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REENTRY READINESS: THE RELATIONSHIP BETWEEN SELF-EFFICACY, OPTIMISM, AND MOTIVATION TO CHANGE AMONG INDIVIDUALS EXPERIENCING INCARCERATION

A Dissertation in Counselor Education and Supervision
by
Lindsey Fullmer

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The dissertation of Lindsey Fullmer was reviewed and approved* by the following:

Liza Conyers  
Associate Professor of Education  
Dissertation Advisor  
Chair of Committee  
Program Coordinator of Clinical Rehabilitation and Mental Health Counseling

Allison Fleming  
Assistant Professor of Education  
Program Coordinator of Rehabilitation Counseling

Katie Kostohryz  
Assistant Professor of Education

Holly Nguyen  
Assistant Professor of Sociology and Criminology  
Director of Undergraduate Program

Carloz Zalaquett  
Professor of Education  
Professor in Charge of Counselor Educator Program

*Signatures are on file in the Graduate School
ABSTRACT

Mass incarceration continues to be a significant issue for the criminal justice system, presenting new challenges to support mass reentry. The reentry process poses significant challenges for individuals returning to their communities, and individuals with mental illness are often most vulnerable due to their unique needs. The majority of research on reentry has examined context-specific conditions that promote successful reentry, such as access to housing and employment. Minimal research exists that examines reentry readiness. Specifically, investigating the contributions that person-specific conditions on perceived reentry readiness. This study used multiple regression analysis to examine the contributions of three person-specific conditions to reentry readiness (i.e., self-efficacy, optimism, and motivation to change) and three context-specific covariates (i.e., access to identification, income, and housing upon reentry). Results showed that self-efficacy and access to income and housing upon reentry contributed to perceived reentry readiness. Contrary to expectations, mental health status had no contribution to perceived reentry readiness. The present study adds to the reentry literature by extending knowledge to the construct of reentry readiness and the conditions associated with this.
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Chapter One: Introduction

As the rates of incarceration in the United States have increased, so has the number of individuals being released back into the community (Travis, 2005). In 2016, approximately 626,000 individuals in state and federal prisons were released from incarceration (Carson, 2018). Many of these individuals face a variety of personal, social, and economic issues that impact successful reentry (Lutze, Rosky, & Hamilton, 2014). Accordingly, concerns over the challenges that reentry poses for successful transitions into the community have been raised (Baillargeon, Hoge, & Penn, 2010). Researchers have been prompted to explore the process of reentry given the increased rate of individuals being released from incarceration (Garland & Hass, 2015). In order to investigate the process of reentry, it is important to first understand the characteristics of individuals who are incarcerated. Recent reports on correctional populations show rates of young men who are incarcerated continue to be high in criminal justice system (Carson, 2018).

Many efforts have been made to improve successful reentry for individuals who are incarcerated; however, increased recidivism rates further demonstrate challenges to the reentry process (Hunter et al., 2016). One potential area that could support reentry efforts, yet has received minimal attention in the literature is the concept of reentry readiness. In the present study, reentry readiness is defined as individual perceptions of readiness to reenter the community upon release from incarceration. Doherty, Forrester, Brazil, and Matheson (2014) distinguish person-specific conditions and context-specific conditions that impact reentry readiness. Person-specific conditions are viewed as an individual’s mindset for reentry (i.e., self-esteem, the desire to change) whereas context-specific conditions are viewed as the access to resources or services during the reentry process. From a larger perspective, the construct of
readiness among individuals who are incarcerated has been examined within the context of
treatment readiness (see Ward, Day, Howells, & Birgden (2004), career readiness (see Downing,
Stitt, & Murray, 1987), and learning readiness (see Alewine, 2010). Accordingly, this study aims
to build upon existing literature on readiness by examining person-specific conditions while
accounting for context-specific conditions that may contribute to reentry readiness.

Several studies have identified potential person-specific conditions associated with
successful reentry, such as self-efficacy (see Bahr, Harris, Fisher, & Harker Armstrong, 2010;
Friestad & Skog Hansen, 2010), optimism (see Visher & O’Connell, 2012), and motivation to
change (see Gideon, 2010). Moreover, several demographic characteristics have also been
known to impact successful reentry. For instance, Bales and Mears (2008) note race, age, history
of incarceration, and length of incarceration is often characteristics controlled for in reentry
research given their strong predictive abilities. This would seemingly be true when examining
the construct of reentry readiness. In fact, Wolff and Shi (2010) found older age groups are
associated with decreased perceptions of reentry readiness. Moreover, individuals who have
served long-term sentences have also associated with decreased perceptions of reentry readiness
(Wolff, Shi, & Schumann, 2012).

Several context-specific conditions are also theorized to impact both person-specific
conditions and perceived reentry readiness, specifically access to identification, income, and
housing upon reentry, and therefore must be taken into consideration. Few studies have
examined the unique contributions of person-specific conditions on perceived reentry readiness
while accounting for context-specific conditions. As such, this study aims to understand the
contributions of three person-specific conditions to perceived reentry readiness (i.e., self-
efficacy, optimism, and motivation to change) while also considering three context-specific
conditions theorized to impact perceived reentry readiness. In addition to this, a secondary aspect of the present study is to examine contributions of mental illness on perceived readiness.

