (Subramanian, Delaney, Roberts, Fishman, & McGarry, 2015). Prisons typically house inmates with sentences over one year and provide minimum, moderate, maximum, or super-maximum security depending on the type of criminal charges (Muñoz, 2011). State governments, the federal government, or privately owned, contracted establishments can run prisons (Austin & Coventry, 2001; Muñoz, 2011).

The National Commission on Correctional Health Care (NCCHC) aims to regulate health care practices provided to inmates in corrections settings through certification and accreditation services (Ferszt & Clark, 2012); however, facility participation is voluntary (National Commission on Correctional Health Care [NCCHC],

2015). The nature of jails is short-term and transitory making the provision of medical, mental, and rehabilitative services frequently inadequate (Kerridge, 2008; Lamb, Weinberger, Marsh, & Gross, 2007; Lindquist & Lindquist, 1999; Subramanian et al., 2015). The disparities among jails and how they are regulated complicate both standardized provision of services and any standardized study of relationships between institution, inmate, policy, and community. Prisons, being part of the state or federal governing systems, are somewhat more regulated than jails; however, the disparities between state and federal government in conjunction with the privatization of some prison facilities complicates the standardization of institutional regulations across the board (Austin & Coventry, 2001; Ferszt & Clarke, 2012; Stephan, 2008).

Over the last decade, the national discourse and much of the literature about the individual, community, and national outcomes of mass incarceration has been focused on the prison population (Subramanian et al., 2015). In the past, jails have largely been overlooked regarding recidivism and its costs, both financial and human (Subramanian et al., 2015). Recently, local jails have garnered more attention as they play a critical part in the development of offenders' involvement in the criminal justice system (CJS) and the subsequent impact on the community at large (Subramanian et al., 2015). The role and current "misuse" of local jails herein will be discussed in greater detail as a part of Chapter 2: Review of the Literature (Subramanian et al., 2015, p. 1).

There is an estimated 6.89 million adults in the correctional system, and roughly 1.5 million men and women are incarcerated in state and federal prisons (Glaze & Kaeble, 2014). Incarceration puts an enormous financial burden on society. Though corrections spending can vary widely between states and federal government, the average

annual cost of incarcerating one adult in a state prison is $31, 286 (Henrichson & Delaney, 2012). The average annual cost of housing one federal inmate is slightly less at $28, 283 (National Association of State Budget Officers [NASBO], 2013).

Incarcerated populations have grown rapidly since the 1970s, and as such corrections budgets are unable to keep up. In 2010, state corrections expenditures exceeded the aggregate corrections department budget by $5.4 billion (Henrichson & Delaney, 2012). In the same year, state and federal incarceration costs totaled $80 billion making corrections the second fastest growing national expense after Medicaid (Henrichson & Delaney, 2012; U.S. Department of Justice, 2013). Despite the high financial cost of incarceration, there is a well-documented and surprisingly common cycle of individuals being released from prison, re-offending in the community, their subsequent re-arrest, and potential return to prison. This "revolving prison door" phenomenon is called recidivism (Baillargeon et al., 2009, p.103; Durose, Cooper, & Snyder, 2014; Visher & Travis, 2003).

A national, standardized analysis of recidivism is difficult because of its multi-layered components (Durose et al., 2014). Recidivism includes one or a combination of the following after release from prison: arrest for offense (of a new crime or technical parole violation [TPV]), conviction (of a new crime), and possible jail or prison sentencing for conviction of a new crime or TPV (Durose et al., 2014). In the U.S., more than half (56.7%) of the 76.6% of individuals who *recidivate* within five years after prison do so within their first year back in the community and 49.7% *return to prison* within three years of release (Durose et al., 2014).

Comparing international rates of recidivism is difficult due to the variation in how nations define recidivism (Deady, 2014). The length of time used to define recidivism (i.e., one year, 3 years, 5 years) and the subsequent consequences of recidivism, like re-arrest, community service, increased community supervision, or incarceration are all variables (Deady, 2014). While rates of recidivism in America (52%) are comparable to Ireland (62%), Scotland (50%), and the United Kingdom (England and Wales, 46%), only in the U.S. does recidivism result in a higher rate of re-incarceration (Deady, 2014).

The International Centre for Prison Studies disseminates a report summarizing incarceration rates for every country in the world. In the tenth edition of the report, Walmsley (2013) compared incarceration rates as numbers of people imprisoned per 100,000 of the national population and found that America incarcerates 716 people, Ireland 88 people, Scotland 147 people, and the United Kingdom 148 people. One might argue that because the national population of America is much larger than the other countries of comparison, direct comparison is inaccurate; however, the two largest population counts in the world come from China and India (CIA, 2014). China incarcerates 121 people per 100,000 of the national population and India only 30 (Walmsley, 2013). Deady (2014) surmises that the incredible disparity between America's incarceration rate and that in other countries comes from the U.S. CJS incarcerating individuals for offenses that are less likely to result in imprisonment elsewhere, such as nonviolent offenses, minor drug charges, technical parole or probation violations, or minor fraudulent charges.

Eventually, 95% of the 1.5 million men and women imprisoned in America will be released and return to their communities (Woods, Lanza, Dyson, & Gordon, 2013).

The data on recidivism suggests that the majority of the newly released inmate population will reoffend over time, creating negative effects for both the individual and communities at large (Durose et al., 2014; Drakulich, Crutchfield, Matsueda, & Rose, 2012). The cycle of recidivism and reentry is called "coercive mobility" (Drakulich et al., 2012, p. 497), which disproportionately affects poor, urban, minority communities by displacing and replacing large numbers of the populace (Subramanian et al., 2015).

Coercive mobility is a phenomenon with an effect that is counterproductive to that intended by mass incarceration. While incarceration does prevent crime by incapacitating offenders, recent literature demonstrates a curvilinear relationship between coercive mobility and crime rate. When incarceration, and subsequently reentry, is concentrated in a community, a tipping point occurs when higher rates of incarceration and reentry perpetuate more crime than prevent it (Drakulich et al. 2012; Morenoff & Harding, 2014). Morenoff and Harding (2014) conducted a review of the current literature exploring the impacts of mass imprisonment and reentry on communities. Empirical evidence demonstrated that areas with higher admissions to prison, and thus higher prisoner reentry, experienced weakened social and economic structures making successful integration for returning prisoners much more difficult (Morenoff & Harding, 2014).

The successful integration into a community after release from prison is the largest predicting factor of recidivism (Woods et al., 2013). Community integration is a complex phenomenon that involves individual barriers, social barriers, and barriers of government policy (Lucken & Ponte, 2008; Woods et al., 2013). The most crucial elements for community integration include obtaining employment, adequate housing,

health care, and social support (Woods et al., 2013). Before, during, and after incarceration, individuals of the U.S. prison population often experience lower rates of employment, lower socio-economic status, less education, poor social support and poor access to resources when compared to the general population creating distinct challenges to community reintegration (Morenoff & Harding, 2014; Woods et al., 2013). The communities that experience the most prisoner return have higher rates of unemployment and weakened economic structures, greater family dysfunction and single-parent homes, greater social disorganization, overwhelmed social services, and higher rates of crime and substance abuse than other communities (Drakulich et al., 2012; Morenoff & Harding, 2014; Visher & Travis, 2003).

Public health is an additional barrier for returning prisoners as well as a simultaneous concern for communities impacted by large numbers of reentry. U.S. prisons serve as amplifiers for blood-born diseases (Baillargeon et al., 2008; Fazel & Baillargeon, 2011; Wilper et al., 2009). Elevated rates of contracted communicable diseases exist among prison populations including HIV/AIDS, hepatitis B and hepatitis C (Baillargeon et al., 2008; Fazel & Baillargeon, 2011; Wilper et al., 2009). An increase in the number of incarcerated drug offenders, intravenous and illicit drug use, inadequate access to medical services, and sexual assault all have contributed to the rise of blood-born illnesses (Baillargeon et al., 2008; Fazel & Baillargeon, 2011; Human Rights Watch, 2003; Wilper et al., 2009; Woods et al., 2013). As more individuals are released from incarceration and return to communities across the nation, there is an increased risk of spreading infectious diseases throughout the communities to which individuals return (Fazel & Baillargeon, 2011).

U.S. prisoners also experience significantly more hypertension, diabetes, heart disease, substance abuse, and mental illness than the general population (Cloud, 2014; Fazel & Baillargeon, 2011; Wilper et al., 2009; Woods et al., 2013). The elevated and diverse healthcare needs of the prison population place an additional financial burden on the communities to which individuals return after incarceration. The lack of medical coverage for many ex-offenders coupled with inadequate healthcare availability in many of those communities results in an elevated reliance on emergency care and hospitalization services (Fazel & Baillargeon, 2011; Leukefeld et al., 2006; Prince, 2006; Wilper et al., 2009; Woods et al., 2013).

Prison is a life changing experience. For some, it means a bed, shelter, regular meals, and access to medical care. For some it is an opportunity to redevelop the self through educational opportunities (Stephan, 2008). For others, prison is an introduction to different schools of crime and connection to gang activity (Morenoff & Harding, 2014). For others still it is exposure to violence, sexual assault, trauma, and mental anguish (Human Rights Watch, 2003). For everyone, prison is a deprivation of freedom and choice.

Human beings are biological, unique individuals possessing the capacity to enact choice upon their lives; simultaneously, humans are also social creatures shaped by their interactions with family, peers, and society. Throughout history, people have always found ways to occupy themselves. Humans are doers and are innately driven to engage and participate across a broad spectrum of occupations (Forsyth & Kielhofner, 2003; Townsend & Wilcock, 2004a; Wilcock, 2003). Occupational science is a discipline dedicated to systematically exploring the dynamic relationships between human beings,

the occupations in which they engage and how those occupations affect health and well-being (Wilcock, 2003; Yerxa, 1993).

Occupational scientists have established that the ability to engage in occupation is directly linked to health and make the argument that the *opportunity* to engage in occupation is necessary for development, health, and well-being (Wilcock, 2003). During incarceration, one loses the right to choose how to occupy one's time and loses the opportunity to engage in life roles for a predetermined amount of time. Occupational deprivation is a term used to describe a state of being in which over an extended period of time, external circumstances prevent a person or a group of people from engaging in occupations that would normally be done (Whiteford, 1997). Research exploring the effects of occupational deprivation on human health and well-being is limited, yet the findings are consistent (Farnworth & Muñoz, 2009; Farnworth, Nikitin & Fossey, 2004; Molineaux & Whiteford, 1999; Townsend & Wilcock, 2004a). When people are prevented from engaging in everyday life in ways that are important and meaningful to them, they develop deficits in their ability to function adequately and independently in everyday life (Farnworth et al., 2004; Molineaux & Whiteford, 1999; Whiteford, 1997; Whiteford, 2000).

Prisonization is a term used to refer to the process of inmates assimilating to prison culture and developing environment-specific habits to cope with the daily deprivations (Farnworth & Muñoz, 2009). Prisonization happens at different rates for different inmates depending on inmate characteristics, institution characteristics, and length of sentence (Farnworth & Muñoz, 2009). As people feel bound and deprived by their circumstances for a certain period of time, they begin to feel unsatisfied, restless,

and dependent upon that which constrains their behavior (Farnworth et al., 2004). By depriving mass quantities of a population of what is so intrinsically human, the prison system becomes counterproductive as it releases individuals back to communities with unmediated limitations in their ability to function in society independently (Drakulich et al., 2012; Kupers, 2008; Whiteford, 1995).

Recidivism is a national problem that carries heavy consequences on individual, societal, and governmental levels (Drakulich et al., 2012; Morenoff & Harding, 2014; Woods et al., 2013). Despite its complexity, recidivism is a problem that can be addressed. There are reduction strategies that have been employed in different states with positive results (Henrichson & Delaney, 2012; Morenoff & Harding, 2014; Visher & Travis, 2003; Woods et al., 2013). Utilizing drug courts and mental health courts for non-violent offenses has been shown to divert individuals away from prison and into treatment programs (Baillargeon, Hoge, & Penn, 2010). Utilizing more community supervision (e.g., parole, probation, house arrest, or community service) reduces the number of parole and probation violators who are returned to prison (Henrichson & Delaney, 2012). Research supports early implementation of reentry and transition programs. Due to the long-term nature of the prison experience, early implementation of support programs utilizes the length of time to facilitate the development of realistic expectations and coping mechanisms (Henrichson & Delaney, 2012; Salina, Lesondak, Razzano, & Parenti, 2011; Woods et al., 2013).

In a 1989 issue of *Occupational Therapy in Health Care*, Yerxa and colleagues stated that occupational science could help the applied practice of occupational therapy "contribute new knowledge and skills to the eradication of complex problems affecting

everyone in society" (as cited in Wilcock, 2003, p. 166). Recidivism is a complex problem affecting everyone in society. Occupational therapy is a client-centered practice that utilizes client assistance to develop individualized goals that are intrinsically motivating (Forsyth & Kielhofner, 2003). Through the use of assessment, activity analysis, and client-centered and occupation-based interventions, occupational therapists can 1) identify individual limitations pertaining to community reentry, 2) help create individualized and meaningful goals to remediate those limitations, 3) teach or rehabilitate the skills necessary for successful community reentry, and 4) design and implement programs that can serve the needs of an entire institution (American Occupational Therapy Association [AOTA], 2014).

Problem

The problem is that the occupational deprivation inherent in incarceration often causes social and behavioral deficits for prisoners that translate to an inability to integrate into the community after release, thus contributing to a revolving door phenomenon of incarceration. Occupational science and occupational therapy are well-suited disciplines to remediate the effects of occupational deprivation and address prisoner reentry. However, little is known about how occupational therapy can address occupational deprivation in corrections settings and facilitate successful community integration.

Rationale

Without providing systematic opportunities to remediate the social and behavioral deficits caused by the occupational deprivation of incarceration, recidivism will continue to place both financial burdens and public safety concerns over communities. By helping remediate individual limitations and barriers to reentry, occupational therapy can

facilitate successful community reentry and help mitigate recidivism, ultimately reducing the costs of incarceration and the burdens it places on society.

Purpose of Study

The purpose of this thesis is to capture through qualitative interview analysis, a snapshot of the current roles that occupational therapists fill in corrections settings.

Basic Definition of Terms

Coercive mobility: The concentrated phenomenon of forcibly removing residents into prison while releasing other prisoners to the public community resulting in community instability and turmoil (Drakulich et al., 2012).

Context: The variety of interrelated conditions that are within and surrounding a client. Contexts include cultural, personal, temporal, and virtual (AOTA, 2014, Table 5, p. S. 28).

Corrections: The supervision of persons arrested for, convicted of, or sentenced for criminal offenses (Bureau of Justice Statistics, 2015).

Environment: The external physical and social conditions that surround the client" in which daily occupations occur (AOTA, 2014, Table 5, p. S. 28).

Forensic occupational therapy: The application of mental health specialty practice in legal contexts (Muñoz, 2011, p. 526).

Mass incarceration: Mass incarceration refers to the millions of adults who are incarcerated proportional to the crime rate. The 'war on drugs', mandatory minimum sentencing, three-strikes laws, and return-to-prison-consequences for technical parole violations have caused the numbers of individuals housed in jails and prisons to expand rapidly since the 1970s (Cloud, 2014; Kupers, 2008). People are incarcerated for longer

periods of time and for nonviolent, minor crimes causing an expansion in the numbers of facilities built to house inmates and the subsequent costs related to the enormous growth of corrections (Drakulich et al., 2012; Kupers, 2008).

Occupational alienation: Occurs when people experience daily life as meaningless or purposeless and typically results when occupations are rigidly repetitive, and without opportunities for individual choice, control, decision-making, or creativity (Townsend & Wilcock, 2004a, p. 253).

Occupational apartheid: The systematic oppression of and lack of opportunity available to groups of people due to their socioeconomic status (Kronenberg & Pollard, 2005).

Occupational deprivation: The influence of an external circumstance that prevents a person from engaging in desired or necessary occupations over an extended period of time (Molineaux & Whiteford, 1999; Whiteford, 2000).

Occupational enrichment: The deliberate manipulation of environments to facilitate and support engagement in a range of occupations congruent with those that the individual might normally perform (Molineaux & Whiteford, 1999).

Occupational imbalance: Occurs when one is forced (i.e., socioeconomic status, physical impairment, physical environment) to focus a disproportionate amount of time and energy to certain areas of occupation, leavings others neglected (Townsend & Wilcock, 2004a).

Occupational marginalization: Occurs when social forms and policies implicitly exclude groups of people from engaging in certain occupations because those people

cannot navigate the required physical or social environments. For example, public places that are inaccessible by wheelchair (Townsend & Wilcock, 2004b).

Occupational science: The study of human as an occupational being including the need for and capacity to engage in and orchestrate daily occupations in the environment over the lifespan (Yerxa et al., 1990, p. 6).

Occupational therapy: Therapeutic intervention that promotes health by enhancing the individual's skill, competence, and satisfaction in daily occupations (Yerxa et al., 1990, p. 6).

Parole: The community supervision that offenders received when they are released from prison (Subramanian et al., 2015).

Prisonization: The process of inmates assimilating to prison culture and coping with the daily deprivations (Farnworth & Muñoz, 2009).

Probation: The community supervision that offenders receive who either do not receive jail time or are released from jail (Subramanian et al., 2015).

Recidivism: The relapse into criminal behavior by individuals who have been convicted, incarcerated, and released on charges of a previous crime (Durose et al., 2014). Recidivism is measured by arrest for a new crime or technical parole violation, conviction of a new crime resulting in a jail or prison sentence or technical parole violation resulting in a return to prison (Durose et al., 2014).

Chapter 2: Review of Literature

Occupation: The Human Experience

Humans are occupational beings. The drive to 'do' or act upon the world is an inherent concept of human nature (Wilcock, 1993). History is itself a chronicle of how humans have occupied mind, body and space over time (Wilcock, 2003; Yerxa et al., 1990; Yerxa, 1993). An occupation involves three basic components: 1) the person who finds value or meaning in the occupation, 2) the occupation itself, which has certain requirements that need to be fulfilled in order to be completed, and 3) the environment in which the person is performing the occupation (Forsyth & Kielhofner, 2003; Kielhofner & Burke, 1980). Occupational science is a discipline dedicated to systematically exploring the relationships between person, occupation, and environment (Yerxa, 1993). Occupational therapy is the applied practice of knowledge about the relationships examined between person, occupation, and environment (Yerxa, 1993).

The American Occupational Therapy Association (AOTA) updates and publishes a number of professional documents that serve as tools for the practitioner and scholar. Among these professional documents is the AOTA (2014) Occupational Therapy Practice Framework: Domain and Process (OTPF 3), which outlines the scope and practice of occupational therapy. The OTPF 3 offers definitions, explanations, and a walkthrough of the occupational therapy process. Though occupation is a multifaceted, multivariable function of life, the OTPF 3 delineates eight areas of occupation ("activities of daily living [ADL], instrumental activities of daily living [IADL], rest and sleep, education, work, play, leisure, and social participation" [p. S4, Exhibit 1]) and posits that if any one

of those areas is out of balance with the other seven, a person's well-being and health can be affected (AOTA, 2014).

The foundation of occupational science aims to inform the applied practice of occupational therapy, and other disciplines, by exploring the dynamic relationships of human occupation, and how engaging in occupations impacts health and well-being (Hammell, 2007; Wilcock, 1993; Wilcock, 2003; Yerxa, 1993). Law, Steinwender, and Leclair (1998) conducted a systematic review of empirical support exploring the aforementioned relationships. While the evidence is sparse, it overwhelmingly demonstrates that the engagement in meaningful and productive occupations has positive outcomes on health and well-being (Law, Steinwender, & Leclair, 1998). The collection of positive results presented in the review included decreased stress and depression, a decrease in negative behaviors from patients with dementia, as well as increased feelings of satisfaction, self-efficacy, and confidence (Law et al., 1998).

The study of human occupation is complex because individual context and environment are each instrumental in shaping both the person and the occupations in which he or she chooses to engage (Forsyth & Kielhofner, 2003; Yerxa et al., 1990). As a result of the variation in personal context and individual skill level throughout society, occupations are widely subjective in the meaning and value they hold for people. In addition, occupations are not equally accessible to all people (Burke, 2003; Forsyth & Kielhofner, 2003; Hammell, 2007; Wilcock, 2003). Thus, the exploration of the importance of occupation to individual health and well-being is difficult to standardize. Notwithstanding, occupational science aims to explore how different levels of

occupational engagement shape and develop individual lives (Wilcock, 2003; Yerxa, 1993; Yerxa et al., 1990).

The Model of Human Occupation

The Model of Human Occupation (MOHO) is a theory of occupational therapy, first written and published in the *American Journal of Occupational Therapy* as a four-part series by Gary Kielhofner and his colleagues in 1980 (Kielhofner, 1980; Kielhofner, 1980b; Kielhofner & Burke, 1980; Kielhofner, Burke, & Igi, 1980). Part one in the series served as a conceptual framework, which proposed foundational principles of human development and practice of occupation (Kielhofner & Burke, 1980). Forsyth and Kielhofner (2003) offered an updated and comprehensive version of MOHO in *Perspectives in Human Occupation: Participation in Life*, and posited the theoretical foundation as built upon two principles. First, the complexities of the individual, including occupational choices, are inextricably linked with environment and context; second, occupation is inherently self-organizing (Forsyth & Kielhofner, 2003). There are multiple components of MOHO that converge to explain why and how people come to do what they do, and each component is integral to the development of the next. The most necessary starting point is to describe how a person is driven to act upon the world (Forsyth & Kielhofner, 2003).

In order to explain how occupational behavior is "chosen, patterned, and performed" (p. 48), the authors of MOHO begin by explaining humans as made up of three constituent parts: volition, habituation, and performance capacity (Forsyth & Kielhofner, 2003). Volition is the thoughts, feelings, and interests that drive people to act (Kielhofner & Burke, 1980). Through context and perception of experiences individuals

develop a sense of what is important, what is enjoyable, and how effective they perceive themselves to be at acting on the world (Forsyth & Kielhofner, 2003). The positive and negative reactions that people experience coupled with what they value and desire determine their subjective level of competence and the occupational choices they make (Forsyth & Kielhofner, 2003; Yerxa et al., 1993). When performed on a regular basis, those occupational choices become automatic and habitual over time (Forsyth & Kielhofner, 2003; Kielhofner & Burke, 1980).

Habituation allows people to carry out their daily routines more efficiently (Forsyth & Kielhofner, 2003). The daily activities one performs require a certain amount of energy. As one acclimates to his or her routine actions and the relationship those actions have with the surrounding environment, less concentration and attention is needed to perform those regular activities. Stability of environment and routine allows people to attend to unexpected elements during the course of the day while still performing daily activities (Forsyth & Kielhofner, 2003). Habituation connects people to their surroundings in a functional way, allowing them to layer activities, or multitask, and fulfill multiple roles (Forsyth & Kielhofner, 2003).

The lives people lead largely depend on what they are capable of achieving. Performance capacity refers to the physiological and cognitive abilities that a person possesses (Forsyth & Kielhofner, 2003). Performance capacity will determine if a person is able to engage in an occupation, is unable to engage, or if the person must make modifications and adapt before they can perform the occupation. An example of performance capacity and how it impacts occupational engagement is the aging body. As the body ages it slows down and is more susceptible to injury, aches, and pains, often

requiring aging people to reevaluate the occupations they engage in and make necessary adjustments (Forsyth & Kielhofner, 2003).

Once the components of the person are established, one using MOHO would then consider how the interaction of those components with the environment works to form both habits and roles. Habits are a regulated, learned pattern of doing things that unfold into automated behavior (Forsyth & Kielhofner, 2003; Yerxa et al., 1990). Habits "regulate behavior…by providing a manner of dealing with environmental contingencies" (Forsyth & Kielhofner, 2003, p. 55). Habits allow people to perform daily routines more efficiently because they provide a template of action against the backdrop of the surrounding environment (Forsyth & Kielhofner, 2003).

Roles are social and cultural constructs that reflect a specific set of expected behaviors and values (Forsyth & Kielhofner, 2003). Roles often dictate the occupations that people engage in through a combination of external expectation and internal identity profoundly affecting both, how an individual perceives him or herself and how he or she is perceived by society (Forsyth & Kielhofner, 2003). Engaging in roles influences who people are and who they will become because being a teacher, a student, a mother, an actor, a doctor, a volunteer, comes with a list of social guidelines and rules for action. Every role is context dependent and an inextricable element of context in the environment (Forsyth & Kielhofner, 2003).

The environment is a critical element in any occupation, habit, or role. A person's surroundings will dictate which actions they can carry out, or not, and which actions must be modified within a given setting (Forsyth & Kielhofner, 2003). For example, once familiarized with the driving route to work, the motions and directions

become almost second nature. If there is construction along this familiar route and a detour is required, it can throw an entire morning off and can continue to affect the rest of the day. Likewise, if an individual's car breaks down and he or she must get a ride or take public transit, additional planning and rescheduling must occur in his or her daily routine to accommodate the changing setting and requirements of getting to work. MOHO serves as a guiding tool for practitioners and scholars alike because it provides a comprehensive lens with which to view and analyze the relationships between people, occupations, and environments (Forsyth & Kielhofner, 2003).

MOHO theorists recognize the impact that development, ability, context, and environment all have on occupational engagement. Use of MOHO provides therapists with the tools to assess areas of need pertaining to each component and subsequently address those needs. Forsyth and Kielhofner (2003) summarize MOHO assessment tools developed since the theory's conception. Overall, MOHO theorists have created fifteen different assessment tools that can be used to address volition, habituation, motor skills, processing skills, communication skills, and the physical or social environment (Forsyth & Kielhofner, 2003, p. 64-69). Overwhelmingly, the supporting literature indicates how occupational engagement impacts health and well-being (Law et al., 1998). Much of the literature explores the impacts of engagement in productive, healthy, legal occupations.

Occupational Science

Occupational science was introduced in the late 1980s as the scientific foundation to occupational therapy practice (Yerxa et al., 1990). Occupational scientists seek to inform occupational therapy and to justify and differentiate its place among other established therapies (Yerxa et al., 1990). Yerxa (1993) discusses the relationship of

occupational science to occupational therapy and points out that while "occupational therapy has had 70 years of experience" developing interventions to remediate peoples' limitations in daily activities, that knowledge has not been "conceptualized or organized [into] a coherent framework" or put into terms understood by the public (p. 4). As a basic science, occupational science has more freedom to explore the diverse and complex relationships between person, occupation, and environment than the applied practice of occupational therapy (Yerxa, 1993; Yerxa et al., 1990). Pulling from interdisciplinary research to establish a foundation upon which it could evolve, occupational science uses an open-systems model of human development across a continuum to reflect its humanitarian tenets, which are grounded in holism, diversity, and justice for all people (Yerxa et al., 1990).

The philosophical assumptions driving occupational science maintain that occupational patterns are naturally self-organizing because of an inherent temporal quality. Occupational engagement forces people to organize and manage time throughout the day, week, or month in order to accomplish goals and fulfill roles facilitating adaptive responses to the changing environment. A pivotal determinant of the occupational choices people make is skill level. Yerxa (1993) refers to skill level in two contexts. First, skill refers to the abilities people possess that allow them to engage in tasks of varying difficulty. Cleaning house does not involve great skill, however swimming, woodworking, or astrophysics all require different levels of honed skill.

The second context of skill involves the individual's self-perception of competence he or she has for any given activity and is largely determined by the negative or positive experiences that person has (Yerxa, 1993). Forsyth and Kielhofner (2003)

stated, “when we know ourselves to be incapable, we feel compelled in the opposite direction” (Forsyth & Kielhofner, 2003 p. 51). A young child who struggles with math may likely embrace studying and consequently may improve his or her skills when faced with encouragement and support to understand the concepts. Conversely, a young child who struggles with math, and is faced with ridicule and pressure to improve his or her grades, will likely avoid it; consequently his or her grades will suffer further.

There is some mention of maladaptive responses in the occupational science and occupational therapy literature that are discussed in the context of disability. Kielhofner (1980) discusses a young, active individual who acquires a spinal cord injury and develops maladaptive responses becoming depressed, withdrawn and apathetic toward therapy. In the “Conceptual Framework for Therapeutic Occupation,” Nelson and Jepson-Thomas (2003) mention briefly the concept of maladaptation as a function of weakened developmental structures such as when an older adult withdraws from social interactions due to hearing loss and endures subsequent embarrassment. The research that populates occupational science largely ignores the effects of the engagement in maladaptive occupations (i.e., occupations that are self-destructive or criminogenic) on the motivation, health, and well-being of individuals.

Philosophically and theoretically, occupational science recognizes the negative effects that socioeconomic, cultural, or environmental strain can have on engagement in productive occupations (Burke, 2003; Hammell, 2007; Townsend & Wilcock, 2004; Whiteford, 1997; Whiteford 2005; Wilcock, 2003). While there is some occupational research exploring the negative effects of boredom and the effects of engaging in passive leisure pursuits like watching TV or sleeping, there is little research addressing

engagement in maladaptive or illegal occupations such as drug use, drug trafficking, or gang activity (Farnworth, 1998; Farnworth, 2000).

Matsueda, Gartner, Pilianvin, and Polakowski (1992) explored how criminals ranked conventional occupations compared to criminal occupations. The authors found that many of the respondents ranked conventional, legal occupations as more prestigious. In some instances, respondents ranked criminal occupations as more prestigious than conventional occupations, and the authors postulated that respondents were often rationalizing their inability to participate in conventional society (Matsueda, Gartner, Pilianvin, & Polakowski, 1992). Little is explicitly known about the mechanisms that drive people to choose to engage in maladaptive and illegal occupations over productive and empowering occupations.

Occupational scientists, as well as MOHO theorists, recognize that achieving balance across all eight areas of occupation in the OTPF 3 is a luxury (Forsyth & Kielhofner, 2003). Wilcock (2003) admits that occupational choice is often dependent upon opportunity and economic resources as well as environment and context. A child growing up in an economically disadvantaged area will not be afforded the same resources or opportunities as a child growing up in an affluent area. As people age and develop along with their habits and roles, they learn to juggle the demands of multiple roles. Role strain occurs when a person cannot meet the multiple demands represented in several roles (Forsyth & Kielhofner, 2003). Maladaptive occupations are a derivation of maladaptive response, and can be used to compensate when role strain occurs and creates an imbalance in occupational fulfillment.

Occupational Justice

Townsend and Wilcock (2004a) developed a theory of occupational justice which puts forth the notion of an occupationally just world in which people have the freedom to choose their occupations regardless of socioeconomic status or cultural constructs. The theorists offer ideological explanations of how social constructs and policies can lead to an imbalance of occupational access across society. Occupational injustice occurs when some people flourish while the struggle of others is ongoing and unresolved (Townsend & Wilcock, 2004a).

Occupational injustice is a function of economy, national policy, and cultural values (Townsend & Wilcock, 2004a). Economy, national policy and cultural values are determinants that affect how the labor force is divided; how education, and health services are allocated; how media, recreation, and sports are valued; and how environmental conservation and transportation services are prioritized and funded (Townsend & Wilcock, 2004a). The national, cultural, and social effects of the determinants trickle down and subsequently cause isolation or overcrowding, loss of meaning and purpose, boredom and burnout, and a variety of different stressors that can impact an individual, community, or nation (Townsend & Wilcock, 2004a).

Much the same way medicine seeks to understand the positive effects of pharmacotherapy, exercise, and nutrition on the body, occupational science seeks to understand the effects of occupational engagement on human health and well-being. As humans are occupational beings by nature, it is as important to understand the effects of maladaptive occupations on health and well-being, as it is to understand the effects of disease and illness on the body. A theory of occupational justice provides a platform on

which occupational science can extend its research to explore the effects of maladaptive and illegal occupations on human health and well-being (Townsed & Wilcock, 2004a; Whiteford, 2000).

Currently, there are five major outcomes of occupational injustice and they include occupational imbalance, occupational marginalization, occupational alienation, occupational apartheid, and occupational deprivation (Kronenberg & Pollard, 2005; Townsend & Wilcock, 2004a; Townsend & Wilcock 2004b). Occupational alienation, occupational imbalance, and occupational marginalization have very little supportive literature. Therefore they are defined in the *Basic Definition of Terms* in Chapter 1 and will be discussed under "The Incarcerated Environment" section of Chapter 2.

The concept of occupational apartheid labels the systematic oppression of large groups of people by the mechanisms perpetuating mass incarceration, mass reentry, and the resultant degradation of specific communities. The long-standing lack of opportunity faced by subgroups of people, who are often geographically clustered, is often influenced by political and cultural beliefs like social assistance and the notion of the American dream—picking oneself up by the bootstraps and overcoming adversity to live a life of comfort and opportunity (Kronenberg & Pollard, 2005). Occupational apartheid is a globally developed concept and carries with it cultural and political implications that extend far beyond the scope of incarceration (Kronenberg, Algado, & Pollard, 2005).

As a term, occupational deprivation is not well integrated into occupational therapy, yet it provides a strong platform to justify the presence of occupational therapy in corrections settings (Whiteford, 1997; Whiteford, 2000; Whiteford, 2005). As a concept, occupational deprivation has been experienced by groups of people across the

globe and throughout history. Occupational deprivation occurs when external forces prevent people from engaging in desired or necessary occupations for prolonged periods of time (Farnworth & Muñoz, 2009; Molineaux & Whiteford, 1999; Townsend & Wilcock, 2004; Whiteford, 2000). Whiteford (2004) provides five illustrations of occupational deprivation: geographic isolation, problem conditions of employment, sex-role stereotypes, refugeeism, and incarceration. The broader results of occupational deprivation are not well researched, but current understanding of the phenomenon is that it results in reduced occupational capacity, lowered self-efficacy, diminished adaptive skills, and loss of identity (Molineaux & Whiteford, 1999; Whiteford, 1995; Whiteford 1997; Whiteford, 2000; Whiteford, 2005).

The unique attribute of incarceration is that deprivation is philosophically woven into the institution of punishment. Criminals are often precluded by mainstream society from consideration for anything. However, by failing to consider the effects of incarceration on inmates, society fails to note the efficacy or lack thereof, of locking people away from society for extended periods of time. Not only does incarceration by definition imply occupational deprivation, the prison environment also facilitates, often by necessity, maladaptive responses and habits with an ultimate negative effect on society as a whole (Human Rights Watch, 2003; Morris, Carriaga, Diamond, Piquero, & Piquero, 2012).

The Incarcerated Environment

Imprisonment creates a harsh environment vastly different from mainstream society. The imprisoned environment, from an occupational justice perspective, is ripe with occupational injustices. The actions inmates are required to do (e.g., in-house or cell

chores) and the actions they are allowed to do (i.e., during allotted time periods in the day) are highly regimented and rigidly repetitive, making those actions meaningless and purposeless (Farnworth & Muñoz, 2009; Whiteford, 1995; Whiteford, 1997). Inmates are forced to address certain areas of occupation, like self-care and sleep, and prohibited from addressing others like community involvement and family care. Prisoners have extremely limited resources with which to fill enormous spans of time because tool use is high restricted for safety and security (Farnworth et al., 2004). With the removal of choice and control, inmates experience occupational imbalance and occupational alienation.

There are a variety of correctional settings where charged offenders can be sent. Prison and jail are the most commonly used facilities. According to Muñoz (2011), there are many adult settings including "boot camp, prison farm, forestry or conservation camp…forensic hospital, drug and alcohol treatment facility…detention center, half way house, or community corrections facility" (p. 528). Jails and prison are the focus of corrections literature because they hold the largest numbers of people involved in the CJS (Subramanian et al., 2015). Annually, there are nearly 12 million jail admissions, which is approximately 19 times that for state and federal prisons (Subramanian et al., 2015). The ensuing discussion is limited to the correctional contexts of jails and prisons where the most extensive data is available.

Jails and prisons are run differently and serve different purposes; however, they both involve a similar degree of occupational deprivation, limited opportunity for rehabilitation, poor access to medical and health services, and are often overcrowded and unsanitary (Human Rights Watch, 2003; Rich, Wakeman, & Dickman, 2011;

Subramanian et al., 2015; Wilper et al., 2009). The negative qualities of imprisonment are in fact often exacerbated in jails due to their transitional and temporary nature and lack of systematic regulation and resources (Subramanian et al., 2015). Statistical trends suggest that American jails have become reservoirs for poor, uneducated minorities with even higher rates of chronic medical and mental health illnesses and substance abuse than that observed in prisons (Cloud, 2014; Freudenberg, Daniels, Crum, Perkins & Richie, 2005; Kerridge, 2008; Lamb, Weinberger, Marsh, & Gross, 2007; Lindquist & Lindquist, 1999; Subramanian et al., 2015).

In a report disseminated by the Vera Institute of Justice about the misuse of jails in America, Subramanian et al. (2015) elaborated on the distribution of offenses for jail detainees and found that 62% were not yet charged and awaiting trial. The vast majority (approximately 75%) of detainees, charged or not, had nonviolent offenses (Subramanian et al., 2015). In the same report, researchers found that spending just two days in jail pre-trial resulted in the increased likelihood of receiving a prison sentence over community service or probation, increased likelihood of receiving a longer sentence, and increased likelihood of recidivating upon release across all risk levels and offenses (Subramanian et al., 2015). Jail is an important preface to the discussion of the prison environment because it serves as an entry point into the CJS and has an enormous impact on future criminal involvement.

Prison is a violent, oppressive, criminal environment comprised of hyper-masculinity, volatile emotional expression, exploitation, and gang activity (Farnworth & Muñoz, 2009; Human Rights Watch, 2003; Morris et al., 2012). Inmates must often develop maladaptive skills and habits such as hyper-vigilance and social withdrawal or

isolation simply to cope (Farnworth & Muñoz, 2009). Inmates can also become increasingly volatile and aggressive while learning the criminal enterprises of their environment (Drakulich et al., 2012; Visher & Travis, 2003). Ultimately, inmates experience prisonization as environment-specific. Any maladaptive behaviors that do develop turn into habits over time (Farnworth & Muñoz, 2009).

Federal law mandates inmates have access to healthcare while incarcerated. The restriction of health services is considered cruel and unusual punishment under the 8th amendment of the United States Constitution (Wilper et al., 2009). Despite the healthcare requirement, the provision of health services is inconsistent and often grossly inadequate (Cloud, 2014). Wilper and colleagues (2009) reported on the health and health care of U.S. prisoners. The research retrospectively examined two national surveys administered by the U.S. Census Bureau to inmates in a range of correctional institutions across the country. The sample size of 39 federal prisons, 287 state prisons, and 417 jails provided a total number of 25,167 inmates who were surveyed (Wilper et al., 2009).

Inmates across all settings experienced chronic conditions like diabetes, hypertension, prior myocardial infarction, and asthma between 38% and 42% higher than the prevalence among the general population after adjusting for age comparisons (Wilper et al., 2009). Almost 14% of federal, 20% of state, and 68% of jail inmates reporting a chronic condition were not given an additional medical examination after the intake examination (Wilper et al., 2009). One in five inmates taking medication for chronic conditions before incarceration no longer received that medication after incarceration (Wilper et al., 2009). The prevalence of respondents testing positive for HIV was more

than double that among the general public population (Wilper et al., 2009). Following serious injury, 7% of federal inmates, 12% of state inmates, and 24% jail inmates were not given medical attention (Wilper et al., 2009). The authors recognized the anonymous, self-reported surveys as an underlying limitation of the study; nonetheless, the authors maintained that health services in corrections settings are generally inadequate (Wilper et al., 2009). The list of inadequacies demonstrates how poor access to healthcare leaves prisoners vulnerable to complications during incarceration.

The vulnerable and sick experience particular hardships in prison as they are more often singled out, victimized, bullied, raped, and beaten by other inmates and corrections officers (Human Rights Watch, 2003; Wolff & Shi, 2009). Rates of overall sexual assault occur in 2-5% of the incarcerated male population, and rates of overall physical victimization are ten times higher (Wolff & Shi, 2009). Victims are more often small in stature, effeminate, attractive, younger or older than the general prison population, homosexual, and mentally ill (Wolff & Shi, 2009). Transgendered prisoners experience sexual assault at a rate that is roughly 20 times higher than other prisoners (Wolff & Shi, 2009). In the non-incarcerated population, male victims of sexual assault rarely report attacks, victims are widely under acknowledged and statistics of prevalence vary; however, male victims tend to be young, white and suffering from mental illness, physical or cognitive impairments (Du Mont, Macdonald, White, & Turner, 2013; Ralston, 2012).

The breakdown of sexual and physical victimization in prison is complex because much of it is motivated by race and ethnicity, and corrections staff is reported to perpetrate both types more often than inmates (Beck, Berzofsky, Casper, & Krebs, 2013;

Wolf & Shi, 2009). Truman and Langton (2014) state that about 50% of violent victimization goes unreported outside of prison. Given the hyper-macho and oppressive atmosphere of incarcerated environments, it is difficult to estimate how many incidents go unreported.

Interracial inmate on inmate victimization is significantly more common than intraracial inmate on inmate victimization, with black inmates victimizing non-Hispanic white inmates more often (Wolff & Shi, 2009). Wolf & Shi (2009) provided a breakdown of staff on inmate victimization. Black inmates are about twice as likely to be sexually victimized by corrections staff than white inmates (Wolff & Shi, 2009). Black and Hispanic inmates are also significantly more vulnerable to staff on inmate physical violence (Wolff & Shi, 2009). The U.S. Department of Justice published a 108-page document cataloguing sexual victimization in prisons and jails as reported by inmates. The document categorizes facilities by ratings of staff on inmate and inmate on inmate victimization. Overall, findings suggest that, "serious psychological distress in prisons (14.7%) and jails (26.3%) were substantially higher (3.0%)" than rates found in the general, non-incarcerated population (Beck et al., 2013, p. 7).

The oppressive stressors of the prison environment can lead to prisoner suicide. Prison suicide is the leading cause of death among prisoners and accounts for approximately half of all prison deaths (Fazel & Baillargeon, 2011). Of particular note, half of prison suicides occur in the 6% to 8% of the prison population held in isolation (Kupers, 2008). Suicide is also among one of the leadings causes of death for recently released prisoners (Fazel & Baillargeon, 2011). The additional element of negative social culture within the prison environment further compounds the effects of occupational

deprivation. The nature of the prison environment inhibits the development of habits and coping strategies that can facilitate successful community integration by rerouting an individual's time and energy to personal safety, regulation, rules both institutional and social, and the stressors of life behind bars.