Abracen et al. (2014) note the rate of individuals with mental illness in the criminal justice system has seen a particular increase. The Bureau of Justice Statistics (BJS; James & Glaze, 2006) reported in midyear 2005 that 705,600 individuals incarcerated in state prisons had a mental illness. Between 2011 and 2012, approximately 14% of individuals incarcerated in state or federal facilities (i.e., 1 in 7) reported symptoms for a serious mental health issue (Bronson & Berzofsky, 2017). Similarly, 37% of individuals incarcerated in state or federal facilities and 44% of individuals incarcerated in local jails reported having previously been told by a mental health provider they had a mental health diagnosis. The increased number of individuals who are incarcerated with mental illness is widely attributed to the rapid deinstitutionalization of people with mental illness without appropriate community supports (Lamb & Bachrach, 2001). As many people with mental illness do not receive effective mental health treatment in the community, they are susceptible to engaging in behaviors that can lead to incarceration (Palermo (2014).

Johnson, Kondo, Brems, Ironside, and Eldridge (2016) underscore the importance of investigating the potential impact of mental health on research outcomes to better understand and design appropriate treatment options. Given the high rates of individuals with mental illness in prison, this study will examine whether mental health status impacts person-specific and context-specific conditions associated with perceived reentry readiness. Considering the impact of mental health diagnoses is important, prior studies have found that some people with mental illness have lower levels of self-efficacy compared to those without (see Andersson et al., 2014; Hart, Vella, & Mohr, 2008; Hirsch, Conner, & Duberstein, 2007; Rabani Bavojdan, Towhidi, &
There is also some evidence that certain mental health disorders may be associated with lower motivation to change a specific behavior (see Siru, Hulse, & Tait, 2009).

**Statement of the Problem**

In 2016, approximately 1,505,400 people were incarcerated across state and federal prisons in the United States (Carson, 2018). Reentering the community upon release from incarceration poses many challenges (Harley, Cabe, Woolums, & Turner-Whittaker, 2014). Individuals are likely to return to a world that is vastly different prior to their incarceration (Davis, Bahr, & Ward, 2013). They often develop certain behaviors in order to cope with the prison environment during their incarceration (Rotter, McQuistion, Broner, & Steinbacher (2005). Visher and O’Connell (2012) suggest the way individuals think and act while incarcerated may have an impact on their behaviors and attitudes upon reentering the community. Accordingly, effective planning needs to occur at all phases of the reentry process in order to improve reentry for individuals who are incarcerated (Frazier, Sung, Gideon, & Alfaro, 2015).

One concern for current reentry research, as noted by Wolff, Shi, and Schumann (2012), is that it has failed to develop standards that determine whether individuals who are incarcerated will have an increased chance of success upon reentering the community. Current standards focus primarily on context-specific conditions and fail to account for key person-specific conditions that can impact one’s self-efficacy, optimism, and motivation to achieve successful reentry; however, the authors argue “common sense standards” (p. 382) would suggest that it is obvious these individuals will need specific supports and services (i.e., employment and income) in order to reduce the likelihood of recidivating back into the criminal justice system. As such, it is important to consider other factors that may contribute to successful reentry that could support
the development of objective standards. One potential area to consider are the person-specific conditions that contribute to successful reentry. In fact, Visher and O’Connell (2012) suggest individuals who are optimistic about their intended release from incarceration are more likely to be receptive of change and the factors that facilitate change.

Research indicates some of the most prevalent issues individuals face during reentry include access to employment or income (Visher, Debus, & Yahner, 2008) and housing (Kushel et al., 2005). Moreover, many individuals do not have proper forms of identification to obtain necessary supports and services upon release (The National Reentry Resource Center, 2016). Each of these conditions can both diminish an individual’s self-efficacy, optimism, and motivation to change as well as negatively impact their perceptions of reentry readiness. As such, it is important to account for context-specific conditions when examining the potential contribution of person-specific conditions on perceived reentry readiness.

With the overrepresentation of mental health in the criminal justice system, Torresy, Kennard, Eslinger, Lamb, and Pavle (2010) claim, “America’s jails and prisons have become our new mental health hospitals” (p. 1). As such, mental health professionals have become increasingly concerned about the increased rate of individuals with mental illness in the criminal justice system, particularly for the treatment provided during incarceration, transitioning, and post-reentry into the community (Lamb, Weinberger, & Gross, 2004). These concerns are valid considering individuals with mental illness faced additional barriers when reentering the community (Baillargeon, Hoge, & Penn, 2010; Pope, Smith, Wisdom, Easter, & Pollock, 201). As such, when conducting research investigating reentry readiness, it is important to consider how the characteristics of individuals who are incarcerated diagnosed with mental illness may differ from individuals who are not diagnosed with mental illness. Furthermore, when examining
the person-specific conditions associated with perceived reentry readiness, it is important to assess if having a mental illness would impact the key person-centered variables (i.e., self-efficacy, optimism, and motivation to change) given that mental illness is associated with lower levels of these person-centered conditions.

**Purpose of the Study**

The purpose of the present study was to examine perceptions of reentry readiness among individuals who are incarcerated. Specifically, the contributions of person-specific conditions on perceived reentry readiness were examined when controlling for demographic variables and accounting for context-specific conditions. Understanding the reentry process requires understanding the perceptions that individuals who are incarcerated have about their readiness for their intended release (Forste, Clarke, and Bahr (2011). Visher and O’Connell (2012) note the perceptions individuals who are incarcerated have about their readiness for release can provide important information needed to develop methods aimed at reducing recidivism.

This study is guided by three central aims. First, this study aims to examine the characteristics of men who are incarcerated in order to understand their unique perspectives towards reentry readiness. Second, this study aims to understand the person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) that contribute to reentry readiness for individuals who are incarcerated while controlling for demographic variables (i.e., race, age, incarceration history, and length of current incarceration) and accounting for context-specific conditions (i.e., have identification, income, and housing). Finally, this study aims to understand whether mental health status further contributes to perceptions of reentry readiness.

Results from this study have the potential to expand understanding of the person-centered factors that may contribute to perceptions of reentry readiness. Results of this study also have
the potential to support future research aimed to develop and implement programming and services to address person-specific readiness issues. Wolff and Shi (2010) posit that as government funding continues to be directed towards addressing issues of reentry, it is important to understand the population (i.e. individuals who are incarcerated) to ensure funding is properly allocated to reentry initiatives. Studies that address person-specific conditions of perceptions of reentry readiness can increase our understanding of how ready individuals are to engage in the reentry process and use other context-specific conditions. Finally, this study can also provide insight into the strengths, needs, and resources of individuals who are incarcerated, and determine whether there is a relationship between mental health status and perceptions of reentry readiness. Accordingly, further understanding of the unique person-specific factors associated with reentry readiness and considerations for individuals with mental illness can help inform future readiness interventions to better meet the needs of this population.

**Research Question**

Literature on successful reentry for individuals with mental illness who are incarcerated has primarily focused on the effectiveness of specific supports and services offered during incarceration and in the community upon release (Baillargeon et al., 2010; DeMatteo, LaDuke, Locklair, & Heilbrun, 2013; Lamb et al., 2004). Despite this, little is known about the perceptions of reentry readiness that individuals who are incarcerated have about their intended release, specifically the contribution of the person-specific conditions of self-efficacy, optimism, and motivation to change on perceptions of reentry readiness. Moreover, even less is known about how these person-specific conditions contribute to perceived reentry readiness based on the presence of mental illness. As such, this study is guided by the following research questions:
1. What are the characteristics of a sample of individuals who are incarcerated in three male state prisons in Pennsylvania? Are there differences in these characteristics based on the presence of mental illness?

2. What are the relative contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness while controlling for demographic variables and accounting for context-specific conditions?

3. Does mental health status effect perceptions of reentry readiness?

Based on the research questions listed above, the central hypothesis is that individuals who are incarcerated will face key person-specific and context-specific barriers to reentry and that there will be differences in the overall characteristics (i.e., demographics, context-specific conditions, and person-specific conditions) in a sample of individuals who are incarcerated with and without a diagnosis of mental illness. Given the presence of mental illness has been identified as a risk factor for recidivism in the literature (see Abracen et al., 2014; Lurigio et al., 2004), it is also hypothesized that the presence of a mental illness diagnosis will effect perceptions of reentry readiness.

**Significance of the Study**

Research shows the reentry process poses significant challenges for individuals who are incarcerated as they return to their communities. To address these issues, correctional facilities have implemented reentry programs as a part of reentry planning in order to increase successful outcomes. As such, the majority of reentry research has examined the efficacy of such programs. One criticism of this research is that it does not account for the underlying factors that promote successful reentry, such as perceptions of reentry readiness. In fact, research has demonstrated perceptions of readiness is linked to positive outcomes in a variety of contexts (e.g., treatment
readiness, job readiness, and learning readiness) among individuals who are incarcerated.

Accordingly, this study aims to extend current understandings of the reentry process by examining the construct of perceived reentry readiness, specifically the contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness. Second, research has identified mental illness as a significant risk factor for unsuccessful reentry; however, minimal research has examined its impact on person-specific conditions within the context of reentry readiness.

Implications of this study will demonstrate support for the need of tailored supports and services that address both person-specific and context-specific conditions to reentry readiness. Given the increased focus within the criminal justice system to improve successful reentry, implications of this study will demonstrate support for further research on reentry that includes efforts to maximize perceptions of reentry readiness so that individuals with and without mental illness can better engage in the reentry process. Researchers outside of the counseling profession (i.e., sociologists and criminologists) have traditionally studied the context-specific conditions (e.g., employment and housing) on reentry. This study adds to the depth of reentry studies because it contributes new ideas through a nontraditional perspective. Counselors possess the knowledge and training to understand the person-specific conditions examined in the present study and the importance of these factors on maximizing the engagement in the overall reentry process. Moreover, the high rates of mental illness in state prisons requires increased attention from the counseling profession, particularly the person-specific factors that can impact reentry readiness.