Mental Illness in the Incarcerated Population

During the late 1960s, deinstitutionalization was a drastic socio-political shift in care for persons with mental illness in the general population. The foundation of this shift was to improve mental health care and provide better, community-based treatment to people with mental illness, and to reduce the overcrowding and inhumane practices often viewed in large psychiatric hospitals (Baillargeon et al., 2009; Cloud, 2014; Kupers, 2008; Lamb & Weinberger, 2005). Following the closing of hundreds of psychiatric hospitals and subsequent displacement of thousands of individuals suffering from mental illness, the second part of deinstitutionalization was government programming providing communities with the necessary funding to develop housing and community support for the multitude of recently homeless citizens (Baillargeon et al., 2009; Cloud, 2014; Kupers, 2008). The second part of deinstitutionalization lost impetus and only a fraction of the communities promised funding for mental health services received financial support (Baillargeon et al., 2009; Cloud, 2014).

Arguably, individuals with serious mental illness (e.g., psychotic disorders, schizophrenia, bipolar disorder, major depressive disorder) are the nation's most vulnerable population (Human Rights Watch, 2003). People suffering from serious mental illness (SMI) can experience cognitive impairments in limited judgment, sensory perceptions, and limited impulse control, rendering them frequently unable to care for

themselves without community support or hospitalization (Baillargeon et al., 2008; Human Rights Watch, 2003). Deinstitutionalization resulted in creating many homeless people with little to no resources. Gradually, through the combination of substance abuse and criminogenic activity with the war on drugs, the involvement of persons with mental illness in the criminal justice system increased (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Baillargeon et al., 2010; Cloud, 2014; Kupers, 2008). Over time, jails and prisons became the modern day psychiatric hospitals, housing large percentages of people with mental illness (Lamb & Weinberger, 2005).

Prevalence studies of mental illness vary significantly due to variation in methods and procedures. Kupers (2008) estimates prevalence rates of inmates with SMI needing mental health treatment between 30% and 56% while only 10% to 12% actually receive it. The most consistent prevalence statistic states that the incarcerated population has a two to fourfold representation of individuals experiencing mental illness than the general public (Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014; Farnworth & Muñoz, 2009; Fazel & Baillargeon, 2011; Lamb & Weinberger, 2005; Wilper et al., 2009). The rates of mental illness occurring in jails is particularly high with 14.5% of males and 31% of women experiencing mental illness compared to 3.2% and 4.9% of men and women in the general public (Subramanian et al., 2015). Prisoners with mental illness experience more homelessness before and after incarceration, greater social stigma, higher rates of unemployment, higher rates of comorbid substance abuse, higher incidents of comorbid communicable disease, less education, fewer social supports, and higher exposure to trauma than prisoners with no mental illness (Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014; Fazel & Baillargeon, 2011; Mueser et al., 2004).

The Human Rights Watch (2003) disseminated an extensive report on the maltreatment of persons with mental illness in U.S. prisons both by inmates and correctional officers. Inmates suffering from severe mental illness are roughly six times more likely to be the victims of sexual assault (Beck et al., 2013). Many symptoms of mental illness such as suspicion, inability to cooperate or follow directions, assaultiveness, auditory and visual hallucinations, social withdrawal, and sensitivity often lead to either the victimization of individuals by fellow inmates or increased disciplinary measures (Baillargeon et al., 2008; Human Rights Watch, 2003). Despite the various types of prison isolation units used to segregate inmates, researchers widely caution against the use of severe disciplinary measures or solitary confinement on prisoners with serious mental illness as it is counter effective to treatment, and often leads to acute psychosis and mental breakdown (Baillargeon et al., 2010; Butler, Johnson, & Griffin, 2014; Cloud, 2014; Fazel & Baillargeon, 2011; Kupers, 2008; Human Rights Watch, 2003).

Mueser and associates (2004) examined the prevalence of trauma exposure among a male and female population with SMI such as schizophrenia, psychotic disorders, bipolar disorder, and major depression. The sample population was recruited from various mental health treatment programs in communities across four different Northeastern states (Mueser et al., 2004). The types of measured trauma exposure included physical and sexual assault during childhood, adulthood, within the past six months, and over the lifetime (Mueser et al., 2004). Findings demonstrated that together, 85% of men and women with SMI, experienced lifetime physical assault and 52%

experienced lifetime sexual assault (Mueser et al., 2004). Childhood exposure to trauma of any type was significantly associated with higher adult exposure (Mueser et al., 2004).

Overall, correlations of trauma exposure and PTSD were strong among persons with SMI (Mueser et al., 2004). The authors indicate the many symptoms of PTSD can exacerbate symptoms of SMI (Mueser et al., 2004). PTSD has high associations of substance abuse including alcohol, which further exacerbate symptoms of SMI (Mueser et al., 2004). While Mueser and colleagues (2004) did not examine trauma exposure among incarcerated persons with SMI, they did urge that institutions serving people with SMI must consider the impact of trauma exposure and PTSD on consumers of services because they complicate treatment outcomes (Mueser et al., 2004).

Baillargeon, Binswanger, Penn, Williams, and Murray (2009) analyzed incarceration patterns for inmates with SMI including major depressive disorder, bipolar disorder, schizophrenia, and psychotic disorders using one of the largest prisons systems in the nation. Overall, prisoners with SMI were given longer sentences, were incarcerated until their maximum date and more often released without community supervision, and engaged in more violent crime leading to repeat incarcerations (Baillargeon et al., 2009; Kupers, 2008). Of note, inmates with bipolar disorder, psychotic disorders, and schizophrenia all experienced recidivism in a stepwise fashion, indicating that with each previous incarceration, individuals became less able to cope outside prison walls (Baillargeon et al., 2009). Society's approach to mental health creates a revolving door of incarceration for inmates with mental illness as adequate mental health care is virtually unavailable to many whether they are behind bars or not (Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014).

The literature exploring the treatment of incarcerated persons with mental illness demonstrates that the prison environment is counterproductive to treatment and environmental conditions often accelerate mental deterioration or exacerbate acute psychosis (Cloud, 2014). Despite the distinct needs of inmates with mental illness, few correctional institutions have specialized mental health treatment units removed from the general prison milieu (Baillergeon et al., 2010; Kupers, 2008). Upon release back into the community, all prisoners immediately face an entirely different set of stressors. The physical and psychological stressors of the prison environment make all inmates more vulnerable when coping with community reentry (Woods et al., 2013). Inmates with mental illness are exceptionally vulnerable to the stressors of the prison environment, and the challenges they face when reentering into the community are compounded by mental illness (Baillargeon et al., 2010; Wilper et al., 2009; Woods et al., 2013).

The Forensic Hospital

Individuals whose mental status renders them unable to cope within the social prison milieu are sent to a forensic psychiatric setting to receive treatment. A forensic psychiatric setting is a treatment-focused setting with the dual purpose of rehabilitating severe mental illness while protecting the public (O'Connell & Farnworth, 2007). Forensic patients also include individuals who have been deemed Incompetent to Stand Trial, individuals labeled Not Guilty by Reason of Insanity, and individuals who pose a serious physical threat to either themselves or others while in prison because of severe mental illness (O'Connell & Farnworth, 2007).

Forensic psychiatric settings are commonly located on secure units within a psychiatric hospital. There are other settings that provide forensic psychiatric services;

however, due to the parallels between the forensic psychiatric hospital environment and the incarcerated environment, the ensuing section will be focused on secure forensic units (Farnworth et al., 2004). Secure forensic units often include maximum-security units and low-medium security units and are staffed by medical and security personnel. Treatment is typically long-term with the goal to stabilize and rehabilitate patients for eventual community integration (O'Connell & Farnworth, 2007).

Little information is available on the treatment schedules or programs for forensic patients. Farnworth, Nikitin, and Fossey (2004) conducted a time use study on a forensic ward in Australia using mixed quantitative and qualitative methods. Eight men from the forensic ward were recruited for the study, given time use diaries and participated in focus groups. Over 90% of their time was found to be spent sleeping or eating. Due to security constraints affecting opportunity and access to resources, all participants engaged overwhelmingly in passive leisure activities such as watching TV, drinking coffee, smoking or sleeping (Farnworth et al., 2004). The forensic patients also reported on their perceptions of the groups that were available throughout the week (Farnworth et al., 2004). Reports on various groups ranged from boring and meaningless, to demeaning and childlike (e.g., finger painting), to fun and engaging. Unanimously, groups that were enjoyed by patients were reported to be too infrequent and hinged upon staff availability (Farnworth et al., 2004).

The authors argued that occupational imbalance occurred on the ward because patients were severely limited to only a few occupational choices (Farnworth et al., 2004). The participants were forced to engage in repetitive and highly structured activities or risk not complying with treatment, as such occupations became meaningless

and purposeless leading to occupational alienation (Farnworth et al., 2004). Overtime, occupational deprivation leads to institutionalization and patients become dependent upon the structure and lack of control and independence (Farnworth et al., 2004; Helbig & McKay, 2003; O'Connell & Farnworth, 2007).

Forensic psychiatry is reported to be a difficult and challenging setting because the patients can become agitated and violent (Freuh et al., 2005; O'Connell & Farnworth, 2007; Sailas & Fenton, 2012). While patient aggression is often seen as volitional, patients with "trauma history, mental illness, addictions, or those who have developed problematic behavioural patterns" can be unaware of their "sensory needs or stress responses" (Chalmers, Harrison, Mollison, Molloy, & Gray, 2012, p. 35). It is well documented that mental illness, substance abuse, and trauma histories frequently co-occur in both prison and psychiatric populations (Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014; Fazel & Baillargeon, 2011; Meuser et al., 2004). The most common methods of dealing with patient aggression are seclusion and restraint, but research indicates such methods can be harmful (Chalmers et al., 2012; Freuh et al., 2005; Mullen, Champagne, Krishnamurty, Dickson, & Gao, 2008; Wale, Belkin, & Moon, 2011).

Seclusion is a method used to contain an aggressive or assaultive patient in a bare room while restraints are measures used to physically constrict bodily movement (O'Connell & Farnworth, 2007). At times, assaultive patients can jeopardize the safety of patients and staff, and as a result these methods are supported as last resort methods (Freuh et al., 2005). However, seclusion and restraint (S/R) are often overused, and are reported to traumatize and re-trigger patients, while resulting in increased risk to patient

and staff safety (Chalmers et al., 2012; Freuh et al., 2005; Mullen et al., 2008; Wale, et al., 2011). Despite the invasive force required to implement S/R and its frequency of use, the literature supporting its efficacy is sparse.

Sailas and Fenton (2012) conducted a meta-analysis of S/R practices with aims to report on the effectiveness of S/R and the effectiveness of methods used to prevent S/R. The research criteria were strict and limited to randomly controlled experiments (Sailas & Fenton, 2012). The authors discovered 2,155 citations of S/R, of these, 18 studies were identified for potential inclusion (Sailas & Fenton, 2012). Despite the frequent utilization of S/R, zero studies utilized randomly controlled, experimental designs to explore the effects of S/R (Sailas & Fenton, 2012). The author's found limited qualitative studies demonstrating that the invasive and forcible methods caused trauma in patients and compromised safety of both patients and staff; however, these studies were not included because they did not meet inclusion criteria (Sailas & Fenton, 2012). The authors concluded that alternative methods needed to be implemented for ethical reasons (Sailas & Fenton, 2012).

A paradigm shift is occurring across forensic psychiatric settings to incorporate client-centered, sensory-based interventions and reduce the use of S/R (Chalmers et al., 2012; Duncan, Munro, & Nicol, 2003; Mullen et al., 2005; O'Connell, 2007; Wale et al., 2011). Although this culture shift is slow, research is demonstrating that methods used to prevent S/R are effective. Providing sensory education to both staff and patients, utilizing sensory rooms, and incorporating weighted blankets with patients as preventative, preparatory, or purposeful interventions have all been documented to improve patient outcomes regarding agitation, aggression and decreased use of S/R

(Chalmers et al., 2012; Mullen et al., 2005; O'Connell & Farnworth, 2007; Wale et al., 2011).

Chalmers, Harrison, Mollison, Molloy, and Gray (2012) developed personalized safety plans for patients and implemented the use of a multi-sensory room on a psychiatric inpatient unit in Australia. The personalized safety plans were filled out by patients and used to inform staff of environments or situations that resulted in feelings of anxiety or agitation (Chalmers et al., 2012). A sensory room was built and incorporated items to engage multiple senses such as a massage chair, beanbag chairs, lollipops, music, a water feature, and different lighting options (Chalmers et al., 2012). Patients were to document when, why, and for how long they utilized a sensory room, as well as how they felt before and after (Chalmers et al., 2012). Staff documented similar information while supervising patient use of the sensory room (Chalmers et al., 2012). Although the staff was hesitant to accept the new sensory programming, with education, demonstration, and time they were reporting positive results and were more supportive and engaged in the programming (Chalmers et al., 2012). Overall, results were encouraging and positive with patients and staff both reporting significant decreases in patient anxiety and agitation, as well as a reduction in the use of S/R (Chalmers et al. 2012).

While the aforementioned study did not specify a forensically involved psychiatric population, the implications are still notable. Most forensic patients will be returned to the community where they will face many of the same challenges non-forensic inmates will face but in conjunction with balancing a serious psychiatric illness. Although studies involving psychiatric patients cannot be generalized to a non-

psychiatric population, the implications for promoting successful rehabilitation using positive environmental changes and client-centered care are likely important to consider for community re-integration efforts.

There can be a valuable role for occupational therapy to play in the forensic setting given that, as a client-centered profession, it has long since recognized the importance and effectiveness of using sensory modalities to improve patient modulation and regulation (AOTA, 2014b). Forensic occupational therapy has been an established area of practice in countries like the UK, Australia, and New Zealand (Chalmers et al., 2012; Duncan et al., 2003; Farnworth et al., 2004; Mullen et al., 2008; O'Connell & Farnworth, 2007; Whiteford, 1995; Whiteford 1997). Forensics has yet to gain momentum as an area of practice in occupational therapy in the United States but it is gaining recognition (Eggers, Muñoz, Sciulli, & Crist, 2006; Muñoz, 2011; Wale et al., 2011).

The secure forensic unit is a complex setting. It is an important element to consider in the discussion of corrections because many prisoners suffer from serious mental illness. Additionally, researchers have established that certain punitive practices can result in psychiatric deterioration. Despite the treatment-focused nature of the secure forensic unit, women who are treated in such units are treated differently than men, and remain a vulnerable and "neglected group with specific needs" (O'Connell & Farnworth, 2007, p. 187).

The Female Incarcerated Population

Women are currently the fastest growing incarcerated population (Baillargeon et al., 2010; Cloud, 2014; Fazel & Baillargeon, 2011; Ferszt & Clark, 2012; Freudenberg et

al., 2005; Salina et al., 2011; Salem, Nyamathi, Idemundia, Slaughter, & Ames, 2013). There are distinct gender differences between incarcerated men and women, and while there is increasing recognition and attention being paid to the needs of female inmates, research and reintegration efforts are still largely focused on the male population (Baillargeon et al., 2010; Bergseth, Jens, Bergeron-Vigesaa, & McDonald, 2011; Binswanger et al., 2011; Martin, Dorken, Wamboldt, & Wootten, 2012). Current researchers established that female prisoners have very distinct needs across the continuum of their involvement in the criminal justice system, including release and community reentry (Bergseth et al., 2011; Cloud, 2014; Ferszt & Clark, 2012; Freudenberg et al., 2005; Martin et al., 2012; Salem et al., 2013; Salina et al., 2011).

Women involved in the criminal justice system experience significantly higher rates of physical, emotional and sexual trauma, mental illness, and substance abuse than do their male counterparts or women in the general public (Baillargeon et al., 2010; Cloud, 2014; Ferszt & Clark, 2012; Freudenberg et al., 2005; Martin et al., 2012; Salem et al., 2013). Estimates of trauma experience range between about two-thirds and three-quarters of the entire incarcerated female population, with some regions experiencing even more (Freudenberg et al., 2005; Salem et al., 2013; Salina et al., 2011). Salem and colleagues (2013) reported on various findings of trauma among incarcerated females indicating that 75% of women experience severe physical trauma (e.g., stabbing, rape, shooting) by an intimate partner, 35% experience marital rape, and 77% experience severe physical trauma by individuals with whom they are not intimate. Given the high incidence of physical, sexual, and emotional violence that so many incarcerated women experience, the female population also experiences significantly higher rates of mental

illness, substance abuse and dependency than do their male counterparts (Fazel & Baillargeon, 2011; Freudenberg et al., 2005; Salem et al., 2013).

Post Traumatic Stress Disorder (PTSD) is becoming an increasing point of interest among researchers regarding the incarcerated female population. Incarcerated women experience extensive exposure to trauma and lifetime physical, emotional, and sexual abuse, prior to, during, and after incarceration (Ferszt & Clark, 2012; Salina et al., 2011; Salem et al., 2013). Salina and colleagues (2011) examined the needs of incarcerated women in a large urban county jail and found that 75% of the women in their sample experienced diagnosable PTSD. The implications of PTSD are many because self-medicating is common to try and abate symptoms (Mueser et al., 2004; Salina et al., 2011). Subsequent deterioration of daily functioning, personal relationships, and mental health are often a result (Freudenberg et al., 2005; Salina et al., 2011).

In a report published by the U.S. Department of Justice, more than half of the women included had past drug offenses; one-third admitted that their offenses were specific to obtaining drugs; and 40% were under the influence at the time of arrest for their current offense (Bureau of Justice Statistics, 1994). Freudenberg and associates (2005) conducted a retrospective analysis of two programs implemented in New York City jails aimed at the effects of substance abuse treatment and public policy related to reintegration for adolescent males and adult women. Drug involvement was found to be a major predictor of recidivism for women (Freudenberg et al., 2005). With a sample size of 476 women, 91% of women reported using hard drugs (e.g., crack, cocaine, heroin) six months prior to their arrest while only 42% participated in drug treatment programs during incarceration (Freudenberg et al., 2005).

The increase of substance abuse leads to an increase in dependency and quite often an increase of risk-taking behaviors such as intravenous drug use, needle sharing, and promiscuity (Baillergeon et al., 2008; Fazel & Baillargeon, 2011; Ferszt & Clark, 2012). Ultimately, the behaviors associated with substance abuse degrade professional and personal relationships as well as family functioning (Freudenberg et al., 2005). The increase of risk-taking behaviors demonstrated by many incarcerated women can lead to an elevated prevalence of communicable disease and sexually transmitted infections (Baillargeon et al., 2008; Fazel & Baillargeon, 2011). Community reentry is further compounded by the elevation of serious health needs, which adds to the public health concern (Fazel & Baillargeon, 2011; Salem et al., 2011).

HIV among incarcerated females is reportedly higher than among male counterparts, ranging from 3% to 35% (Ferszt & Clark, 2012; Salem et al., 2013). Hepatitis B and hepatitis C are also cause for public health concern with reports of prevalence at 36% and 34%, respectively (Ferszt & Clark, 2012; Salem et al., 2013). In addition to higher rates of communicable disease, incarcerated women experience disproportionately higher rates of sexually transmitted infections (STIs) than do their male counterparts or the general public. Cloud (2014) reported that chlamydia and gonorrhea are more prevalent among incarcerated women than in any other setting; likewise the "rates of syphilis among women incarcerated in New York City [is] 1,000 times that seen in the general public" (p.10). The occurrence of STIs and communicable diseases among incarcerated women is not solely attributed to substance abuse and promiscuity; sexual victimization during incarceration is found at higher rates than

incarcerated men. Incarcerated women are sexually victimized by another prisoner three times as much as incarcerated men and twice as often by staff (Cloud, 2014).

A unique gender difference among incarcerated men and women, and one that has a profound impact on the individual and community, is pregnancy. Incarcerated women make up approximately 7% of the entire incarcerated population; of the 7%, about 6% of the population is pregnant (Cloud, 2014; Ferszt & Clark, 2012). Ferszt and Clark (2012) point out that standards of pregnancy care have been established by national organizations such the National Commission on Correctional Health Care and the American Public Health Association. Participation in these national, accredited programs is voluntary, thus there is no process to ensure standardized access and accountability in state prisons across the nation (Ferszt & Clark, 2012; NCCHC, 2015). In the same study, the authors attempted to administer surveys to state prisons across the nation covering a range of prenatal and postnatal care administered to incarcerated women, only 19 facilities participated (Ferszt & Clark, 2012). Though a range of care exists between state facilities, overall the findings indicated that prenatal and postnatal care, including education and support services, is inadequate for incarcerated women compared to women in the general public (Ferszt & Clark, 2012).

The inadequate prenatal care available to incarcerated women, compounded by high levels of stress and carcinogenic exposure, results in higher rates of premature birth, low birth weight, and preeclampsia compared to women in the general public (Cloud, 2014; Fazel & Baillargeon, 2011; Ferszt & Clark, 2012). In comparison to their non-incarcerated counterparts and with variables adjusted for, women who give birth in prison experience fewer stillbirths and low birth weights (Fazel & Baillargeon, 2011). This

difference is most likely due to women in prison having shelter, regular meals, safety from abusive partners, some degree of prenatal care, and preclusion from substance abuse (Fazel & Baillargeon, 2011). Nonetheless, the ramifications felt by incarcerated women with children are complex. Parenting responsibilities create an additional stressor for women during incarceration and an additional barrier for women reentering the community.