Limitations and Delimitations
The current study was designed to understand the contributions of person-specific conditions to perceived reentry readiness while controlling for demographic variables and accounting for context-specific conditions. Moreover, mental health status has an effect on perceived reentry readiness. As with all research, this study is subjected to several limitations and delimitations. First, minimal research has been previously conducted to understand reentry readiness for individuals who are incarcerated. To this author’s awareness, four prominent studies have been conducted thus far (see Doherty et al., 2014; Haas & Hamilton, 2007; Wolff, Shi, & Schumann, 2012; Wolff & Shi, 2010). Consequently, there are also various theoretical interpretations of readiness that exist, such as treatment readiness, career readiness, and learning readiness. Although these interpretations can be applied to the context of reentry, a clear definition specific to reentry readiness is needed.

Another limitation to this study is the sample. Participants were recruited from state correctional facilities across Pennsylvania. Results cannot be generalized to the experiences of reentry readiness for all individuals who are incarcerated. Moreover, the sample uses individuals serving long-term sentences in state facilities, therefore the perceptions of reentry readiness for individuals serving short-term sentences in local jails may differ. There is also a significant limitation related to mental health criteria for inclusion in the study. This is a self-report item, and although eligible participants will be screened prior to the study to ensure they meet inclusion criteria, it is not possible to confirm the reported mental illnesses participants are treated for are accurate. Another limitation to this study is there are many potential factors that can impact reentry readiness for individuals who are incarcerated. As such, it is difficult to encompass all potential factors in one study.
Finally, there are also limitations to study’s design. Both Wolff et al. (2012) and Wolff and Shi (2010) address methodological challenges related to self-report measures. This approach is subjected to a variety of errors and respondent bias, including faulty recall of experiences. Similarly, the survey used in the present study was self-administered. The researcher was not immediately available to address any questions from participants, which is especially important considering literacy gaps within correctional populations. There are also limitations related to respondent burden. Due to safety and security concerns in correctional facilities, a reserved space for participants to respond to their surveys that was free from distractions and/or disruptions could not be guaranteed. Furthermore, a cross-sectional study like the present case cannot examine the impact reentry readiness has on decreased recidivism and/or success in the community. Moreover, the present study only accounting for person-specific conditions. Future studies on reentry readiness should account for both context-specific and person-specific conditions.

Definitions

There are several key terms that are referenced throughout this study that are responsible for illustrating the experiences and/or perceptions of incarcerated individuals with mental illness. These terms are defined below in order to remove any potential for open interpretations by providing accurate definitions as they are used for the purpose of this paper. It should be noted that other works of research might have differing terminology that may be specific to the institution and/or participants used in the studies.

*Reentry*, as defined in this study, uses DeMatteo, LaDuke, Locklair, & Heilbrun’s (2013) conceptualization. The authors view reentry as a general term that focuses on the collaborative efforts made by institutions and community providers to help individuals reintegrate back into
the community upon release from incarceration. Reentry involves strategies and effective planning that helps eliminate the chance individuals will return to the criminal justice system upon their release.

_Readiness_, as defined in this study, uses Ward, Day, and Howells’ (2004) conceptualization of readiness for a treatment program as “the person is motivated, is able to respond appropriately, finds it relevant and meaningful, and has the capacities to successfully enter the treatment program” (p. 647). If we use the conceptualization for readiness in a treatment program as a foundation for reentry readiness, we can then apply this to readiness to reenter the community. The definition would still be quite similar. The individual needs to want or have the desire to successfully reenter, needs to recognize he or she is able to successfully reenter, needs to be engaged in the reentry process (i.e. treatment planning), and is able to successfully reenter the community.

_Recidivism_, as defined in this study, uses Palermo’s (2014) conceptualization of the “revolving door” (p. 763, which is used to describe a cyclic pattern. It refers to the unsuccessful reentry of Individuals who are incarcerated. thus resulting in the individuals recommitting crimes. Those struggles of social reintegration keep individuals repeating this cyclic pattern of committing a crime, incarceration, and reentry.

_Individuals who are incarcerated and have a mental illness_, as defined in this study, are those who self-report receiving mental health treatment at the correctional facility they are housed. Categories for disorders are consistent with prior research that has examined reentry among individuals with a mental illness (see Wolff & Shi, 2010).
Chapter Two: Literature Review

The mass incarceration rate is well documented, particularly for individuals with mental illness (see Abracen et al., 2014; Hall, 2015; James & Glaze, 2006). Accordingly, greater attention has been given to address new challenges presented by this, specifically mass prison reentry (Garland & Haas, 2015). Approximately 626,000 individuals in state and federal prisons were released from incarceration in 2016 (Carson, 2018). As such, concerns for the barriers individuals who are incarcerated experience during reentry have been raised (Baillargeon, Hoge, & Penn, 2010; Lutze, Rosky, & Hamilton, 2014). Unfortunately, increased recidivism rates continue to challenge the reentry process (Hunter et al., 2016). Bales and Piquero (2012) note this occurs when individuals are convicted of a crime after release for prison or jail, and then sent back to the institution to serve time for the new sentence. Frazier, Sung, Gideon, and Alfaro (2015) believe recidivism “represents a significant societal cost” (p. 2) because most individuals who are incarcerated will recidivate. Individuals with mental illness are often returned to criminal institutions soon after reentry (Palermo, 2014).

Challenges to successful reentry have been linked to substance use history, job skills and employment history, presence of mental and physical health issues, and nonconventional supports and behaviors (Visher & Travis, 2003). For instance, Ward and Merlo’s (2016) study on prison reentry in rural communities among individuals preparing for release found limited employment opportunities, inability to pay fines/court fees, and low wages were the top concerns reported by participants. Wolff, Morgan, and Shi’s (2013) study on attitudes and emotions among individuals who are incarcerated found the presence of mental illness and substance use issues were significantly correlated with criminogenic thinking, aggressive behavior, self-control, and hopelessness. Binswanger et al.’s (2011) study on prison reentry among individuals
recently released found the majority of individuals were homeless and felt “dumped” (p. 251) back into their communities with minimal supports and services.

**Characteristics of Correctional Facilities**

Before discussing the importance of perceived readiness in reentry planning, it is important to have a foundation of the characteristics of Correctional Institutions in Pennsylvania as well as the characteristics of individuals who are incarcerated in Pennsylvania prisons. To begin, an important distinction needs to be made to understand the differences between jail and prison. Individuals who are sentenced for a year or less will serve their sentences in jail (Davis, Bahr, & Ward, 2013). Most of those individuals are released early in order to serve the remaining time on probation or parole. These programs supervise individuals who are serving their sentences while still living in the community (Draine & Solomon, 2001). Alternatively, prisons typically house individuals who have committed felony crimes and are serving sentences for more than one year (Santos, Lane, & Gover, 2012)

Pennsylvania currently has 25 state correctional facilities that housed approximately 47,000 individuals at the time of the present study (Pennsylvania Department of Corrections [DOC], 2017). Two additional facilities are currently under construction. Of the facilities currently operating, 21 house all male populations. Two facilities house all female populations while one facility is co-ed. There is also a motivational boot camp that houses youth populations. Given the present study used male participants, the following literature examines characteristics of this population within Pennsylvania’s state correctional system.

**Characteristics of Individuals Incarcerated**

By the end of year in 2017, Pennsylvania housed 45,582 individuals in state correctional facilities (Pennsylvania DOC, 2017). Of those individuals, 48% were black, 41% were white,
10% were Hispanic/Latino, and 1% other. The majority of individuals serving a minimum sentence was two to five years (27.8%), while the majority of individuals serving a maximum sentence was five to ten years (24.9%). Most crimes sentenced for were classified as Part I offenses (57.9%), such as aggravated assault, robbery, or first-degree murder. In terms of risk for re-offending, 43.9% of individuals were identified as moderate risk, while 31.6% were identified as high risk.

Specific to the needs of Pennsylvania’s state correctional population, 41.9% of individuals were reported as needing intensive drug or alcohol treatment, while 22.5% of individuals were in need of outpatient drug or alcohol treatment (Pennsylvania DOC, 2017). In terms of mental health treatment, 29.5% of individuals were identified as receiving mental health services. Of those individuals, 8.3% were identified as having serious mental health issues. Drug and alcohol reports are consistent with previous data collected in 2016; however, the mental health reports indicated a slight increase. By the end of year in 2016, 26.6% of individuals were identified as receiving mental health services (Pennsylvania DOC, 2016). Of those individuals, 7.9% of individuals were classified as having a serious mental health issues.

Importance of Perceived Readiness in Reentry Planning

One of the earliest conceptualizations of readiness derives from Thorndike’s (1913) *Law of Readiness* in learning theory, which implies a degree of eagerness or preparedness to learn. DiClemente, Schlundt, and Gemmell (2004) expand on this notion in their conceptualization of readiness as the “willingness or openness to engage in a particular process or to adopt a particular behavior and represents a more pragmatic view of motivation as preparedness” (p. 104). Readiness has been examined in different contexts throughout the literature for individuals who are incarcerated, such as treatment readiness (see Ward, Day, Howells, & Birgden (2004),
career readiness (see Downing, Stitt, & Murray, 1987), and learning readiness (see Alewine, 2010). Few studies have examined readiness in the context of reentry.

One prominent study conducted by Wolff and Shi (2010) surveyed 4,000 individuals who were soon-to-be-released from incarceration. Their measurement of reentry readiness included questions on self-assessed readiness, dimensions of readiness, and hope. Results concluded that 28.1% of male participants indicated their readiness as “good,” while 20.3% of participants indicated their readiness as “fair.” Alternatively, nearly half of the male participants (46.4%) reported they did not think or know whether they would be able to support themselves in the community. Factors that decreased perceptions of readiness included having no income and obtaining housing. In a separate study conducted by Haas and Hamilton (2007), 496 men and women soon-to-be released from incarceration were surveyed on their perceptions of the use of core correctional practices in transitional services and readiness for release. Authors concluded that individuals who are incarcerated tend to have positive feelings regarding their readiness to reenter the community upon release. Factors that decreased perceptions of readiness included paying bills and obtaining housing.