Approximately 80% of incarcerated women have minor children (Bergseth et al., 2011; Freudenberg et al., 2005; Salina et al., 2011). In 2000, 1.3 million children had mothers in jail or prison and since then the numbers of incarcerated women has grown (Salina et al., 2011). Less than 25% of minor children live with their biological father while their mother is incarcerated (Salina et al., 2011). Children of female inmates are five times more likely to be placed in state care than are children of male inmates (Bergseth et al., 2011). Supportive family relationships are essential to women in prison because the majority of those children live with grandparents or other relatives while their mothers are detained (Salina et al., 2011). The reality for many women is that incarceration places serious strain over family and mother-child relationships (Bergseth et al., 2011; Ferszt & Clark, 2012; Salina et al., 2011). It is not uncommon for women to be detained in correctional facilities that are hours away from their families and children. Long distance transportation can make visitation impossible for those who do not have the financial capacity to travel. Such situations further complicate efforts to preserve personal relationships (Bergseth et al., 2011).

The literature on gender differences for incarcerated adults highlights a cyclical pattern for a majority of women: trauma and abuse, self-medication and the subsequent

drug, and sex-related charges for which incarceration is the consequence (Ferszt & Clark, 2012). The provision of treatment for substance abuse, health care, and mental illness during incarceration is inadequate (Bergseth et al., 2011; Salem et al., 2012; Salina et al., 2011). The findings of Salina and associates (2011) support the assertion that PTSD often "interferes with the utilization of positive social supports and community services" (p. 374). Many women are faced with compounded barriers to successful community reintegration, leaving them exceptionally vulnerable to relapse and recidivism (Bergseth et al., 2011; Cobbina, 2010; Salem et al., 2012; Salina et al., 2011).

A tragic by-product of this ineffective system, aside from the revolving door phenomenon itself, is felt by millions of children. Perhaps due to unstable parent relationships, shuffled and often temporary living conditions, and poor financial stability, "children of prisoners are twice as likely to have antisocial outcomes and mental health issues than their peers without imprisoned parents" (Fazel & Baillargeon, 2011, p. 961). The rapid increase of incarcerated women has enormous community implications as it is highly damaging to family structure (Bergseth et al., 2011; Ferszt & Clark, 2012; Salina et al., 2011). The focus of rehabilitation efforts to improve community integration for all prisoners is of growing concern and importance.

Racial Inequalities

The disproportionate representation of minorities in the CJS is factual and detrimental to minority communities (Wilper et al., 2009). According to Subramanian and colleagues (2015), together blacks and Latinos make up 31% of the general population, yet they account for 51% of the entire U.S. jailed population. In prisons, 37%

of the population is comprised of black males, 32% white males and 22% Latino males; black women are incarcerated at twice the rate of white women (Carson, 2014).

The literature exploring the unequal distribution of race in the U.S. penal system overwhelmingly points to a deleterious cycle that begins with early involvement in the CJS by young black males. Poor, urban, minority communities experience higher policing practices (Subramanian et al., 2015). Black males are imprisoned at a rate six times higher than white males (Cloud, 2014; Subramanian et al., 2015). Communities experience the subsequent degradation of minority family structure, the reduced employability of formerly incarcerated black males, and ultimately community disintegration as the collective economic viability drops (Drakulich et al., 2012; Subramanian et al., 2015). Discourse on racial inequalities in the CJS and the barriers they create for many people is imperative to the improvement of current incarceration practices and for national cohesion. Given its complexities, it is beyond the purview of this literature review.

Community Integration

For both men and women, community reintegration is indirectly correlated to recidivism because inadequate community reentry is the largest predicting factor of criminal re-offense (Woods et al., 2013; Visher & Travis, 2003). Reentry is a complex process that places high demands on a population with very limited resources (Drakulich et al., 2012). The returning prisoner population often has inadequate finances, unstable housing, poor social ties, and faces rigid social stigmas that can be felt fourfold. Social stigmas exist against people with substance abuse and dependency issues; people who experience mental illness; people who experience both; and particularly people who are

female and experience one or any combination of the aforementioned stigmas (Baillargeon et al., 2010; Drakulich et al., 2012; Freudenberg et al., 2005; Morenoff & Harding, 2014; Salem et al., 2011; Visher & Travis, 2003; Wolff, Shi, & Schumann, 2012; Woods et al., 2013). Woods, Lanza, Dyson, and Gordon (2013) describe three types of barriers to community reentry that prisoners must manage to work through in order to reintegrate successfully: universal, selective, and indicated.

Universal barriers are those faced by all prisoners returning to the community (Woods et al., 2013). All prisoners upon return must find employment, housing, social support, and access to health care. Economic strain is the primary barrier to reentry (Drakulich et al., 2012; Morenoff & Harding, 2014; Woods et al., 2013). Individuals with criminal records who have spent time in prison have an extremely difficult time finding work, not only because many employers refuse to hire ex-criminals but also because individuals with a felony charge are legally prohibited from employment in a variety of positions (Drakulich et al., 2012; Lueken & Ponte, 2008; Morenoff & Harding, 2014; Salem et al., 2011; Salina et al., 2011; Visher, Debus-Sherrill, & Yahner, 2011; Woods et al., 2013). Additionally, many social programs preclude individuals with felony charges (Salina et al., 2011). Lack of employment reduces housing options and access to health care. Social connections are another primary barrier because incarceration places great strain on family relationships, which often provide financial, housing, and emotional support (Bergseth et al., 2011; Morenoff & Harding, 2014; Salina, et al., 2011; Visher & Travis, 2003; Woods et al., 2013).

Selective barriers affect a "subgroup of formerly incarcerated individuals [with] specific needs that place them at increased risk of recidivism" (Woods et al., 2013, p. e2).

Examples of selective barriers include the portion of the incarcerated population that has less education, fewer resources, poor social support, and individuals who return to areas of high crime (Woods et al., 2013). Incarcerated women with children experience particular selective barriers as the reentry needs of mothers are compounded by the time and financial constraints of parenting; simultaneously, women must balance the demands of community integration, and locate and pay for childcare while they dedicate time to supporting themselves and their family (Ferszt & Clark, 2012; Salina et al., 2011). A selective barrier of particular note is substance abuse. The percentage of the incarcerated population with substance abuse problems is so far above that of the general population that it becomes a subgroup (Cloud, 2014; Fazel & Baillargeon, 2011; Salina et al., 2011; Woods et al., 2013). Research varies, but estimates of substance abuse among the incarcerated population are between five and nine times higher than those among the general population (Cloud, 2014).

Indicated barriers affect returning prisoners on an individual level and involve existing health issues (Woods et al., 2013). Physical and mental health issues, as well as substance abuse, compound the difficulties of finding employment, financial support, and access to medical care (Baillargeon et al., 2010; Fazel & Baillargeon, 2011). There is a disproportionate prevalence of both acute and chronic physical and mental health problems among the prison population (Cloud, 2014; Fazel & Baillargeon, 2011). Inadequate treatment during incarceration can leave health issues exacerbated upon release (Cloud, 2014; Fazel & Baillargeon, 2011; Rich, Wakeman, & Dickman, 2011).

Prisoner reentry is not solely an individual problem; it drains community resources and compromises public safety (Drakulich et al., 2012; Fazel & Baillargeon,

2011). Returning prisoners carry higher rates of communicable diseases, such as HIV, hepatitis B, and hepatitis C; they have significantly higher rates of substance abuse and dependency; and they represent a disproportionate percentage of the national population experiencing mental illness (Baillargeon et al., 2008; Cloud, 2014; Drakulich et al., 2012; Fazel & Baillargeon, 2011; Morenoff & Harding, 2014; Wilper et al., 2009; Woods et al. 2013). Despite the diverse medical needs of much of the prison population, often times ex-offenders are dropped from Medicaid during incarceration, leaving them without access to health care (Baillargeon et al., 2010; Fazel & Baillargeon, 2011). An additional financial burden is placed on families and communities to support returning prisoners who must rely on emergency services.

Not only does reentry compromise public health and safety, it degrades the social and economic fabrics of a community. Drakulich and colleagues (2012) found that the social "churning" (p. 495) of coercive mobility reduces community efficacy by way of weakening family structures, causing mistrust among neighbors, draining social resources, and disenfranchising a large percentage of the returned population. From an economic perspective, in addition to the difficulties obtaining employment that returning prisoners face, they often incur substantial debt from legal fees (Drakulich et al., 2012). The high rates of un- or underemployment in areas that experience coercive mobility place higher demands on social welfare programs. There is often an increase of criminogenic situations because people have poor access to legal financial means, greater financial stressors, more free time, and more criminal associations (Drakulich et al., 2012).

Living as a member of society places expectations and demands on all people. People are sent to prison because of an inability to cope with the demands of society and thus they often resort to crime. By "locking [people] in isolation with no meaningful activities" society is exacerbating "uncontrollable behavior" instead of "correcting …errant behaviors" (Kupers, 2008, p. 1007). Failing to provide rehabilitative programs to prisoners ultimately dissolves certain communities and further isolates them from mainstream society, perpetuating a revolving door phenomenon of incarceration and social fragmentation. (Baillargeon et al., 2009; Drakulich et al., 2012; Morenoff & Harding, 2014; Visher & Travis, 2003).

Prisoner Support and Rehabilitation

Providing supportive programming in prison improves community reentry success by diminishing the effects of occupational deprivation inherent in the prison environment. It is well researched, though methods and results are inconsistent, that adequate rehabilitative and supportive programming offered in prison or during transition into the community can be effective in reducing recidivism (Lipsey & Cullen, 2007; Morenoff & Harding, 2014). Successful programming has been found more effective when it provides holistic, client-centered care (Cobbina, 2010; Lipsey & Cullen, 2007). Numerous programs have been developed and implemented in prisons, and jails, across the country, which have been documented to drastically improve reentry success.

Woods and colleagues (2013) analyzed the Connecticut Building Bridges Reentry Initiative (CRI) which was developed to support community reentry through stable housing and employment initiatives, and increased community support, substance abuse, and mental health treatment. The overall aim of the CRI was to reduce recidivism and

lower incarceration costs. Using a prevention framework and client-centered methods, community supervisors were engaged and involved, meeting regularly with individuals (n= 173) to check in and establish and revise personal goals. The program strengths included helping men obtain housing, social support, education, and quality of health. Additionally, the program demonstrated a 12% recidivism rate after one year compared to the national one-year recidivism rate of nearly 50 percent (Durose et al., 2014; Woods et al., 2013).

Windsor, Jemal, and Benoit (2014) from Rutgers, State University of New Jersey, School of Social Work, implemented and revised a manualized reentry program called Community Wise. The program, designed to support both men and women transitioning back into the community, utilizes an empowering philosophy to educate and support the enrollees. Community Wise "aims to empower participants to combat structural and internalized oppression by developing critical analysis skills and implementing social change projects" (Windsor et al., 2014, p. 502). Due to a small sample size (n=26), the positive effects across all outcome measures did not reach statistical significance, but the vast majority (79%) of participants found Community Wise to be greatly helpful. All participants experienced reduced psychological distress and substance abuse, as well as increased recognition and understanding of cultural and ethnic issues. The male group and the female group both had better outcomes than the mixed group, emphasizing the need for gender-specific programs (Windsor et al., 2014).

Salina, Lesondak, Razzano, and Parenti (2011), associated with the Department of Psychiatry and Behavioral Sciences at Northwestern University, Chicago, Illinois, implemented a program designed for women with co-occurring disorders in a large,

urban county jail. The jail setting already utilized a Gender Responsive Treatment Program (GRTP), a diversion program providing the opportunity for substance abuse treatment during the day and community return at night (Salina et al., 2011). The sample of participants used was drawn from those already involved in the GRTP (Salina et al., 2011). The aim of the trial Safety and Empowerment program was to provide women with co-occurring substance use and Axis I mental disorders with "trauma-informed integrated treatment and HIV-prevention skills" (Salina et al., 2011, p. 369).

The overall study highlighted which needs of incarcerated women were unmet and how they impacted reentry (Salina et al., 2011). A large percentage of women reentering the community had many basic needs that were unmet including housing, jobs, job skills, medical care, substance abuse, and mental health treatment. Safe housing was considered among the most critical because women subject to homelessness or abusive, unsafe environments are much more likely to reoffend (Salina et al., 2011). The authors supported beginning reentry programming as early as possible during incarceration to allow more time for development of new habits and skills (Salina et al., 2011). The importance of discerning areas of need for women transitioning out of incarceration is critical to delineate funding for supportive programming (Bergseth et al., 2011).

A unique program, the Community Reintegration Project (CRP), was born from the occupational therapy department at Duquesne University and their collaboration with community resources (Eggers et al., 2006). The CRP was developed and implemented community reentry programs for qualified inmates detained in the Allegheny County Jail. The aims of the program were to develop occupational patterns among the inmates that promoted successful community integration and diminished maladaptive occupations

such as substance use and criminogenic activity (Eggers et al., 2006). The collaboration between community resources and the occupational therapy department led to the Allegheny County Jail Project (ACJ Project) which sought to provide inmates with vocational and community living skills in order to help them obtain and maintain employment (Eggers et al., 2006).

Ultimately, the CRP and the ACJ Project saw one enrollee return to jail after 11 months compared to a 60% recidivism rate for the area. The ACJ Project saw only 12.1% of enrollees who were successfully placed in competitive employment recidivate compared to the 46.5% who were never placed (Eggers et al., 2006). Eggers, Muñoz, Sciulli, and Crist's (2006) program is paramount to the justification and future development of the provision of occupational therapy services to support community reentry and reduce recidivism.

Supportive programming can address a variety of inmate needs such as education, job skills training, parenting, strengthening family relationships, coping strategies, adaptive skills, mindfulness, self-expression, and choice-oriented opportunities (Dekhtyar, Beasley, Jason, & Ferrari, 2012; Salina et al., 2011). Increasing occupational involvement and choice-oriented opportunities is challenging while maintaining the strict security and safety protocols necessary in corrections settings; yet, occupational science provides a platform for addressing this dichotomy (Farnworth & Muñoz, 2009).

Occupational Therapy

Occupational therapy is the applied practice of knowledge regarding the dynamic interactions between person, occupation, and environment. Occupational therapy has existed as a profession since the early 1920s (Gordon, 2009). Due to a growing

collection of ever-morphing frames of reference and the profession's migration from mental health to the medical model and then to the adoption of more holistic, client-centered philosophical tenets, a uniform conceptual framework has never been accepted (AOTA, 2014; Gordon, 2009; Hammell, 2007). Neither has a uniform definition of occupation itself been accepted by the profession (AOTA, 2014). This lack of clarity about the professions scope and provision of services has translated to constant public misunderstanding of occupational therapy (Hammell, 2007; Yerxa, 1993).

At its conception, occupational therapy was focused in psychiatric institutions and was considered the skilled application of productive work to remediate mental disturbances and increase patients' self-efficacy, competence, and independence (Gordon, 2009). During war times, occupational therapy experienced a paradigm shift when it began providing occupation-based therapies to wounded soldiers and veterans (Gordon, 2009). With this shift in setting, the field began to mirror a biomedical model in order to align itself more closely with medicine (Gordon, 2009). Since that time, occupational therapy has cemented itself in traditional roles that are most commonly acute, inpatient, or outpatient hospital settings, skilled nursing facilities, school districts, and community-based settings (Evenson, 2009). Additionally, occupational therapists are qualified to provide consultation services to organizations, institutions, and entire communities (AOTA, 2014). The last few decades have seen another paradigm shift, as occupational therapists and scientists alike are trying to return the profession back to its roots of engaging in productive, functional, meaningful work to facilitate rehabilitation of a variety of different limitations (Gordon, 2009).

Regardless of the frame of reference, setting, or client limitation, the fundamentals of occupational therapy remain the same: using holistic and client-centered interventions in order to create, promote, remediate, restore, maintain, modify, or prevent physical, cognitive, or environmental limitations from inhibiting a client's desired performance and participation in life (AOTA, 2014, Table 8, p. S33). Imprisonment creates a bleak and incredibly restricted environment, but occupational therapists are trained to consider all components that impact occupational performance and find creative ways to offer interventions.

Occupational enrichment is the deliberate manipulation of environment in order to facilitate engagement in occupations an individual might normally perform (Molineaux & Whiteford, 1999). Occupational therapists are specially trained at skilled activity analysis, which allows them to analyze and determine solutions to providing holistic, client-centered care to inmates while staying within the confines and regulations of corrections (AOTA, 2014b; Farnworth & Muñoz, 2009). Activity analysis is a complex synthesis of knowledge about physical and mental body systems, recognizing the necessary components of an occupation, considering the implications of the environment and culture; and how, together, they all impact function (AOTA, 2014). Occupational therapists can use occupational enrichment as a conceptual framework to providing adequate and effective supportive programming in corrections settings (Molineaux & Whiteford, 1999).

Client-centeredness and holistic care are central tenets to occupational therapy practice (AOTA, 2014; AOTA, 2014b; Crepeau, Schell, & Cohn, 2009). Through clinical assessment, occupational therapists may identify individual needs during and

after incarceration, and also provide motivating, functional treatment that can address a range of areas of need (AOTA, 2014). Occupational therapists are trained to address areas of need pertaining to neurological and cognitive rehabilitation, physical dysfunction, mental health care, and living skills (AOTA, 2014; AOTA, 2014b). Not only are occupational therapists skilled at providing customized care to individuals, their skilled knowledge and application of needs assessments allows them to also develop customized programs for entire institutions (AOTA, 2014; AOTA, 2014b).

Conclusion

The effects of occupational deprivation on the incarcerated population are of great cost to the nation and have become impossible to ignore (Townsend & Wilcock, 2004; Whiteford, 1995; Whiteford, 2000; Whiteford, 2004). Multiple disciplines including psychology, medicine, sociology, law, and public health have explored the implications of mass incarceration for the individual, the community, and the nation (Bergseth et al., 2011; Drakulich et al., 2012; Salina et al., 2011; Windsor et al., 2014; Woods et al., 2013). A plethora of information exists supporting the need for change in the current U.S. penal system (Baillargeon et al., 2008; Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014; Cobbina, 2010; Deady, 2014; Drakulich et al., 2012; Durose et al., 2014; Eggers et al., 2006; Farnworth & Muñoz, 2009; Fazel & Baillargeon, 2011; Freudenberg et al., 2005; Harding et al., 2013; Henrichson & Delaney, 2012; Human Rights Watch, 2003; Kerridge, 2008; Lamb & Weinberger, 2005; Lipsey & Cullen, 2007; Martin et al., 2012; Morenoff & Harding, 2014; Salem et al., 2011; Salina et al., 2011; Subramanian et al., 2015; Townsend & Wilcock, 2004; Visher & Travis, 2003; Whiteford, 1995; Windsor et al., 2014; Woods et al., 2013). The success of Eggers and

colleagues' (2006) jail-based supportive programs indicates that occupational science and occupational therapy are both valuable disciplines in the discussion of solutions for providing successful, supportive programming. The help that occupational science and occupational therapy could provide might facilitate community reintegration for released prisoners and ultimately mitigate recidivism (Eggers et al., 2006; Whiteford, 1995; Whiteford, 2004). The lack of occupational related literature pertaining to corrections testifies that occupational science and occupational therapy are absent from this discussion.

Occupational science has begun to establish the detriments of occupational deprivation (Whiteford, 2000). The extensive literature on mass incarceration and its impact on individuals and communities demonstrate that the current U.S. penal system is in need of change. Occupational science provides a conceptual foundation using occupational deprivation to justify and reinforce the presence of occupational therapy in corrections (Farnworth & Muñoz, 2009; Eggers et al., 2006; Whiteford, 1995; Whiteford, 2004). The concept of occupational enrichment establishes that the provision of occupational therapy services to inmates could help counteract the deteriorative impact of occupational deprivation on individual capacity to manage the demands of society (Farnworth & Muñoz, 2009; Molineaux & Whiteford, 1999).

While occupational science has neither explicitly explored the effects of maladaptive occupations on health and well-being, nor ventured far into studying the effects of occupational deprivation on incarcerated populations, an opportunity exists for occupational therapy and occupational science to study systematically the concepts in corrections that degrade the capacity of individual and community alike to flourish

(Hammell, 2007; Whiteford, 2000). Exploring the negative side of occupational engagement would allow occupational science to better inform occupational therapy, and other disciplines, about the impacts of all types of occupation on human health and well-being (Wilcock, 2003).

The early view, and arguably the current role, of occupational therapists was to "prepare patients to take their places as constructive members of society" (Burlingham, 1948, p.iii, as cited in Burke, 2003). Wilcock (2003) charges, "occupational scientists studying humans as occupational beings have to take ideas seriously which were raised at earlier times, even though the ideas might take occupational therapists well and truly into a political arena in which they have little experience" (p.164). Occupational scientists and occupational therapists have an opportunity to improve the lives of potentially millions of people by participating in the study and development of supportive programming for inmates.

Chapter 3: Methods and Procedures

To better understand the phenomenon of working as an occupational therapist in corrections, a phenomenological method was used to guide and structure this qualitative exploration of what it means to be an occupational therapist in a correctional setting.

Creswell (1998) discusses the utility of employing qualitative research when exploring a topic that is not well understood. When the aim of research is to ascertain the lived experience of a phenomenon, qualitative methodology gives freedom to the researcher to gain an in-depth understanding of what it means to experience that phenomenon (Creswell, 1998). It is imperative to study participants who live and experience the phenomenon first hand (Creswell, 1998; Patton, 2002).

Participants

Purposive sampling is commonly used when research questions aim to explore information regarding a specific group of people (Patton, 2002). In order to capture the essence of the intricacies extant in corrections, and to broaden the perspective on an area of practice that is widely unknown to occupational therapists, purposive sampling was used to select the participants. Inclusion criteria for eligible participants were limited to being eighteen years or older and a licensed occupational therapist working in a correctional setting. Due to the varied nature of corrections settings and the broad scope of practice for occupational therapy, maximum variation sampling was utilized in order to more fully understand the essence of being an occupational therapist in a correctional setting (Patton, 2002).

Ascertaining contact information for occupational therapists working in corrections proved difficult. Currently, there is no connecting professional network

specific to occupational therapists working in corrections in the United States. Therefore, no standardized method of locating participants could be used. Through emailing and networking, four occupational therapists from corrections settings were contacted and agreed to participate. Three females and one male were included in the sample. In keeping with confidentiality, participant names have been changed and identifying information about the locations where they work have been omitted from results. The corrections settings represented in the sample include a state women's prison, secure forensic units within a state psychiatric hospital, and a medical center of the Federal Bureau of Prisons. Two participants work together at the state psychiatric hospital. Detailed participant descriptions will be presented in Chapter 4: Results.

Data Collection

For purposes of credibility in the research process, the researcher began the data collection process with a self-reflective analysis of her personal biases and assumptions, which will be discussed in the following section, "Assumptions." Identifying assumptions and personal narrative helped the researcher to bracket ideals that would influence the qualitative process (Patton, 2002). Many authors of qualitative methods and analysis support and encourage disclosure of researcher assumptions and biases (Creswell, 1998; Hissong, Lape, & Bailey, 2015; Patton, 2002).

Patton (2002) discusses the use of informal, conversational interview styles in qualitative research. This style of interviewing is particularly useful when the sample population represents varied characteristics as opposed to being more uniform and controlled (Patton, 2002). Interviews can vary between participants and the more flexible structure allows the researcher to explore and understand more fully an individual's

experience (Patton, 2002). Informal interview questions do not have to be standardized and can be derived from previous interview content (Patton, 2002). Given the variety within this sample, semi-structured interviews were conducted and kept informal and discursive in order to allow for a more in-depth exploration and understanding of the phenomenon (Creswell, 1998; Hissong et al., 2015; Patton, 2002). Questions aimed at exploring basic demographic information, everyday experiences of the occupational therapists, the culture of corrections, and implications for occupational therapy practice in corrections were included.

Hissong, Lape, and Bailey (2015) and Patton (2002) discuss the researcher as a participant-observer, wherein the researcher develops relationships with the participants. Level of participation can be subject to change, becoming more involved over time or less involved (Patton, 2002). In keeping with the informal and discursive interview style, rapport was built and relationships were indeed formed between this researcher and the participants in order to seek "meaning or understanding about individual or group experiences" (Hissong et al., 2015, p. 121). In the interest of full disclosure, one such relationship led to a job offer to the researcher during the third interview.

Patton (2002) supports and encourages the researcher to become embedded in the environmental context of the study (Hissong et al., 2015). To gain a clearer understanding of an environment that is largely impenetrable by outsiders, this researcher carried out an eight week internship under one participant's supervision at the state women's prison where she worked. The knowledge and understanding gained through the exploration undertaken for this study led to an impassioned interest in the topic for this researcher.

Data Analysis

Overall, twelve semi-structured, informal interviews were conducted. Each participant was interviewed three times, and each interview lasted between 45 and 75 minutes. Interview questions were drawn up before each interview to help guide the structure of conversation. Questions for subsequent interviews were derived from the collective previous interview content. In keeping with an informal and discursive interview style, participants were asked similar questions, but the questions were not standardized due to the variation in settings. A sample of the initial interview questions can be found in Appendix C. The interviews were transcribed verbatim without the use of assistive software by the researcher. Electronic copies of the data have been stored on a password-protected computer located in the on-campus office of this researcher's thesis advisor. Hard copies of the data have been stored in a locked cabinet located in the office of this investigator's thesis advisor. All data will be kept for five years, after which they will be permanently deleted or destroyed.

Transcription of the interviews served as a first phase of data analysis. The second phase of data analysis included a first-pass read through of hard copy transcriptions to ascertain a general and overall sense of the content (Creswell, 1998). The data was then addressed individually so as to identify the personal narratives of each participant. The personal narratives were bracketed to facilitate the reduction and organization of the data as a whole (Patton, 2002). Once participant narratives were bracketed, the data were spread out for examination so content analysis could begin. Data were addressed collectively and in a specific order that highlighted the marked differences between each participant (Creswell, 1998). This organization was completed

to prevent the researcher from forming preemptive conclusions based on clusters of similar data (Creswell, 1998). Data were then organized into meaningful clusters to facilitate synthesis (Patton, 2002).

Through an inductive process, three emergent themes were identified: a) safety and security, b) people are people, and c) advocacy. Multiple subthemes were associated with each emergent theme and will be discussed in detail in Chapter 4: Results. In order to enhance interpretation credibility, data checks were performed by two of the researcher's thesis advisors. Additionally, while time constraints prohibited the utilization of participant data checks on the results, each participant was sent via e-mail his or her participant description. All participants agreed to the accuracy and representation of their roles and settings.

Assumptions

This researcher believes human beings need and deserve kindness, support, and opportunity for self-exploration and the exploration of their environment in order to flourish. Inherent in the criminal justice system is the deprivation of supportive environments, prohibiting self-exploration. Therefore, the belief that the punitive philosophy of the U.S. penal system is ineffective and counter-productive led to a desire for a more in-depth exploration of the setting. Through undergraduate courses in psychology and philosophy, this researcher was exposed to the inadequacies in the criminal justice system and incarceration. The relevant coursework helped create a foundation of knowledge about corrections including philosophical, political and social attitudes. The revolving door phenomenon of incarceration that is created by taking a criminal out of society and placing him or her into an environment saturated with

oppression, violence, and crime, and then placing him or her back into society is felt to be damaging for not only the individual but for communities at large and the entire nation because it does nothing to address the root problem, which varies across individuals.

This researcher has had indirect and direct exposure to corrections, further cementing her beliefs about the inefficiencies throughout the criminal justice system. Both prior to the start of this study and during the process of investigation, a close relative and a personal acquaintance of the investigator were involved in the CJS. This researcher gained an in-depth understanding about the lack of support within the CJS and how it may prohibit rehabilitation. The individuals known to the researcher who were involved in the penal system experienced legal barriers that were perceived as prohibitive to successful community reintegration.

Additionally during investigation, this researcher carried out an internship at a women's prison under supervision of one participant in the study. The internship entailed providing occupational therapy services to groups of incarcerated women with mental illness. The limitations on provision of services at a practical level, such as safety and security, as well as the need for patient and professional advocacy were experienced first hand by this researcher. Many of the women involved in occupational therapy services had a myriad of complex problems, yet the provision of therapy services in the prison remained distant and impersonal, preventing therapists to practice client-centered care. The direct experiences held by this researcher added to her desire to demonstrate why and how occupational therapy services can benefit inmates and corrections facilities.

Learning about occupational justice, occupational deprivation, and occupational enrichment gave this researcher a platform to justify the belief that occupational therapy

is well-qualified and best-suited to revolutionize the penal system by providing client-centered rehabilitative support to inmates thus facilitating positive community integration and mitigating recidivism.

Limitations

There is a dearth of information regarding occupational therapy in corrections, making the results of this study novel, yet the research is not without limitations. Being a novice researcher, and in conjunction with an informal interview style, the study was more susceptible to interviewer effects such as leading questions and researcher biases (Patton, 2002). Additionally, this was the researcher's first official attempt at conducting qualitative interviews and data analysis, increasing the risks of misinterpretation or loss of data. While roles like participant-observer exist for researchers to gain a deeper understanding of a phenomenon, there exists the potential that the relationships formed with participants could have clouded data.

Chapter 4: Results

The following sections present the information obtained from participant interviews. Summaries of participant settings and roles have been provided based upon the individual information provided during interviews. The results of this study are presented in the section following participant summaries and are represented by direct quotations from the raw data. Contextual information is provided to highlight connections between direct quotations and the associated subthemes and emergent themes. The three emergent themes are organized by subheadings and the associated subthemes are identified by numbers and through the use of italics.

Participant Summaries

Participant summaries were derived from information provided by each participant and represent the setting, treatment population, various roles, and professional attitude of each therapist.

Emily

Emily explained that she works in a supervisory position at a state mental health hospital on three different forensic units ranging from low security to maximum security. The treatment population on the forensic units includes people whom the courts have deemed Incompetent to Stand Trial or Not Guilty by Reason of Insanity. She described her role as an occupational therapist as providing rehabilitative treatment to the criminally involved mental health population in preparation for either criminal justice processing or community reentry.

She discussed working with a diverse treatment population that includes all mental health diagnoses and ranges from acute care to long-term care. She addressed a

variety of treatment outcomes, some of which include improving overall cognition, improving sensory and emotional regulation, improving communication skills, social skills, ADL skills, IADL skills, and community living skills. She stated that she predominantly addresses treatment outcomes in group settings but occasionally works one-on-one with individuals who present with more in-depth needs.

She asserted that she frequently advocates for her patients and her profession due to a general lack of understanding of occupational therapy and mental illness, but she felt well supported by the institution's administration and expressed having access to a multitude of resources. She made sure to convey the importance of safety and security while working with an unstable population; however, she was passionate about her professional and ethical commitments to providing skilled intervention to a vulnerable group of people who face enormous social stigmas and have little community support.

As a practitioner, she conveyed that she values maintaining respectful and kind therapeutic relationships. She explained how she utilizes occupation-based interventions to facilitate a sense of confidence and empowerment within her patients. She emphasized the importance of cohesion among the treatment teams she works with in order to provide client-centered and holistic care to support the success of each patient. She felt that occupational therapy can and should be working with all corrections populations to reduce recidivism by helping to teach people the skills they need as individuals to be successful in the community.

Lauren

Lauren explained that she is the director of the occupational therapy department at a state mental health hospital. She described overseeing the provision of occupational

therapy services throughout the hospital, completing evaluations, and occasionally working with individuals one-on-one. The hospital provides mental health services to both civil and forensic patients. She explained that the forensic treatment population she works with is housed on low, medium, or maximum-security units and suffers from a range of serious mental illness in combination with involvement in the criminal justice system.

Lauren stated that many of the forensic patients on the units are found Not Guilty by Reason of Insanity, whereas others have been deemed Incompetent to Stand Trial and are at the hospital to be restored to competency, so they may proceed with court hearings. Overall, the treatment goals within the hospital are to rehabilitate patients so that they may leave the hospital, although some patients will remain for the duration of their lives. As an occupational therapist, she asserted that she provides interventions that address cognitive function, communication skills, social skills, sensory and emotional regulation, independent living skills and basic ADLs.

As a practitioner, she conveyed that she values maintaining respectful and kind therapeutic relationships. She explained how she utilizes occupation-based interventions to facilitate a sense of confidence and empowerment within her patients. She was passionate about her ethical commitments to provide quality, client-centered care to all persons. She stated that she felt well supported by her administration and had ample resources to provide care; although, at times she still must advocate for her patients as well as her profession in order to find a working balance between the dichotomy of providing treatment to ill persons and punishing criminal action. She believed that occupational therapy has a place in corrections because it can help mitigate recidivism by

teaching people independent functioning skills, ultimately facilitating their success in the community. She expressed feeling positive about the increasing recognition of occupational therapy and remained dedicated to her role in educating others about how occupational therapy can serve the forensic and mental health populations.

Kathy

Kathy has worked in corrections for 10 years. She has worked with both male and female inmates. She explained how currently, she works in a state prison for women in a mental health capacity. The treatment population she works with is housed in a maximum-security building dedicated to providing mental health treatment to women who struggle coping in the general prison milieu due to their mental health status. She expressed values of safety and security for all persons, but admited that custodial practices can constrain the provision of occupational therapy services. She described how the provision of occupational therapy services is limited by security, budget, storage, and treatment space.

Despite the ongoing ethical and practical dilemmas that Kathy described, she spoke of the importance in striking a balance of understanding and respect with custody in order to gain their support in providing care to the women. She voiced many frustrations about arbitrary and inconsistent practices among the institution for which she works, and she felt unsupported by administration; although, she recognized their efforts to improve. She felt that occupational therapy should provide individual, group, and consultative services throughout the entire criminal justice system to improve community reentry and mitigate recidivism. She stated that the system is very much in need of more occupational therapy services but is simply unaware of the scope of the profession. As a

professional she expressed taking seriously her roles in advocating for her patients and educating others about the importance of providing adequate services. She said she is currently pursuing her OTD with a focus on dementia care for the aging inmate population.

Tim

Tim explained his position as a United States Public Health Services Commissioned Corps Officer, assigned to the Federal Bureau of Prisons. He is devoted to his position as both a military officer and as a broker of care. While he was sure to emphasize the dangerous potentials existing in a corrections setting, he also expressed that he takes very seriously his ethical commitment to care for all people as a medical provider. He asserted that he does not struggle to reconcile any ethical qualms he may or may not have.

As a provider, he articulated the value of safety and the benefits of forming respectful and positive therapeutic relationships. He was very sensitive to the client-centered and holistic tenets of occupational therapy and voiced appreciation for his position as role model for many of his patients. He explained that he works at a Federal Medical Center (FMC) as an orthopedic hand therapist in a wide range of capacities such as acute care, in-patient, outpatient, long-term care, and palliative care. He said he works with a male-inmate treatment population from a physical dysfunction perspective that includes orthopedic injury, wound care, and provision of services to inmates with severe medical needs, illnesses and diseases.

Though working for a bureaucratic organization can be slow and inefficient at times, he felt the FMC is well staffed and well supplied. For the most part, he

communicated satisfaction with the provision of care he can offer his patients. His view of the scope of occupational therapy was broad, but he described that he does not see much room at his facility for occupational therapy to expand in providing care in corrections settings, perhaps due to compartmentalization, although he was explicit about that being context dependent. He felt strongly that occupational therapy has a role in reentry programming and mitigating recidivism. He thought that occupational therapy is the best profession to provide incarcerated populations with holistic, client-centered supportive programing because occupational therapists are trained with a wide variety of skills and can fill an array of roles as needed.

Results

Although prisons and hospitals are fundamentally different, one being punitive and one rehabilitative, many similarities existed across settings in the raw data. The similarities converged and three emergent themes were identified: a) safety and security, b) people are people, and c) advocacy. The following three sections will explore these themes and the associated subthemes. Important distinctions will be highlighted to ensure accuracy in representation of the data.

Theme A: Safety and Security

The issues of safety and security are a priority when any service is being provided; however, six subthemes were identified among the raw data as specific to corrections. The implications of safety and security surfaced within the raw data as a critical, number one priority because corrections settings can pose unique compromises to the safety of therapists, corrections personnel, and inmates. The six subthemes regarding safety and security were identified as follows: 1) physical environment, 2) social

environment, 3) staff safety, 4) patient safety, 5) treatment versus punishment, 6) constraints on the provision of therapy. The subthemes will be distinguished in the text with italics.

Physical Environment

For patients recovering from serious mental illness, the *physical environment* of corrections can largely impact their recovery. Lauren talked about the effects of the *physical environment* on a patient who experienced chronic psychosis and was known for becoming agitated. "He's on the highest acuity unit right now and so it's very loud. It's very high energy. They're very sick people, um, and so obviously that's, that's agitating."

In a psychiatric setting, seclusion and restraint are often used to prevent injury to staff or other patients, but also to prevent self-inflicted injury. Lauren described the ramifications in terms of *physical environment* for another patient who engaged in severe self-injurious behavior. "They took away all of her therapy services. She is confined to a seclusion room. She is in wrist-to-waist restraints all the time." Lauren described how she felt *physical environment* of confining the patient would impact her recovery.

> Tell me how this person is going to function from being locked in a room in wrist-to-waist restraints, and how much longer it's going to take us to transition her back into a place where she's even socialized on the milieu again, you know, I mean I just saw it as such a huge set back.

Additionally, the *physical environment* created to protect the public and staff impacts how services are provided. Kathy described how security protocols in prison impact the day-to-day workflow when women have appointments outside of the building.

> The women get shackled and handcuffed, and taken out of the building and driven up to the max compound to see the doctor--whoever they have to see--and then when they're done they get brought back down, but so every time, uh, one of the women is getting moved out of the building, everything has to stop because it's a security risk to have people moving around when someone is being moved out of the building.

Emily explained that patients on the highest security forensic unit have unique and rigid security protocols as part of an intensive behavioral program. She described the *physical environment* of the unit among one of many challenges to providing care.

> And so it's really, really hard. That environment's really hard because it's really just one little hallway. It's part of a big unit it's just sectioned off by themselves, so they have one little hallway with five bedrooms and a little tiny, tiny, tiny day hall area that has one table that has five seats, and like that takes up the entire room is just that one table. And so you have four correctional officers there, four nursing staff, and then other treatment team members kind of popping in and out throughout the day.

She continued to explain the *physical environment* for patients on the highest security unit. She described how patients are confined by wrist-to-waist restraints and must be restrained to a table during therapy. She explained that two security personnel make physical contact with patients at all times when they are out of their rooms.

> So like even if they go outside in the courtyard, I don't know how often, two security officers have to have their hands on them the entire time, which again is

> to ensure safety so the patient doesn't fall because they have those ankle restrains on, and I'm sure that messes up their balance significantly.

Social Environment

Confinement, proximity, lack of privacy, and concentration of criminality create unique social expectations in prison. The *social environment* in prison is oppressive, violent, complex and highly stressful. Many of the patients at the FMC where Tim works will return to the general prison population once their physical limitation has been rehabilitated. Tim described the *social environment* of the general prison population.

> They are surrounded twenty-four hours a day by hundreds of other people who have done and do very horrible things. Um, the prison culture is a very confined group of often malevolent people who are doing their best to, often it seems, get away with as much of the rule breaking as they can during their incarcerated time without getting in more trouble and ending up incarcerated for longer periods of time.

Tim discussed the tension that is always present in the *social environment*.

> In the incarcerated environment, it's very much an "us against them" environment. Um, the inmates feel it's inmates against corrections and then the various racial groups feel it's this racial group versus that racial group versus that racial group and then the specific gangs within the racial groups: it's our gang against their gang. It's very much an "us against them" environment, and everybody's looking to find out who is on our side and when they're on our side.

For the long-term patients at the medical center, Tim described a different *social environment*.

> The folks who are in the hospital, uh, the long-term care patients, either because of dementia or pathologies like AIDS, hepatitis, severe diabetes, or spinal cord injured patients who are unable to care for themselves, it's a particularly difficult time now because it's the holidays and they're dependent upon others to meet their basic needs. A lot of them are fearful because they're if not at the end stage of their lives, rapidly approaching it and you see, they look around, you know, twenty-four hours a day at a group of old men dying in prison, and it's a difficult time.

Kathy also discussed the tensions of the *social environment* within prison.

> You know because when we deprive people of the most basic occupations and the ability to fill their most basic needs, they have nothing left to do but, you know, find alternative things to do and sort of go back to their basic instincts, and that becomes a "you or me," and I mean that's why so many fights happen, at least with the male population.

There are boundaries that need to be maintained not only between staff and inmates, but also between staff and custody. Kathy elaborated on how the *social environment* of prison impacts professional relationships with the security personnel.

> In my experience, you have to show custody that you respect and value the importance of maintaining security, and if you can do that they're willing to work with you so you can get done what you need to do. Um, it's when people, from my observations, it's when people don't show that respect that they have trouble getting their work done. They have trouble interacting with custody and getting their support for things, which goes back to that idea that, um, we're guests in

> their house, so we can't just come in and do whatever we want. We have to negotiate with them to be able to do what we need to do. And some people do it better than others.

The *social environment* within the forensic hospital setting is similar to the prison setting. Both share the necessity of strict parameters to ensure safety and security, as well as the impact of those parameters on the relationships between custody, patient, and therapeutic staff. Lauren discussed how the dynamic between enforcing safety and security yet providing therapeutic treatment at times creates tension in working relationships. She described a story about a colleague who conveyed the idea that a professional in forensics does not need to adhere as stringently to professional codes of ethics.

> That's a doctor! That shows you the mentality of somebody who is well educated in a forensic system of, "Oh, oh! Well we don't have to follow our codes of ethics in a forensics setting, silly!" [Laughter] And obviously that got addressed, um needless to say, but just for someone to say that out loud and to harbor that thought, um, not a lay person, someone who's extremely well educated, that just shows you what we're up against. Not to even count all the officers we deal with who don't have any education about health care. You know and they are of a mindset of safety and security and take 'em down.

Lauren elaborated on the punitive attitude that some of the staff embody.

> I feel a lot of staff in these types of settings, and I'm sure you've seen it too, is this very punitive way of dealing with things. Because there's this authority, there's this power struggle and, "I'm the staff member and you're here and you're

> court ordered to be here, what I say goes, and what you say doesn't matter at all, ha!" You know? And unfortunately there's a lot of providers that go about their day with that mindset.