Wolff, Shi, and Schumann’s (2012) study of 4,000 individuals who were soon-to-be released from incarceration examined reentry readiness based on length of current incarceration. Results found individuals serving longer sentences at the time of the study were more likely to perceive their reentry readiness less positively, and were also less likely to report having the instrumental resources to support their reentry. These results are supportive to Wolff et al.’s (2013) notion that, “the ‘normal’ challenges associated with reentry are likely to be compounded by thinking styles and emotional dispositions that are supportive of criminal behavior” (p. 1,103). Accordingly, studies on prison reentry have identified person-specific conditions
associated with successful reentry outcomes, such as self-efficacy (see Bahr, Harris, Fisher, & Harker Armstrong, 2010; Friestad & Skog Hansen, 2010), optimism (see Visher & O’Connell, 2012), and motivation to change (see Gideon, 2010). Although researchers have effectively demonstrated the importance of including investigation of perceptions of re-entry readiness in research related to community reentry following incarceration, little is known about the underlying factors that may contribute to the construct of reentry readiness. Specifically, the contributions of person-specific conditions on perceived reentry readiness.

**Social Cognitive Theory**

The theoretical framework guiding the present study is social cognitive theory. This theory provides a framework for understanding behavior and the ways in which learning and change occur (Bandura, 2012). This theoretical framework is grounded in an agentic perspective (Bandura, 2001). An agent means individuals’ intentionally make things happen through their actions. As such, “agency embodies the endowments, belief systems, self-regulatory capabilities and distributed structures and functions through which personal influence exercised, rather than residing as a discrete entity in a particular place” (p. 2). From this perspective, individuals have a significant role in shaping the events and courses of their lives.

**Properties of Human Agency**

Social cognitive theory identifies four core properties that explain human agency (Bandura, 2001; 2006). These include intentionality, forethought, self-reactiveness, and self-reflection. Within the social cognitive framework, agency refers to actions done intentionally, usually with some type of plan or strategy for doing so. Accordingly, intentionality represents the future course of action that will be performed. Intentionality is proactive, not an expectation or prediction of future actions. Forethought involves the temporal extension of agency, which
includes more than future-driven plans. Individuals set goals and anticipate possible outcomes of their actions, which help to guide and motivate them as they move forward. Over time, this can provide meaning, direction, and consistency in one’s life. Agency also requires self-regulation, which broadens the role of planning and fore thinking. This entails transitioning plans into some course of action, and having the motivation and self-regulation to ensure those plans are achieved. Self-reflection is the core of human agency, which refers the ability to examine one’s own functioning. This includes reflecting on one’s personal efficacy, thoughts and actions, and the meaning of life. By doing so, individuals can make any necessary adjustments for moving forward.

**Self-Efficacy.** The central component of human agency is perceptions of self-efficacy (Bandura, 1997). Efficacy is not a fixed trait; rather it is the organization of cognitive, social, emotional, and behavioral skills that impact personal capability. Accordingly, perceived self-efficacy can be understood as the assessment of personal capability. Self-efficacy is often used interchangeably with self-esteem, although both terms have distinct differences (Bandura, 1997), but can be understood as the belief individuals have that they can do something regardless of the circumstances (Bandura, 1986). It is further described as “a generative capability in which cognitive, social, emotional, and behavioral subskills must be organized and effectively orchestrated to serve innumerable purposes” (p. 36). An important distinction here is that perceived self-efficacy is not based on the number of skills possesed, but rather the belief individuals have in their ability to use their skills under a variety of conditions. As such, individuals with lower perceived self-efficacy are less likely to confront challenging situations and may avoid using coping skills (Bandura & Adams, 1977). Moreover, they will maintain their self-defeating beliefs and defense mechanisms.
Perceived self-efficacy has a significant influence on human functioning. It has an impact on cognitive, motivational, affective, and decision-making processes (Bandura, 2006). Moreover, whether individuals will possess optimistic or pessimistic outlooks in life, as well as the environment and types of activities individuals will engage in (Bandura, 2001). From this notion, it is important to identify how individuals develop perceptions of their self-efficacy. Bandura (1977) notes this is done through four primary sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states.

Performance accomplishments have a significant influence on perceived self-efficacy because it is based on personal mastery successes (Bandura, 1977). Individuals experience mastery expectations through gradual accomplishments that inherently build skills and increases coping abilities. As such, occasional experiences of failure will have less of a negative impact. Vicarious experiences are helpful even in the absence of performance accomplishments. They help model behaviors that demonstrate persistence even when faced with challenging tasks. Verbal persuasion is helpful for making individuals believe they have the capability to complete a specific task. Although verbal persuasion has less of a significant influence on perceived self-efficacy compared to performance accomplishments, in can lead to success when applied to corrective behaviors. Physiological states are important because anxiety or stress-inducing tasks can have a significant impact on performance capability. As such, individuals experiencing anxiety or stress may interpret this as fear, thus likely to increase their vulnerability to failure.