In contrast to punitive staff attitudes clouding the *social environment*, there are nurturing staff attitudes that can have a similar, though unintended effect. Emily described holding higher-level patients accountable for time management in preparation for life outside the institution. She discussed how the social roles of nursing staff are to care for and provide for patients. She explained how the unintended byproduct of the dynamic between nursing and patients often facilitates institutionalization in hospital patients, which creates a counter-weight to therapy.

> I remember nursing staff getting so angry with us saying, "Why do you keep leaving him behind?" Because we wouldn't go and get him, and it's like, again, trying to teach them how not to institutionalize patients, so we said, "Ok, when he's out in the community, the bus driver is not going to call him on his phone and say, 'Hey I'm going to be there in 5 minutes, and if you're not I'll wait for 15.'" You know? It just, it doesn't happen. So um…trying to provide education to nursing staff of what the real world is gonna look like for our patients has been difficult at times.

Staff Safety and Patient Safety

Safety is the number one priority when working with patients in any setting; however, given the violent and oppressive nature of incarceration in conjunction with the complicated *social environment* for staff and patients alike, safety issues become more

complex in corrections. Tim discussed the use of extreme disciplinary measures to ensure both *staff safety* and *patient safety*.

> Putting someone in a Special Housing Unit protects everyone. It protects the inmates around them so nobody gets attacked, beaten and/or killed. It protects the staff so that they can continue to come to work and treat those persons who aren't behaving violently. And it protects the inmate because if someone attacks with the intent to harm me or one of my co-workers, I'm going to defend myself and my co-workers, and that is a terrible situation to be placed, so we have to protect everybody.

Despite the potential for deliberate patient aggression, Tim described the overall attitude of inmates receiving therapy at the FMC.

> Certainly for safety but that's not as big a concern here—I mean at [the medical center]—because so many people are there specifically for rehab and rehab is something that is very valuable to the individual so they're very, they're very likely to do whatever they have to do to continue to receive rehab as long as they feel they need it.

He elaborated on how patients are "motivated to treat the medical staff quite well," but he emphasized the need to remain guarded. "You have to be savvy enough to not be manipulated too often because to say that you never get manipulated then you're fooling yourself [laughter] because there's some very tricky folks, but um, to learn from it."

In a forensic psychiatric setting, there is also a potential for patient aggression; however that aggression often occurs as a result of severe mental illness. Nonetheless,

staff safety is imperative. Emily discussed the importance of knowing each patient's history in order to remain guarded as a therapist.

> It's always important to know what your patient's history is because you can see what they have been capable of doing. I mean always know—"past behavior is the best predictor of future behavior," everybody always says that—and so it's important to know because if somebody does stop taking their medications and starts decompensating, it's important for us to know as staff what could potentially happen when they are acutely psychotic.

She also elaborated on the mandatory staff trainings that are provided to ensure both *staff safety* and *patient safety*.

> So like if somebody is trying to punch you, what techniques are you gonna use so that you're not, um, doing something forcibly to them, but you're getting yourself out of danger so you can call for help, that sort of thing. So they have that every two years. They also have, um, part of that course is more on seclusion and restraint protocols and practicing how to do them so that if somebody requires that, um, people are still skilled to be able to do that appropriately. And the other one that we do every two years that they really focus on is verbal, um, de-escalation techniques. And so it used to be called "verbal judo," but it's all just about, you know, that's what they really push is being able to talk somebody down so that you don't have to put hands on them.

Kathy gave a rich example from her past work history with the male-inmate population that embodied the complexities of maintaining *staff safety* and *patient safety* in corrections.

> What had happened was that a gun had been smuggled in, um, which was, um, very scary [chuckle] as you can imagine. I mean especially at [the male prison] where you have people who are already there for life so, you know, like, "What the hell?" Um, and when we expressed our concerns, our safety concerns to *our* administration, not custody but our administration, who do not work in a prison, they work at the administrative facility, the response was, "Well you're lucky you don't work in an emergency room because that's even more dangerous. Guns come in there all the time, so I don't know what you're complaining about." And, and we were like, "Yeah but people literally having nothing to lose using a gun here. It's a little bit different than the ER."

Treatment Versus Punishment

The issue of *treatment versus punishment* is one of ethics and pragmatics. When dealing with criminal action (or even bad behavior) the prevailing philosophy is punishment. When dealing with a volatile population, it is essential to take measures that will promote safety. When dealing with people suffering from limitations, rehabilitation is needed to facilitate growth, independence, and success. These complex ideals are in frequent conflict in corrections settings. Protecting everyone from patient aggression and protecting patients from self-injurious behavior while at the same time facilitating recovery creates a dichotomy that therapists must work around. Lauren discussed *treatment versus punishment* from a preventative perspective.

> I understand that from the stand point of, if you are being very unsafe, and you're getting ready to hurt yourself or somebody else there needs to be an intervention. Hopefully, we are providing—you know that's all about prevention right? Where

> we should be checking in with patients. We should be observing them clinically on the milieu. We should know what their triggers are. We should know what their warning signs are, and we should be hopefully preventing a lot of takedowns that way.

Lauren explained that although she works with a volatile population, they are at the hospital to receive treatment and she feels there are often more productive ways to achieve that goal than certain punitive actions.

> There are so many people that are, will go to first either takedown or giving emergency medication rather than trying to use de-escalation techniques whether it's verbally, um, whether it's offering a different coping strategy, a different environment, and things like that that are so much more therapeutic, um, and helpful. We know that seclusion and restraint causes trauma, so we're almost triggering people again when we have to use that level of force, um, to maintain safety.

Conversely, Tim discussed the necessity of a punitive environment in prison and the role corrections officers play in maintaining order. Corrections officers in prison carry heavy responsibility and rehabilitation of prisoners is not among their concerns. Tim explained,

> Their objective is to ensure that illegal and dangerous things like drugs and weapons don't find their way into prison, at the same time trying to make sure that people are treated humanely and that their welfare is maintained. So we've got to try and make sure that conflicts don't, you know, verbal or emotional conflicts don't erupt into physical assault, sexual assault, sexual conduct is not

> permitted. So there is a lot of oversight and it's entrusted into a relatively small number of guards compared to the number of inmates, you know.

Kathy spoke of blurrier lines between *treatment versus punishment* when working on the mental health unit within a prison setting. She stressed the importance of involving custody in the treatment process and providing them with the tools to classify behavior they observed. "And really they are our biggest ally, our biggest source of information. They're the ones that are spending all the time with the patient, not us." Although she works in an inpatient mental health setting, the setting still remains within a prison. She elaborated on the dichotomy of *treatment versus punishment* in a prison setting.

> I think, well I think in corrections, the mental health population in corrections is even more vulnerable because that's not what corrections is there for. They don't know how to address the issues. You know if they wanted to run a state hospital then that's what they would be doing.

Measures of behavioral control, such as seclusion and restraint, are an integral component of *treatment versus punishment* because while patient misbehavior must be addressed, certain disciplinary measures can result in negative patient reactions. The use of seclusion and restraint elicited ethical dilemmas for both Emily and Lauren. As a practitioner who has witnessed the impact of seclusion and restraint, Emily questioned the efficacy of the controversial disciplinary measures.

> It's such a double-edged sword. So us putting somebody in S and R, it's because we are protecting that patient, peers, and staff because they are at a very dangerous place. At the same time, when you put somebody in S and R you know

> that re-traumatizes them, so we're making it worse, you know. So I think it really depends, um [pause] if you, I guess my thing is if people are using S and R as a final means, I get that. I don't feel like that always happens and that's where I have issues with it. And then the wrist-to-waist restraints, again, like I understand the reasoning behind it, but they're all, in a way it's like you're setting somebody up to fail because it's like you're telling them, "You're so untreatable that we have to do this to you."

Lauren discussed the prevention of punishment through the use of treatment. Lauren described a situation wherein a patient was getting agitated and instead of restraining and confining him in order to prevent an outburst, she was able to use alternative methods, which he had been practicing during therapy sessions, to de-escalate the situation and successfully prevent the use of seclusion and restraint.

> The other thing that we've been working on, um, he—the last time I was there—got very agitated with the staff and, um, I was able to get him to do some, they were surrounding him. They were getting ready to do a takedown, and I was able to convince him to come in the other room. We did a few Tai Chi exercises and then I had one of the therapists bring a weighted blanket, and I was able to get him on the floor, um, laying supine and got a 18 pound weighted blanket on him and we did some guided imagery and he fell asleep.

Similarly, Emily talked about the relationship between *treatment versus punishment.* She described observing a novel treatment technique used with positive results on one of her patients confined on the highest security unit.

> He usually is a patient who, you can't get him to focus for more than 20 seconds. He's all over the place. He sees one tiny thing and he changes the subject and he is here and there and all over. After we went through and she did the tapping session with him, it was *amazing* how well he was able to focus. There was so much going on in his environment. There was lunch coming in, so they had this big cart and all the staff were talking, and he was like *zoned* in to what the COTA was doing with him, and I mean I have never seen him do that ever. He cannot keep focus like that ever. So we've been able to see some really powerful things, which is awesome.

Constraints on the Provision of Therapy

As mentioned, working in corrections necessarily places significant emphasis on safety and security, but *constraints on the provision of therapy* exist as a result. Lauren talked about working with patients on the highest security level within the hospital who are in wrist-to-waist restraints and the difficulties that restriction places over the provision of services.

> You are taking away everything from this person that makes them a person: their ability to move freely; their ability to engage the left and right side of their bodies, do functional tasks. They can't feed themselves. They can't adjust their clothing. They can't, I mean it just, it limits everything that everyone considers to be normal or what we as OTs consider occupation. They can't do it when they're in those types of restraints and, um, it's interesting when we get orders for those types of patients for X, Y or Z. They want us to do, you know, sensory stuff with them or things like that, and it becomes such a huge challenge of, "Ok how do I

> get this patient what they need, the deep proprioceptive input or heavy work or whatever, when they can't move their body!"

Emily illustrated how therapy options are limited depending on the security level of the patient. She explained that as security levels increase, so to do the *constraints on the provision of therapy*.

> It's most difficult to work in the highest security area just because you're so limited on what you can bring. If you try to bring new ideas, um, it sometimes can be really challenging to get everybody on board because they don't think it's safe even if you can try to explain to them what you're going to do to ensure safety. They don't always, they're not always treatment focused, you know?

Kathy also described the *constraints on the provision of therapy* from a security perspective.

> I'm thinking about mentally it would just be what you can and can't use or can and can't bring in and it doesn't necessarily make any sense at all. Um, like I can't bring in a newspaper or like a Time magazine or something like that, um, but an inmate can get a neighborhood newspaper in their mail, but I can't bring one in for a current events group, like things like that. And when I would ask, "Well I don't understand because the inmates can get it subscribed and get it in the mail so why can't I bring it in?" "Well that's just the way it's always been."

Emily admitted that the corrections aspect on the highest security unit, while necessary, at times places the greatest *constraints on the provision of therapy*.

> I think our correctional officers, who really want to do a good job and I understand that, I think that they forget that they are at a hospital and they're not

> at a prison, so they're very much still kind of have that prison mentality in a way and they're not very treatment focused. So it's, that unit right now I think for me is the most challenging and the most frustrating, and it's frustrating because I feel like we could do so much for those patients but we're so limited by their staff, you know?

In contrast to the forensic units and the state prison, Tim explained that the FMC is well supplied, and he does not typically experience *constraints on the provision of therapy*. He pointed out that regardless of the type of setting, working in corrections creates a unique concern and does place a unique *constraint on the provision of therapy*.

> Corrections is a really big concern. We have to make sure that the things we are giving to people aren't easily turned into weapons, and if they are we have to make sure that we don't, if it's the kind of person who might use it as a weapon, we don't give it to them.

In order to maintain safety and security, restricted tool use is a cornerstone of incarceration. In order to promote individual growth fostered by meaningful engagement in occupation, tool use is a cornerstone of occupational therapy. A basic, practical conflict exists between occupational therapy in corrections, but occupational therapists are trained to work around physical, environmental, and human *constraints on the provision of therapy*. Lauren admitted that providing occupational therapy in a corrections setting requires flexibility.

> You use your OT brain in even a very different way of, "How am I modifying the task, the activity, and the environment to adhere to the safety parameters of this facility that's still going to meet my patients' needs in the plan of care that has

been established." So it's really actually kind of an interesting problem solving experience.

Despite the differences in settings, all participants illustrated examples of how the physical and social environments affect staff and patient safety. The security measures and safety concerns create a unique dichotomy that the therapists must face, and also place restrictions on the services they are able to provide.

Theme B: People are People

Despite the stressors of working in corrections, all participants maintained a quality of benevolence regarding their patient populations. All participants espoused philosophies related to see past labels and treating all people with kindness, respect, and dignity, giving rise to the second emergent theme: people are people. It is impossible to determine if the beneficent qualities of each therapist is a result of character, which drew them to occupational therapy and subsequently corrections, or a result of training as an occupational therapist. Three subthemes were identified relating to the beneficent attitudes of these occupational therapists: 1) people are dynamic, 2) improving patient self-worth, 3) people deserve kindness.

People are Dynamic

Occupational therapists are trained to work with people across the lifespan, from birth to death, who experience a variety of impairments including physical, mental, and cognitive. Providing client-centered care to such varied populations exposes therapists to a multitude of temperaments, background stories, and perspectives leading to an intimate understanding that *people are dynamic*. Tim explained his overall professional philosophy.

> The individual, the person is a bio-psycho-socio-cultural-spiritual person. All five of those pillars support the entire person, and if any one of those pillars is injured, the other four have to compensate and depending upon the degree of compensation, it injures one or more of the other four and the whole system suffers.

He applied his philosophy to a prison population.

> If you take that idea and you transpose it to a prison population, this is a very dangerous place and um, there is a lot of psychological and spiritual and physical and social injury here at all times and so I'm working with them as best I can so I can help them to, them, um, rehabilitate any of those parts of their person that they're having difficulties.

Emily shared how working with a marginalized population has expanded her worldview.

> When you really get to know your patients as people, it changes your views on things, you know. I mean you can understand this person is a really good person now, and they did some really bad things, and they were very ill at the time that those things happened. And so it's just having a better understanding of, I don't know, just, you know, I don't know how to explain it. I think you just have a better, I think I have much more empathy towards people.

Although the hospital is a treatment-focused environment, there are some staff members who box patients into labels, which can prohibit further progress. Lauren discussed how *people are dynamic* by describing a patient whom the rest of the staff had labeled beyond rehabilitation.

> People have such fixed beliefs on who he is as a person, his inability to change, to grow, to learn new coping skills, to be a good person. Um, right now what am I doing with him? We started finger knitting because he wants to make scarves for women who are in shelters from domestic abuse. Okay? So you know I, we in OT see these wonderful qualities of people, um, you can't tell me that somebody has no empathy or no caring when they are independently initiating a task that is so giving and thoughtful to other people.

Lauren described another patient who is normally regarded unfavorably by staff because he frequently becomes agitated and can be verbally threatening. She demonstrated that *people are dynamic* by explaining that he is chronically psychotic but is very intelligent. She stated she has been working with the patient on sensory awareness and education. During their session, the patient was resistant to trying scented lotions for the purpose of experiencing the calming or alerting affect of the fragrances and the sensation of smooth lotion on his skin because he thought it was "girly." Once he conceded, "he was like slathering lotion all over himself and he's like, 'Oh my gosh!' He's like, 'this feels so good! It makes me feel better.'" She went on to explain that because his mind is "constantly delusional, and um, hallucinating" he has been practicing Tai Chi.

> Tai Chi allows him to slow his mind, and that is the most therapeutic thing for him because he's always thinking. He's always, um talking. You know, it's just kind of a constant thing for him, and he's able to be quiet, um, and to be mindful and to be present, so it's like giving himself a little bit of a break.

While some staff view patients as one-dimensional, occupational therapists are in a unique professional position to observe that *people are dynamic* through client-centered care. The client-centered tenets of occupational therapy push practitioners in corrections settings to see past criminal charges. When discussing the qualities that make an occupational therapist successful in corrections, Kathy said, "I was more willing to just kind of experience people where they are versus where they've been." She spoke to the philosophy that *people are dynamic* by describing an eye-opening experience she had working with the male-inmate population. She described how she engaged in in-depth, intellectual discussions with inmates.

> I mean it just [pause] it really makes you recognize that, you know, sometimes it really is that somebody made one bad choice or that if they had been able to grow up in a slightly different environment, you know, what amazing things they would have been able to do. But then again, everyone that works in prison isn't able to see that.

Regardless of the differences in treatment population and provision of services between mental health and physical dysfunction, hospital and prison, Tim discussed the unique advantage occupational therapists have in understanding *people are dynamic*.

> Occupational therapy, as you probably know by now, is a very intimate profession. Now it's intimate when you're teaching someone how to use a long-handled sponge in the shower, but it's also intimate when a person has some injury and they're talking to you and they're talking to you about themselves and their lives.

Improve Patient Self-Worth

Occupational therapy is a profession that strives to improve patient self-esteem. When patients are lead to accomplish tasks and build upon their existing skills, they develop a sense of mastery over their environment, which leads to *improved patient self-worth* and empowerment. Lauren described how she is able to foster empowerment in her patients.

> To be able to teach people and empower them to have a sense of control and to know, "Oh my gosh, there's things I can do to change the way that I feel." Um, that makes people…just so proud, um you know, and it gives them tools. It gives them resources. It gives them choices. That's one of the things in a hospital or any health care setting, we're always taking away peoples' freedom from their choices, um, so when you can ever give that back to a patient you're giving them, like, the biggest gift that you can give them.

She provided an example of one of her staff *improving patient self-worth* through the use of client-centered intervention.

> [He] doesn't engage in anything, um, and is now gardening and finds that to be extremely rewarding, and it's like the one thing that he'll participant in, um, and the one group he'll go to because, um, he really enjoys it, and he makes beautiful things. Um, and it gives him such a sense of pride.

Living an institutionalized life, deprived of stimulation and control, is difficult for any length of time; however, for individuals confined for life, the future paints a bleak picture. Lauren discussed how occupational therapy is a critical service for *improving patient self-worth* of people living long-term at the hospital.

> We have to build hope. We have to build resiliency, and as OTs we do that through occupation because we know it's healing, um, and if we can find meaning and purpose for someone, even if it's just for them to have that in an institutionalized facility, um, that means a whole lot.

Similarly, Emily spoke to occupational therapists role of instilling hope and *improving patient self-worth*.

> We do a great job in OT of instilling hope because we are so, as OTs we're always focused on the next step, and what else can we do, and let's make you independent, and what other skills can you build on, that I feel we do a really good job of making our patients much more hopeful for the future and much more confident in their own skills and abilities.

Emphasizing the client-centered nature of occupational therapy, Emily provided an example of how meaningful engagement in productive activity helps to *improve patient self-worth*. She described a new volunteer program at the hospital that connects low-security patients with volunteer opportunities in the community. She explained how the group of patients currently involved in the program selected a community mental health center and teamed up with management of a warehouse containing used hotel furniture. She described the patient-directed efforts of refurnishing, cleaning, and decorating the clubhouse community center and their plans to help create a community garden in the summer.

> I feel like it's directly related to us getting out there with them and them being able to see, you know, that they really can make a difference and that they really were the ones that initiated a lot of it afterwards, which is even cooler to see.

> Yeah and they're like so excited about it. They're so motivated. You know, I mean they're just, it's so cool to see them being so proactive and really wanting to help somebody.

Similarly, Tim discussed the impact of remaining client-centered in his interactions with his patients and how that intimacy helps to *improve patient self-worth*.

> [They] come to me at another point in time and talk to me about their regrets or how they feel they're on the road to redemption, whether that be in the eyes of their family or in the eyes of society or in their own personal self-worth or in the eyes of their religious community.

People Deserve Kindness

There exists a uniquely traumatic component within corrections settings because the physical and social environments are so hostile. Inmates or patients are in a vulnerable position as some professional attitudes devalue the population. In keeping with the beneficent attitudes displayed by all participants, *people deserve kindness* was a philosophy present in the practice and interactions of all participants with their patients. Kathy shared her thoughts on the inherent counter-productive effect of extremely punitive and degrading conditions practiced in prison.

> I mean how can we expect people to leave prison and become productive members of society if we're teaching them that they deserve less than everyone else? And I think that's when we don't respond to their medical needs, when we don't provide them proper nutrition. I mean when we do all of those things we're telling them that they're less than.

Corrections is a difficult area of practice for any professional and is ripe with moral and ethical dilemmas. Tim discussed the dilemmas that many professionals face when providing care to people who have committed "heinous" crimes. "That's hard for a lot of people to reconcile. For me, it, I don't have a problem reconciling it. It's a sick person." He expressed a point about moral dilemmas beyond the confines of a correctional institution. "Everyone will treat people who on critical inspection of that person's life could find something that they disagree with that person about." And his solution to those ethical dilemmas is simple: *people deserve kindness*. "They're sick people, and they need to be cared for."

Lauren spoke about ethical dilemmas as well. "Here's the thing: No matter what setting you're working in, whether it be forensic or not, you're going to work with patients who have done shitty things." She relies on her professional code of ethics to resolve "moral conundrums," as well as leaving judgment up to the judicial system.

> "That's not what I'm here for. I am an OT. I am here to rehab his hand. That is my job. And that, you know, I just, and that's how I moved forward with it. It's not that, I am not God. I am not a judge and jury."

Unanimously, all four therapists espoused a humanitarian philosophy, one that assumes all *people deserve kindness* and respect. Tim spoke of the positive impact he was able to have on his patients by treating them with kindness.

> It can be quite, it can hold, create quite an effect on them. And so I have patients regularly who seek me out and ask my advice about one idea or another, and I always treat them as, I treat them very respectfully and speak to them as I would

> any other of my colleagues. They appreciate that I don't speak down to them, and I don't look down upon them.

Lauren explained that she forms "kind and positive" relationships with her patients. "They're human beings. Because human beings deserve respect and dignity and to be treated well just like everyone else. And that's it. That's the easy answer." She explained the result of treating patients with kindness and respect.

> Patients love OT because we're bringing, you know, fun and engaging things to do with them. We're spending time with them. We're talking to them. We're seen as huge resources and support.

Kathy shared the same humanitarian philosophy that *people deserve kindness* and why it is necessary to provide fair treatment to all people, regardless of criminal charge or diagnosis.

> They're human beings. You know? I don't know who said it, there's something along the lines of "you can judge a society by how they treat the worth of their…"—there's different versions of it—"by how they treat their weakest, by how they treat their criminals," but I think it's very true. I think that no matter what someone does there's, they deserve at least basic care and basic, their basic needs met.

As discussed, corrections environments are ripe with injustices and trauma, and as such there is typically a dearth of trusting relationships formed within those settings. In keeping with *people deserve kindness* Emily shared how she feels treating people with kindness produces the best results for treatment outcomes.

> That's such a powerful tool. I'm able, and I feel like that's something I do really

> good at with patients that I have, and that's why we're able to have such good treatment outcomes, and it's because I treat them like a person, like an adult. I don't treat them like a baby. I don't treat them like they are less of a person than I am. I treat them with the same respect that I want them to treat me with, and it's really sad that I think that's kind of lost in this kind of setting, but I think that's what makes people more successful.

All participants shared similar opinions regarding *people deserve kindness* and how treating people accordingly facilitates success with patients in corrections. Tim:

> You have to be seen, they have to, to be truly respected, to be truly successful, you have to be seen with sort of the night in shining armor concepts of ensuring your patients dignity, being honest, treating them fairly and, um, and doing what's right.

He shared how at different times, patients have come up to him to thank him for treating them like people who matter. He said,

> I have a lot of young patients who have never been around people of good character. They don't know--they've never had an example of a person who isn't a pathological liar or a thief or a conman or who doesn't use them for some nefarious reason.

Kathy spoke about seeing past the label of a person's criminal charge and working with the person as a whole. "I think you really need to be able to separate what the person did from who the person is [pause] and I've, in most cases, you get two very different people when do that." She continued, "I think for the most part if you can separate that out, the person isn't as bad as what they've done." Similarly, Lauren talked

about meeting patients' needs with dignity and respect because *people deserve kindness.* She explained how treating patients well improves patient outcomes.

> Where nurses are going around and checking in with patients. "How are you doing? Is there anything I can get you?" That's evidence-based shown to decrease seclusion and restrain, agitation and irritability in patients in psychiatric facilities and nursing homes and all other types of facilities. In nursing homes it prevents falls. It's called interacting with people and meeting their needs. It's not, you know, brain science.

Though the data is unclear as to whether therapist attitudes are a function of being an occupational therapist or a more innate function of individual character, the value of seeing the individual as a whole and treating him or her with kindness and respect remains clear for all participants.

Theme C: Advocacy

Participants spoke frequently about advocacy for either their patients or the profession. Professional and social attitudes towards criminals can be prohibitive to treatment, and as such, advocacy becomes a critical component in corrections. Five subthemes were identified under advocacy specific to corrections including 1) patient advocacy, 2) role of occupational therapy in corrections, 3) implications of occupational therapy on recidivism, 4) improvement in community support, 5) professional advocacy.

Patient Advocacy

Patient advocacy is an important role of the occupational therapist in any setting; however, the complex ethical attitudes of criminal action held by some corrections staff

can be prohibitive to treatment. Emily describes the tendency of some staff to adopt a fixed point of view on patient recovery.

> I think especially with our folks who have been at our facility for a long time, people tend to just kind of place them in their category even if that category happened 13 years ago. Like, "Oh well he's really assaultive, so he's always just gonna be like that." They don't give them enough credit, and I think that's one of our major roles in OT is to say, "No but look, we're seeing all of these other things."

Lauren spoke of the same tendency for some staff to develop rigid opinions on patient ability and "blacklist" certain individuals, adding to the importance of *patient advocacy* in forensics.

> Anyone with a disability is vulnerable. Anyone with a cognitive disability or, um, deficits with communication puts them at higher risk. Then you take it to psychiatry and you think of all the stigma, that makes it even worse, and then you put it in forensics and that, yeah, I would say that that definitely is the highest level, but you will see it everywhere. No matter where you go, no matter what setting. And that is why OT and one of our biggest roles is to be a patient advocate is because we always need to be assessing the situation and standing up for our patients. *Talking for them when they can't*.

Additionally, Lauren discussed the new animal assisted therapy program at the hospital and how some patients can be drawn out to participate through utilization of functional activity with therapy dogs. She argued that because occupational therapists have the unique advantage of seeing patients from a different perspective, it is their job to

promote *patient advocacy* by conveying to the treatment team that those patients are capable of progressing.

> "Look! This person is a human being. Look at them engage with the animal. Look at how kind they can be. Look at how gentle they can be." You know? So it's almost like I feel like I'm constantly justifying like, "Look this is human, let's treat them that way." You know, let's consider what they're saying. Let's see them in another light.

Kathy also provided an example of the complexities surrounding patient care and the necessity for *patient advocacy*. In her example, Kathy explained how one particular doctor "doesn't really acknowledge that anyone has any issues" and referred a woman who had her shoulder closed in a cell door to Kathy for a shoulder evaluation.

> I haven't worked with shoulders since I was in OT school, so I didn't really feel qualified to do that so then I recommended that she get a physical therapy referral because they do have a physical therapist that comes in as needed, and I was told by the doctor basically to mind my own business. Um, the woman, I suggested to her, I actually, this is one of our routes around medical not addressing issues is we recommend to the women to call the ombudsman and complain, file a grievance.

In contrast to roles heavy with *patient advocacy*, Tim has access to adequate resources, no time constraints on therapy, and works in a "well-supplied, generously equipped clinic in a state-of-the-art facility." In explaining why he does not need to do much *patient advocacy* he stated, "I'm fortunate in that doing particularly orthopedics, there's some pretty standard protocols that need to be followed in order to take a person

from pathology to well." He continued to explain his position as a service provider within the federal prison system.

> I can treat a patient, in fact I can just see patients through the course of rehab much more easily than in other contexts because it's a controlled environment, um, but I don't really have to do all that much advocating in the prison system.

He admitted, "Sometimes it takes a long time to acquire some things that would be readily available in other contexts, but generally anything that I need I am able to get."

Role of Occupational Therapy in Corrections

Corrections is a relatively unknown area of practice to occupational therapists. With such a wide scope of practice and such a unique patient population and treatment setting, there are unique duties of the occupational therapist within the *role of occupational therapy in corrections*. Tim described his role in the federal prison system to rehabilitate individuals from a physical dysfunction perspective.

> We have some very, very sick people, but they have a debt to society that will not have been paid before they are too sick to care for themselves or protect themselves in the general population of the prison, so it's our responsibility to care for them.

Emily explained the *role of occupational therapy in corrections* in the context of a forensic setting.

> I feel that our role as OTs is to help come in and provide a lot of sensory stuff, you know, so that we can help these people feel more calm, be able to engage in activities because they're able to regular their emotions, um, better.

> Say somebody had charges of attempted murder and so their lawyer feels like they're acutely psychotic and they don't think that they can understand court proceedings, they're going to send us, them to us for a competency evaluation. If they're found incompetent to proceed then we're going to restore them to competency.

She continued to explain that once a person is restored to competency and can work with the lawyer and understand court proceedings they will go to trial. For individuals found Not Guilty by Reason of Insanity, Emily explained that they have gone to trial and the judicial system determined the severity of their mental illness was significant enough to warrant treatment instead of prison time. She explained that occupational therapy works with those individuals to prepare for their eventual release into the community, which ultimately the courts decide. Some people will never leave the hospital.

Malingering occurs when an individual is faking psychiatric involvement in order to delay court proceedings or avoid going to jail. Lauren described the *role of occupational therapy in corrections* within the forensic context as part of the "detective team because we're able to elicit, um, things that are not seen when they're engaged in other types of therapies."

> It turns into a situation where, you know, in their competency evaluation they've identified different cognitive deficits or, um, sometimes it's psychotic symptoms or behavioral issues or things like that and then we put them in an OT group and all of a sudden all those skills are present, you know, when you get them engaged in something functional and meaningful.

Functional activity can often elicit progress when it seems a patient is stalled.

Kathy shared an example of her *role* in helping a woman, who wouldn't participate in therapy due to lack of insight into her condition, move forward and find meaning during her prison sentence.

> She said, "People like me don't get mental illness, so I don't have a mental illness." Um [pause] in the community, crocheting had been something that she really enjoyed doing, so we got her involved in Community Service [crochet] group and she would, she went from you know, not interacting with anybody at all, keeping very much to herself, to she became the librarian. She was part of the bible study group, and in the Community Service group she actually helped teach other people, um, how to crochet.

Kathy continued that the woman was "someone definitely that, um it was the occupation-based interventions that helped her more than the talk therapy, more than any of the other things. Kathy also discussed the *role of occupational therapy in corrections* as educator and advocate throughout the institution. She discussed bringing issues to the highest levels of administration to get support; although, she admitted that it is often more effective and efficient to start with custody.

> Things like building rapport with the officers. You know showing them that you respect what they're doing, what their role is, um helps them to respect you as well. And then you can work out, you can work out compromises, you can um, you know sometimes I'll go to officers and I'll say, "I really need to do X, Y and Z what do you think will be the best way for me to approach that? Kind of involving them in the process, helping them understand why I need to do what I

> need to do and then help having them become involved in the process of how can I make this fit into your world?

Kathy stressed the importance of working with custody and using them as a resource. She pointed out that compared to all other corrections staff, custody spends the most time with inmates in prison and subsequently gleans the most information about each individual.

As the director of the occupational therapy department at the psychiatric hospital, Lauren feels her biggest *role of occupational therapy* in forensics is as an educator. One of her main areas of focus is decreasing the use of seclusion and restraint. She spends much of her time educating staff during in-service presentations, during meetings, during conversation in the hallway, getting support from doctors, psychiatrists, and administration.

> I am constantly talking about what we do, why it's important and really trauma informed care and how do we prevent putting hands on. How do we prevent utilization of PRNs, E-meds, court meds, things like that for things that are more noninvasive. And people are hearing it, and we're getting buy in, and we're getting support.

An extension of her role as educator is providing knowledge to staff about sensory-based treatments for patients. She has been working to implement sensory-based treatment methods across all units at the psychiatric hospital. She explained one of the interventions that has been recently introduced with positive outcomes, along with weighted blankets and relaxation rooms, is the use of compression garments.

> We have been able to use it with about five different patients up to this point with good outcomes in decreased self-injurious behavior. That's probably been the biggest outcome. So with patients who are cutters, we've gotten the long-sleeve compression shirts on them and really gotten close to extinguishing those behaviors, um, and it's also had a really positive effect on decreasing hours in seclusion and restraint.

Implications for Occupational Therapy on Recidivism

When asked to discuss the ways in which occupational therapy can serve incarcerated populations or why occupational therapy should be present within corrections settings, all participants gave similar answers with *implications for occupational therapy on recidivism*. Tim shared his opinion on why occupational therapy is an important discipline to have in the corrections system.

> We want them to be, um, productive members of society, uh occupational therapy is best suited to find out what would be a purposeful occupation, and by occupation I mean vocation for the person. To figure out at what level they're currently operating, perform activity analysis to determine whether or not the individual is capable of ultimately achieving this goal, and directing them into and often supervising the acquisition of the vocational skills. They've got multiple years over which the therapist can guide individual therapy.

Similarly, Emily commented on the *implications of occupational therapy on recidivism*.

> I think we could do a huge amount to decrease recidivism, which would in turn decrease overall costs, overall, you know, I mean I think we can just do so much. I would say that's probably the hugest piece is really see what we could do to

> decrease recidivism of people going back to jail because, again, if they had the skills and resources—at least the education of the resources—and were able to access those resources in the community because they *know* about them, I feel like there would be at least a lot more potential for those people leaving correctional facilities to be a lot more successful and so I think that we would be able to play a huge role in that.

She continued to share her opinion that recidivism occurs largely due to inadequate skill sets. "A lot of times people reoffend because they don't know what else to do. They don't have skills. They don't have the ability to do something different, so they go back to doing what they used to do." Similarly, Laruen talked about a dearth of skills among the released population and the role occupational therapy can play in remediating those issues.

> We can decrease recidivism if we're teaching them life skills so that they know what to do when they do get discharged, and we can give them some coping skills and some things they can take when they're leaving with them, again to hopefully be able to self-soothe and cope and calm themselves, so you know they're not getting themselves right back to where they started.

Lauren pointed out that the institutionalized environment does not resemble life on the outside and adjusting between the two settings after release is a skill that many patients do not have. She explained that simply spending time confined is not enough to remediate maladaptive behaviors.

> If we're not doing our part while they're here with us and facilitating that transition, we're setting them up to come back to us because if they don't have a

> way to sustain themselves on the outside, they're going to go back to all the behavior, the maladaptive, the criminal behaviors that got them to come to us in the first place because they don't know any other way to live.

She continued,

> Maybe it's not even can we teach you skills but can we find you somewhere that's going to let you work with a felony! Um because guess what? They're not going to have the cognitive capacity nor the patience to do that!

Kathy recalled an old slogan from the American Occupational Therapy Association.

> A few years back the AOTA slogan was, "Teaching skills for the job of living." I think that's why. If we expect people to leave prison and become productive members of society and understand the job of living as a productive member of society then we need to help them learn how, and that's what we do.

Improving Community Support

The *implications of occupational therapy on recidivism* are positive; however, helping individuals establish skills, habits, and roles that will help them facilitate the transition from institution back into community is not enough. *Improving community support* was another subtheme that emerged under the umbrella of advocacy. All of the participants independently mentioned or alluded to deinstitutionalization. Lauren commented on how the outcomes of deinstitutionalization currently affect the forensic system and the need for *improving community support*.

> The outcome of that is we have people in jail and who are homeless. Those are the outcomes for folks who are mentally ill and can't be in a hospital or in a supported community based living situation, which obviously is ideal, but there

> has to be the recognition as well that there are some people who are chronically mentally ill who will need supported living for the rest of their lives. So you know, and we don't have that. That's part of the problem even with the whole forensic system at our hospital is we end up getting people who are stuck. We can't discharge them because there's nowhere for them to go because people don't want them.

Kathy mentioned deinstitutionalization when she discussed how she became involved in the corrections system as an occupational therapist.

> As the state hospitals started closing the patients either went to the community or they went to jail because there weren't enough, there weren't enough community services and they would, ya know, get arrested for this, that or the other thing and, um you know, someone with a mental illness is more likely to serve their sentence than make parole, so I think that people that were actually following where the mentally ill were going were going into community practice or going into prison.

Emily discussed how a lack of community support has directly led to some of the criminal acts committed by people who were in desperate need of mental health care.

> There's two people that I've worked with in the past who, um, really committed a really heinous crime in the end, but all of the events leading up to it, it's just so sad, you know, there's this person who was seeking help over and over and over again and kept getting sent away and sent away and this person became more psychotic and got more delusions, um, and then committed a really horrible crime. And it's like if that person—well several, I can think of three just off the

> top of my head—if these people could have just gotten the help that they needed originally, this whole situation could have been avoided.

Lauren supported increased early intervention methods to *improve community support* and help prevent the development of criminal occupational roles.

> If we can identify kids who are high risk for mental illness, for crime, for these types of things and we can provide treatment *then*, you know, hopefully we can, we can deter some of what we're seeing with adolescents and adults.

She commented on a rampant traumatization of young people occurring throughout society as laying a foundation for criminal behavior.

> We've created a society that is so traumatized, I feel like these days, you know, um and so I think in a general sense, um, it's gotta start there. We need to be working with kids more and providing more support at that stage, but then obviously having the right level of care. We need more group homes. We need more clubhouses. We need more halfway houses for our folks that have mental illness and co-occurring substance abuse issues. I mean there's nowhere for these people to go!

Kathy commented on the existence of transitional support but admitted that it is largely ineffective because much of the programming does not focus on practical, functional issues of reentry.

> Working in the halfway houses, which I mean, we saw them. They're a disaster, um, I mean imagine those programs if they were occupation-based and how much more successful people would be.

Tim explained that because the federal prison system is compartmentalized, there are many disciplines with roles in transitioning inmates out into the community. He commented that much of those responsibilities are filled by social work. As an orthopedic hand therapist working with a diverse treatment population, Tim's role with patients is limited once they are out in the community.

> Folks that are really, really sick, they're probably going to be going to a nursing home or home with family, and outpatient—I mean occupational therapy—at that point would be ensuring that they have the adaptive equipment needs met, such as wheelchairs, um, any adaptive clothing or personal item needs met, and then they typically will start receiving full-time nursing care in a nursing home or in-home care, and we just ensure that they have what they need until those services are established.

Professional Advocacy

Occupational therapy is commonly misunderstood by the public and by other professionals, making *professional advocacy* an important role for any occupational therapist. Given the scope of practice within occupational therapy and the implications it has on recidivism, *professional advocacy* is critical in order to expand the understanding of the profession and gain support and recognition for its place in corrections. Kathy stated simply, "I think the system is crying for OT, and they just don't realize how much we can help them."

Tim felt the answer to why occupational therapy should be present in the correctional system to be rudimentary. "That's like saying what does an occupational therapist do? Um, in every way, really is the answer, depending on the context of the

environment and the individual." He continued his justification and *professional advocacy* for occupational therapy.

> There is no other professional as multi-modal for as inexpensive as occupational therapy. Across the entire continuum of care, from the rehabilitation side, you know generally what we think of as inpatient rehab: back and forth to the bathroom, in and out of the tub, reacher pushers and long-handled shoe horn pushers, um, the outpatient side, orthopedic hand therapy, um, spinal cord injuries with seating, etcetera, but also psychiatric care. Guiding activities for long-term care, uh, over-seeing and supervising recreation therapy, art therapy, music therapy, um, and, *and* from the vocational side, the reentry side, which is the ultimate goal of the prison system.

Emily felt equally as strongly about the importance of occupational therapy in corrections.

> I feel like it's so important for us to be in these kinds of settings as OTs because we can play such an integral, integral part into somebody being able to leave a facility like this and be successful.

Kathy felt that the scope of practice for occupational therapy was enough evidence to suggest a much stronger presence in corrections.

> There are so many, sooo many ways, um, well if we're just looking at corrections in general, not specifically the mental health population, um, one of the biggest problems in corrections is the recidivism rate, and you know why is that happening? Well, people aren't being prepared to return to the community. They

> aren't being prepared on how to be productive participants in society and isn't that like, that's what we do.

She expressed how occupational therapy involvement at the individual level should be a given, but she then expanded her view of *professional advocacy* in corrections and talked about occupational therapy existing at nearly every level of the criminal justice system in consultative positions.

> I mean there needs to be, there needs to be an OT on the parole team. There needs to be an OT, um, working in the court systems, um, you know maybe advising on sentencing, um, there needs to be—ok so now I'm like bigger than corrections—there needs to be an OT at every level of the criminal justice system. Working with the police, working with the prosecutors and the judges, working in corrections because I mean yeah, that's what we do. Helping people to be productive in the community. That's what we do.

Lauren utilizes her position as director of the occupational therapy department to constantly promote *professional advocacy* and counter the misconceptions of occupational therapy at the hospital. She explained how much of the staff, including doctors, were unclear on what occupational therapy does and why it's necessary. She provided an example.

> The doctor told me, he said, "Well when we're really looking at her behavior plan and the thing is is she really enjoys your guys' sessions way too much, so she's going to have to work for them." And I'm like, "I have a doctor's orders to provide these services!"

She explained the ways in which she advocates for occupational therapy throughout the hospital.

> Every meeting I'm in, every um, whether it's an administrative meeting, and it always has to start up there because if you don't have an understanding from administration and support, um, you won't get it elsewhere, um, so I spend my time, I'm never quiet in any meeting I go to. I'm always the one who's like well did we consider this? And did you know that OT can offer that? And did you that it's within our scope of practice to assess this or provide this or to do this.

Kathy discussed her role as an occupational therapist on the treatment team. She emphasized the importance of treatment team cohesion and the role an occupational therapist plays in uniting disciplines. She said,

> I think that [occupational therapists are] really good at being able to bridge the gap between different disciplines just because of our training and, you know, considering all the aspects of the environment, the human, the non-human, observing um, observing what's going on. I think that just makes us really good at bridging the gap.

Throughout the interview process, Lauren emphasized the importance *professional advocacy* and educating others about occupational therapy. "I always say just educate people. Educate other OTs! There's so many OTs that don't know what, what this is about and why we do this."

Chapter 5: Discussion

The problem that inspired this researcher is the inherent occupational deprivation created by incarceration and the subsequent difficulties individuals face when reintegrating the community. The rationale that motivated this researcher is that through an understanding of the relationships between person, occupation, and environment, occupational science may inform occupational therapy on the most effective ways to mitigate the detrimental effects of occupational deprivation. The purpose of this research was to explore the role of occupational therapy in corrections settings.