Perceived self-efficacy influences the choices individuals will make as well as their efficacy expectations (Bandura, 1977). These efficacy expectations determine the amount of energy individuals will exert to cope with certain situations and the duration they will endure when challenged by those situations. Understanding how individuals vary in their efficacy
expectations can be explained through Bandura’s (1997) conceptualization of self-efficacy dimensions. These dimensions include: magnitude, generality, and strength. From this notion, the term *magnitude* refers to a task’s level of difficulty. As such, this dimension focuses on the extent that an individual believes he or she can complete a certain task. The term *generality* refers to the degree of transferability across situations. As such, this dimension focuses on the extent that an individual’s self-efficacy on one task will transfer to another task. The term *strength* refers to the level of confidence. As such, this dimension focuses on the extent an individual is confident he or she can complete a certain task at a given level of difficulty.

Self-efficacy has been studied in various contexts throughout the literature. For example, Treadwell et al. (2016) studied the role of self-efficacy in transition readiness from pediatric to adult care among 113 individuals with sickle cell disease. Results found higher levels of self-efficacy increased perceptions of readiness in youth and young adults with sickle cell disease in preparations for their transfer from pediatric to adult medical care. Keeping with research on transitions, Pinquart, Juang, and Silbereisen’s (2003) studied the association between self-efficacy and school grades at age 12 to 15 with unemployment and job satisfaction at age 21 among non-college-bound adolescents. Results found higher levels of self-efficacy were associated with lower risks of later unemployment and lower levels of job dissatisfaction.

Several studies have examined self-efficacy in correctional populations; however, few studies have examined this within the context of reentry.

Research has also found correlations between self-efficacy and mental illness. For example, Rabani Bavojdan, Towhidi, and Rahmati (2011) examined the relationship between mental health and general self-efficacy beliefs, coping strategies, and locus of control in a sample of 4,493 men who are current drug users. Their results found a negative relationship between
self-efficacy and mental health. Moreover, low self-efficacy was found to be a good predictor of low mental illness. Andersson et al. (2014) surveyed 3,981 individuals to examine the association between self-efficacy, self-reported mental illness, help-seeking behaviors, and barriers to care. Their results were similar, showing individuals with low self-efficacy were more likely to report occurrences of mental illness compared to individuals with higher levels.

Specific to self-efficacy among correctional populations, one study conducted by Friestad and Skog Hansen (2010) examined gender differences in anticipated desistance in a sample of 260 men and women who were soon-to-be released from incarceration. Results showed a negative correlation between prior incarcerations and perceived self-efficacy among men. This is fairly consistent with Bandura’s (1977) notion of the influence performance accomplishments have on perceived self-efficacy (i.e., repeated failures decrease perceived self-efficacy). In a mixed methods study conducted by Bahr, Harris, Fisher, and Harker Armstrong (2010), qualitative data from a sample of 51 parolees showed individuals with lower perceived self-efficacy were less likely to experience successful reentry upon release. There were also differences in perceived self-efficacy among individuals who participated in drug treatment programs during incarceration. Individuals with lower perceived self-efficacy were less likely to have participated in drug treatment for a substance issue, thus supporting the need for targeted treatment programming. Forste, Clarke, and Bahr (2011) found intentions of staying out of trouble were strongly associated with perceptions of self-efficacy in a sample of 103 men who were incarcerated. This is also consistent with Bandura’s (1977) social cognitive theory.

**Modes of Human Agency**

Individuals exercise their influence through different forms of agency. As such, social cognitive theory identifies three modes of human agency: personal, proxy, and collective
Personal agency is exercised individually, meaning individuals can only affect what they can directly control. In many cases, however, individuals do not always have direct control over the factors influencing their lives. As such, individuals may exercise proxy agency, or the affect individuals have on what they can indirectly control. This mode of agency involves requesting others who have access to resources or have areas of expertise, or have the power or influence to secure a desired outcome. Collective agency is exercised in groups, meaning individuals who share common beliefs as a group can produce desired outcomes through collective efforts. Bandura (2001) notes most desired outcomes are only achievable through collective efforts. As such, individuals need to work with others in order to achieve what they cannot do independently.

Agentic Management of Fortuity

Although agency allows individuals to assume some level of control in their lives, fortuity cannot be ignored. In social situations, fortuitous events can be understood as unintended meetings of individuals who do not know each other (Bandura, 1986). Accordingly, these events possess the capacity to impact several important life determinants, such as relationships, careers, or life paths. Bandura, (2001; 2006) notes the separate paths that lead to fortuitous events also possess their own determinants. These paths remain unconnected until they intersect each other, which then create circumstances that will influence individuals’ lives. As such, many fortuitous events may have no impact on individuals’ lives, while others may have lasting effects that lead individuals towards other life courses.

Although fortuity assumes chance, Bandura (2001; 2006) notes individuals can still retain control over the effects of fortuitous events. In fact, individuals can influence fortuity in many aspects of life. This particularly favors those who are willing to experience different places, do
different things, and explore new activities. Individuals further adapt to chance by developing their interests, beliefs, and competencies, which allows them to then make the most of events that occur unexpectedly. Accordingly, the agentic management of fortuity from a self-development perspective explains how individuals’ resourcefulness can be used to make gains from fortuitous events (Bandura, 2001). From a safeguarding perspective, this explains how individuals can resist fortuitous events that lead to negative paths, or remove themselves from such situations should they occur.