The literature demonstrating the existence of occupational therapy in corrections is sparse. There is a stronger evidence base to support the presence of forensic occupational therapy, yet little is explicitly stated about what occupational therapists actually do in forensic psychiatry (Duncan et al., 2003; Farnworth et al., 2004; O'Connell & Farnworth, 2007). The findings obtained from this study are novel in that they attempt to describe the variation in roles for each occupational therapist across corrections settings.

Disparities existed in the data regarding therapist involvement in community reentry or transition preparations, views on extreme disciplinary measures such as seclusion and restraint or solitary confinement, and the need for patient advocacy. These differences may be attributed to gender differences, background experience, treatment setting and population, novice researcher experience and the non-standardized, conversational interview questions used. Despite the compounding effects, each participant helped to provide a snapshot of what services occupational therapy provides within the correctional setting in which he or she was employed.

The settings within corrections vary widely and as such so do the roles of occupational therapy. The three emergent themes of safety and security, people are people, and advocacy represent the overall similarities that were found between participants and across corrections settings. The subthemes that emerged for each overarching theme represent specific ways in which those themes manifested as part of the role of occupational therapy in corrections.

Safety and Security

Safety and security is a critical piece in corrections because the patients in prison or in a forensic hospital can be dangerous and violent with other inmates, patients or staff. Tim, Lauren, and Emily spoke about the potentials of violence in the setting. The unique dangers of aggression and violence present across corrections and forensic environments are described throughout the current literature (Beck et al., 2013; Farnworth & Muñoz, 2009; Freuh et al., 2005; Human Rights Watch, 2003; Morris et al., 2012; O'Connell & Farnworth, 2007; Wolff & Shi, 2009).

The physical and social environments across corrections settings tend to be prohibitive to rehabilitation because rigid, restrictive protocols are essential to maintaining safety and security but complicate the provision of therapeutic services. All participants described the environments in which they worked and how those restrictions led to constraints on therapy. Lauren, Emily, and Kathy referenced or alluded to occupational deprivation and how it results in patients reverting to previous maladaptive habits. The research demonstrating the effects of occupational deprivation is limited; however, what does exist and reinforces the reversion to maladaptive behavior (Molineaux & Whiteford, 1999; Whiteford 2000). Whiteford (1995) and Whiteford

(1997) explored this phenomenon explicitly and determined that the restriction of tool use and occupational engagement in prison caused occupational deprivation and led to inmates' diminished occupational capacity and adaptive skills, reduced self-efficacy, and loss of identity.

Maladaptive behaviors can result in increased volatile and aggressive behaviors (Morris et al., 2012). Tim and Kathy spoke to maladaptive behaviors creating the hostility, aggression, and mistrust in prison environments. Consequences for violent behaviors from inmates and patients are extreme disciplinary measures which are commonly used throughout corrections despite evidence that they are counterproductive to improving misbehavior (Butler et al., 2014; Human Rights Watch, 2003; Kupers, 2008; Wale et al., 2011; Whiteford, 1995).

There was some conflicting opinion between participants about the efficacy of extreme disciplinary measures such as Special Housing Units or seclusion and restraint. Tim expressed the necessity of such disciplinary measures in the prison setting to maintain safety, while Lauren and Emily both discussed feeling ethically conflicted about the efficacy of seclusion and restraint on treatment. Sailas and Fenton (2012) conducted a systematic review of literature regarding seclusion and restraint, concluding that there was no empirical evidence supporting the methods. The literature regarding patient outcomes after seclusion and restraint support the claims that seclusion and restraint causes trauma in psychiatric patients (Chalmers et al., 2012; Mullen et al., 2008; Wale et al., 2011).

The differences in opinion among the participants were perhaps due to variation in setting and treatment population. Non-mental health populations are held to higher

levels of accountability than are mental health populations. Researchers maintain that individuals suffering from serious mental illness have fewer coping skills and diminished capacities to accurately perceive and manage their daily responsibilities, resulting in the necessity for treatment instead of incarceration (Baillargeon et al., 2008; Baillargeon et al., 2009; Baillargeon et al., 2010; Cloud, 2014; Fazel & Baillargeon, 2011; Human Rights Watch, 2003; Kupers, 2008; Mueser et al., 2004; O'Connell & Farnworth, 2007).

Treatment versus punishment was a significant subtheme from the data gathered during the interviews. Treatment and punishment are often viewed as two sides of the same coin, hence the lack of legislation (and lack of public support for legislation) providing criminal populations with opportunities for education, opportunities to develop work skills, and access adequate healthcare and means of social and financial support (Henrichson & Delaney, 2012). An alternative to the duality in incarcerated settings of treatment versus punishment is one of prevention. In expressing their ethical dilemmas regarding extreme disciplinary measures, Lauren and Emily acknowledged the utility and efficacy of providing rehabilitative treatment in order to prevent extreme punishment.

Lauren and Emily indicated that the implementation of positive environmental changes in conjunction with the provision of treatment as prevention has positive patient outcomes and reduces the need for seclusion and restraint. Lauren discussed using compression garments with patients who inflict self-harm and the use of relaxation rooms and weighted blankets with a patient who was easily agitated. Emily discussed her observations of a novel sensory awareness intervention and it's efficacy on a difficult patient. Both therapists referenced sensory-based treatment methods numerous times and commented on the efficacy in reducing patient agitation and aggression.

The utilization of positive sensory-based treatment methods in psychiatric hospitals helps to empower patients, involve them in their own therapy, prevent seclusion and restraint, and is supported by the literature to have positive treatment outcomes (Chalmers et al., 2012; Mullen et al., 2008; O'Connell & Farnworth, 2007). Neither Tim nor Kathy mentioned any supported efforts to provide sensory-based interventions or enact positive environmental changes. The lack of sensory-based interventions in prison settings is perhaps due to the fundamental philosophical differences between prison and hospital (i.e., punishment and recovery); prison systems do not generally support positive cultural shifts in the provision of services.

People are People

All therapists valued holistic, human interaction with inmates and patients and found that forming positive and supportive relationships with their patients facilitated positive outcomes. Client-centered care is a cornerstone of occupational therapy and as such, occupational therapists have an in-depth understanding of their clients. Exposure to clients from varied cultures and backgrounds, who have varied limitations, diseases or impairments, reinforces the philosophical underpinnings of the profession to treat all clients with respect, patience, and kindness (AOTA, 2010; AOTA, 2014). The recognition of and sensitivity to the variety of cultural, environmental, and contextual elements of individual development are essential components in providing client-centered care.

All participants in this study shared examples of patients they have worked with whose personal history played a significant role in shaping the reasons they were either in prison or on one of the forensic units. Tim described how many of the men he treats have

known only criminogenic environments their entire lives. Emily discussed the lack of community support experienced by some as exacerbating the symptoms of their mental illness, which ultimately led to their crimes. Lauren talked about a patient who is very intelligent but suffers from chronic psychosis and as a result is easily agitated and becomes aggressive. Kathy also spoke of criminogenic lifestyles altering otherwise positive life trajectories of intelligent patients.

As Forsyth and Kielhofner (2003) described the elements of MOHO, they highlighted how integral social and physical environments are to development and occupational choice. Kielhofner (1980b) discussed how negative feedback and surroundings often result in a loss of confidence, a sense of helplessness, and lead to an expectation of failure. Although his discussion was centered on physical dysfunction, it has application to other causes of maladaptive behavior because Kielhofner (1980b) maintained that through such "vicious cycles" the "volitional subsystem's urge to mastery [of the environment] cannot find expression" (p. 734).

Two essential components for changing or developing any habit, productive or maladaptive, are time and skill. If one wishes to stop biting his fingernails, to increase weekly exercise, to increase work productivity, to learn French, or to learn how to pick locks, embezzle money, or sell illicit drugs, one must devote time to developing the skills pertinent to each endeavor. It is common knowledge that the longer one engages in a specific activity on a regular basis, the more engrained it becomes as a habit. It is also common knowledge that 'old habits die hard.' MOHO theorists posit that in order to develop new skills and habits, time, repetitive practice, and stability of environment are crucial elements (Forsyth & Kielhofner, 2003).

Emily referred to the development of institutionalization in her patients over time and how that learned complacency acted as a counter-weight to retaining skills for independent function. Prisonization has the same effect on prisoners. Schedule, environment, diet, activities, clothes, and socialization are all dictated, and thus lose meaning, in corrections settings because of the rigid, albeit necessary, safety regulations. The removal of individual choice and control is a function of incarceration, but due to occupational imbalance and occupational alienation, it diminishes motivation for independent function (Townsend & Wilcock, 2004a; Farnworth & Muñoz, 2009).

All participants discussed the limited skills of their clients in their respective treatment populations and how those deficits translate to an inability to independently change maladaptive behaviors. The literature supports that incarcerated and mentally ill populations have fewer education, work, and coping skills compared to the general population (Morenoff & Harding, 2014; Woods et al., 2013; Baillargeon et al., 2010). Woods and colleagues (2013) and Drakulich and associates (2012) maintained that many community integration difficulties experienced by ex-prisoners are compounded by these factors.

Emily described a volunteer group wherein patients at the hospital engaged in community service projects. She explained that with guidance from herself and other therapists, patients were eventually initiating and advancing developments in their projects, resulting in patient skill growth, improved self-efficacy and confidence. Yerxa (1993) explained how skill is a pivotal concept in the development of occupational patterns and roles. This author described self-perception of skill level as essential to

building confidence and pursuing role development, and explained how increasing skill level is essential to motivating mastery of one's environment.

Tim, Lauren, and Kathy also spoke of how they guided skill development and facilitated a sense of self-worth through occupational engagement with different patients and the resulting positive outcomes. Cobbina (2010) demonstrated that in female parolees, positive, therapeutic relationships with their parole officers fostered a sense of support and facilitated progress toward successful reentry compared to those who infrequently met with curt parole officers. Lauren and Emily both spoke about occupational therapy's role in instilling hope as a foundation for confidence and empowerment in patients. Dekhtyar and colleagues (2012) demonstrated hope as a positive function of progress and rehabilitation for incarcerated individuals returning to the community. The authors concluded that individuals demonstrating a strong but realistic sense of hope for success were less likely to be re-incarcerated.

Advocacy

The representations of advocacy contained within the data carry important implications for occupational therapy. Professional advocacy is important to expand the reach of occupational therapy and clarify the role it plays in a variety of settings to both the public and other professionals (Yerxa, 1993). All therapists in this study independently advocated the value of occupational therapy to corrections and the roles it can play in giving a voice to corrections patients and mitigating recidivism.

According to the Occupational Therapy Code of Ethics and Ethics Standards, social justice, which includes advocacy for patients, colleagues, and others as well as "educating the public and society about the value of occupational therapy services in

promoting health and wellness," is a professional obligation (AOTA, 2010, p. 6). Patient advocacy is important for those who cannot or are afraid to speak up for themselves. In corrections settings, mistreatment of the inmates or patients by the hands of security personnel is not uncommon (Beck et al., 2013; Freuh et al., 2005; Wolff & Shi, 2009). All participants mentioned the potential or actual mistreatment of prisoners and patients.

Kathy shared examples of the medical staff neglecting inmate health issues, leading to exacerbations and more costly care. She explained how she advocates for patients by encouraging them to contact the ombudsman and file complaints for investigation. Emily shared examples of how she frequently advocates for patients by encouraging staff to see beyond a criminal or psychiatric label. Lauren described observing unethical staff attitudes toward the patient population simply because the setting was forensic. Kupers (2008) maintained that overcrowding of many correctional facilities results in overwhelmed staff that simply cannot manage the high volume caseloads. He asserted that corrections populations are in a vulnerable position because they are easily manipulated and quieted by institutional staff and administration (Kupers, 2008).

Tim shared a different perception of patient advocacy, stating that because the Federal Medical Center (FMC) where he works is well staffed and generously equipped, he does not encounter the need for much patient advocacy. Given the resources and nature of the treatment setting, Tim felt he is able to provide quality care to those patients in need. Despite his access to adequate resources and supplies, Tim did reference the weight of responsibilities that fall upon corrections officers due to their being vastly outnumbered by the inmate population. In his report for the Bureau of Justice Statistics

on the census of corrections, Stephan (2005) stated that overcrowding and understaffing is an issue for many correctional institutions, federal, state, and private alike.

All participants were eager to utilize the opportunity of participation in this study for professional advocacy. Each therapist expressed delight in knowing that corrections as an area of practice for occupational therapy was being recognized and explored. Lauren, Emily, and Kathy each talked about the misunderstandings of occupational therapy held by other professionals and administration in their respective settings, which Yerxa (1993) and Hammell (2007) have asserted. Often occupational therapy is perceived as fun, recreational, and extraneous because therapists frequently utilize functional activity (e.g., arts and crafts, gardening, or cooking tasks) to facilitate goal achievement; however, what is not seen is the complex skill of activity analysis: analyzing person, task, and surroundings (AOTA, 2014).

Kathy commented on the frequent misunderstandings of occupational therapy's broad scope of practice leading to the profession being under utilized in corrections. Tim commented on the broad scope of practice allowing occupational therapy to functionally accomplish the tasks of other therapeutic disciplines in corrections settings where those disciplines are not present. All participants expressed strong opinions regarding the role for occupational therapy to facilitate community reintegration and ultimately reduce recidivism.

Tim highlighted the differences in patient availability and allocation of resources at the FMC compared to other settings as therapeutically beneficial. He explained how therapists could take advantage of prison sentences in corrections to evaluate areas of need, determine which areas need to be remediated, implement interventions and begin or

oversee skill acquisition, assess outcomes, and make any necessary adjustments. While occupational therapists in any setting must carry out the same occupational therapy process, the significant time differences he expressed would allow reinforcement of developing skills and habits to facilitate carry-over into the community.

Prison sentences or sentences to a forensic unit can span from one or two years to life sentences. Salina and colleagues (2011) supported the implementation of rehabilitative programming as early as possible in order to utilize length of time and establish strong development of skills and habits. Increasing opportunities for occupational engagement in corrections settings can be complicated given all the restrictions. All participants spoke to the concerns and complexities of providing care in a correctional environment. Lauren referred to engaging her "OT brain" more than in other, non-correctional settings by adapting occupations to fulfill patient needs while at the same time accommodating security restrictions. Occupational enrichment is a strong platform to facilitate programming specific to corrections (Farnworth & Muñoz, 2009; Molineaux & Whiteford, 1999; Whiteford, 2000).

The implication of transposing the application of MOHO to an incarcerated setting is that occupational therapy guided by MOHO supports the rehabilitation of criminogenic lifestyles. MOHO was designed to be client-centered and to address volition, habituation, occupational performance, and environment (Forsyth & Kielhofner, 2003). MOHO guides therapists to consider environmental and contextual elements (Forsyth & Kielhofner, 2003). Through activity analysis and occupational enrichment, occupational therapists can adapt meaningful occupations to fit within the safety parameters of corrections; they can facilitate the development of skills necessary for

supporting positive habits and roles; they can grade activities over time to reinforce skills and habits to encourage carry-over into the community; and they can instill hope, motivation, and empowerment in patients through client-centered, supportive care (AOTA, 2014; Forsyth & Kielhofner, 2003; Molineaux & Whiteford, 1999; Yerxa, 1993).

Chapter 6: Summary, Conclusions, and Recommendations

This phenomenological study examined the lived experience of occupational therapists working in corrections settings, including a Federal Medical Center, a state prison, and the forensic units in a state psychiatric hospital. Three themes emerged that were found to represent topics specific to working in corrections: safety and security, people are people, and advocacy. Each contained subthemes that were found to represent specific manifestations of what it means to work as an occupational therapist in corrections.

Occupational therapy as a discipline is broad and all encompassing, making it an asset to improving community integration efforts and ultimately mitigating the costly effects of recidivism. There are practical difficulties of providing meaningful occupation to inmates and patients in corrections settings while operating within the necessary security parameters. Respect and kindness is found to be limited within incarcerated environments. There is a need for society to recognize that current incarceration practices have detrimental effects for the entire nation.

Despite some limitations, the overall conclusions of this study are 1) occupational therapists can utilize their entire scope of practice in corrections, and 2) the inclusion of corrections as a recognized area of practice for occupational therapy is supported. Occupational therapy can provide consultative services to institutions at large or provide individual or group therapeutic interventions to the inmate or forensic patient populations while staying within the necessary security parameters. As supported by both, the results of this study and the related literature, the restrictions experienced by corrections populations both during incarceration and after, can be addressed and remediated by

occupational therapists. From basic self-care skills to independent living skills, from communication and social skills to work skills, from mental health to physical dysfunction, from time management to money management, to emotional and behavioral regulation, occupational therapy can work to remediate these limitations and equip individuals with tools and skills to succeed in the community.

Despite the lack of empirical studies on occupational deprivation in corrections settings, the inability for people to engage in meaningful occupations over extended periods of time because of external circumstances tends to result in negative functional implications. The difficulties in remediating the effects of occupational deprivation lie in the restrictions inherent in corrections. Occupational therapists, however, specialize in analyzing person, occupation, and environment and providing adaptations that facilitate meaningful engagement while adhering to the necessary safety and security protocols to ensure safety and security for all persons.

Future studies in occupational therapy should aim to establish the effect of positive, supportive, occupational programming on reoffending; the development of productive skills, habits and roles and how best to foster the retention of those upon transition into the community. Future studies in occupational science should aim to explore occupational deprivation and the impact it may have on recidivism as well as the effect of maladaptive occupational engagement on health and well-being.

Appendix A: Recruitment Letter

Hello! As part of my thesis work at Ithaca College I am exploring the role of occupational therapy in corrections settings. I am very interested in the details of what you do as a therapist and would like to conduct a series of 3, 45-minute, open-ended interviews with you. Interview formats include face-to-face, Skype, or phone, whichever is possible. Your identity will be kept confidential and will not be included in the data. Please review the attached *Informed Consent Form*. If you agree to participate, send a confirmation email to me indicating that you have agreed to the attached form so that an interview time may be scheduled.

By participating in the interviews you acknowledge and consent to have the conversation audiotaped and transcribed for data collection.

You must be at least 18 years of age to participate.

Thank you very much for helping!

Rebecca Bradbury
Graduate Occupational Therapy Student
Ithaca College
rbradbu1@ithaca.edu

Appendix B: Informed Consent Form

1. Purpose of the Study
   I am conducting a study on the role of occupational therapy in corrections settings in order to expand on the available research in the field and gain a more in-depth understanding of how occupation therapy fits into the penal system.

2. Benefits of the Study
   There are no direct benefits to participation in this study.
   Participation benefits the scientific community by adding to and expanding the research base of occupational therapy.

3. What You Will Be Asked to Do
   Participate in 3 interviews.
   The interviews will take approximately 45 minutes.
   The interviews will consist of about 7 open-ended questions.
   Exclusionary criteria include occupational therapists who do not work in a corrections setting and anyone who is under the age of 18.

4. Risks
   There are very few risks, if any, posed by this study.

5. Compensation for Injury
   If you suffer an injury that requires any treatment or hospitalization as a direct result of this study, the cost for such care will be charged to you. If you have insurance, you may bill your insurance company. You will be responsible to pay all costs not covered by your insurance. Ithaca College will not pay for any care, lost wages, or provide other financial compensation.

6. If You Would Like More Information about the Study
   Participants are free to refrain from answering any question(s) they do not wish to address.

   Rebecca Bradbury
   Graduate Occupational Therapy Student
   Ithaca College
   rbradbu1@ithaca.edu

   Dr. Melinda Cozzolino, OTR/L, MS, CRC
   Associate Professor and Acting Department Chair (Fall 2014)
   Department of Occupational Therapy
   Ithaca College
   mcozzoli@ithaca.edu

7. Withdraw from the Study
   Participants are free to end the interview and/or withdraw from the study at any time.

8. How the Data will be Maintained in Confidence
   Confidentiality will be maintained throughout the duration of the study. Participant identity will not be divulged at any stage of development. Data will be stored on a password-protected computer for 5 years and destroyed after that time.

Interviews will be audiotaped and transcribed for data collection. Data will be stored on a password-protected computer that only the researcher will have access to. Data will be stored for 5 years.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older. **(This sentence should be omitted when it is obviously inappropriate.)**

_____
Print or Type Name

_____ _____
Signature Date

I give my permission to be audiotaped (videotaped). **(This sentence should only be used when appropriate.)**

_____ _____
Signature Date

Appendix C: Interview Questions

According to Creswell (1998) and Patton (2002), the phenomenological study aims at exploring the lived experiences of a person or a group of people. Due to the diverse sample, questions were kept informal and discursive to better capture the lived experiences of each individual as they pertained to working as an occupational therapist in a correctional setting. In keeping with the description of informal, conversations interview styles in Patton (2002), the subsequent interview questions were derived from previous interview content, and questions were used to contain conversation within the objectives of this study. Below is a list of sample questions that may be used during interviews.

- Basic demographic information about education and setting
- How did you become involved in the penal system as an occupational therapist?
- Can you describe what a typical day is like for you working in the penal system?
- What do you find most rewarding about working with an incarcerated population?
- What do you find most challenging about working with an incarcerated population?
- What benefits do you think occupational therapy can serve incarcerated populations?
- Where do you see the future of occupational therapy in corrections settings?

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