**Optimism and Motivation to Change**

Self-efficacy has a significant foundation in social cognitive theory (Bandura, 1977; 2006; 2012). Moreover, self-efficacy has also shown significant contributions to other person-specific conditions. For instance, Bandura (1997) posits efficacy beliefs impact whether individuals will possess optimistic or pessimistic thought processes, or feel motivated to make important behavioral changes. Accordingly, the following literature examines optimism and motivation as two additional person-specific factors used in the present study.

**Optimism**

Optimism is a trait that plays a key role in the human experience (Carver, Scheier, & Segerstrom, 2010). Scheier and Carver (1985) first began identifying the basis of this important characteristic of personality, which they referred to as dispositional optimism. In large, dispositional optimism is the general expectation that good versus bad things will occur. From a broad context, optimism and pessimism are general forms of confidence and doubt (Scheier & Carver, 1992). As such, optimists have higher instances of confidence even when faced with difficult challenges, while pessimists have higher instances of doubt when faced with the same challenges. Moreover, optimists are those who expect positive things will happen to them, while
pessimists are those who expect negative things will happen to them (Carver et al., 2010). The differences between these two distinct groups impact how individuals manage daily challenges, such as problem solving, coping, and resourcefulness.

Several studies on the effects of optimism have been conducted in various contexts. For example, Scheier et al. (1989) examined the effect of dispositional optimism on recovery from coronary artery bypass surgery in a sample of 51 middle-aged men. Results showed that dispositional optimism is a significant predictor of coping efforts and surgical outcomes. Moreover, dispositional optimism was associated with faster rates of physical recovery during hospitalization and returning to daily life activities upon discharge. There was also a strong positive association between level of optimism and post-surgical quality of life after six months. Several studies have examined optimism in correctional populations; however, few studies have examined this within the context of reentry.

One study conducted by Visher and O’Connell (2012) examined individual, family, and situational factors that affect perceptions of reentry (i.e., optimism) in a sample of 956 men and women who were soon-to-be released from incarceration. Results showed individuals serving longer sentences of incarceration were associated with having lower perceptions of optimism about life upon release. Surprisingly, working in prison and participating in education programs did not have a significant effect on optimism. Exclusions to this include participation in substance abuse treatment during period of incarceration. Family support was one of the strongest variables effecting optimism. Increased optimism was also related to higher perceptions of self-esteem. Moore and Tangney (2017) examined anticipated stigma and behavioral outcomes (e.g., social withdrawal) post-release from incarceration in their study of 197 men who were soon-to-be release from incarceration. Results showed optimism is a buffer
on the effects anticipated stigma has on social withdrawal. Accordingly, the authors note optimists may be believe they are able to overcome challenges related to stigma.

Research has also found correlations between optimism and mental illness. For example, Hirsch, Conner, and Duberstein’s (2007) examined the relationship between optimism and suicidal ideation in a sample of 284 college students. Their results found individuals who report higher levels of optimism reported lower levels of suicidal ideation. Moreover, depressive symptoms and hopelessness were associated with suicidal ideation. Hart, Vella, and Mohr’s (2008) study of 127 patients with multiple sclerosis examined the relationship among depressive symptoms, benefit-finding, optimism, and positive affect. Results showed optimism was one of two mediators in the relationship between improved depression and enhanced benefit-finding. Moreover, theoretical support demonstrated optimism might lead to resiliency.

**Motivation to Change**

Motivation is a necessary factor for implementing change (DiClemente et al., 2004). It is described as “the personal considerations, commitments, reasons, and intentions that move individuals to perform certain behaviors” (p. 103). In correctional populations, motivation has historically been treated as a fixed trait (Walters, Clark, Gingeric, & Meltzer, 2007). As such, individuals with low motivation are perceived as difficult to influence change. The authors note probation and parole officers have often perceived compliant individuals as those who will likely commit to change even though compliance is only one part of what constitutes success, which does not necessarily equate to change. One way to understand the impact of motivation on the process of change is through the Transtheoretical Model (TTM) of Intentional Behavioral Change (Prochaska & DiClemente, 1982, 1983, 1986). In general, TTM identifies the ways in which individuals engage in making and maintaining behavioral changes (DiClemente, 2007). It
considers the unique experiences that individuals have as it relates to how they develop new behaviors, stop behaviors, and/or modify existing behaviors.

An important component of TTM is the stages of change. These stages describe how individuals engage in and stop various patterns of behavior (DiClemente, 2003). Each stage identifies specific motivational demands in order to accomplish tasks necessary to move forward to subsequent stages and achieve desired goals (DiClemente et al., 2004). Moreover, each stage represents a specific time period (Prochaska & DiClemente, 2005). Individuals may vary in terms of the duration of time that is spent at each stage; however, the necessary tasks to move forward to subsequent stages are fixed. As such, the five stages of change include: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, and (e) maintenance.

The precontemplation stage represents the beginning of the change process. Accordingly, individuals in this stage are less likely to use the change processes compared to individuals in other stages (Prochaska & DiClemente, 1986). The precontemplation stage describes individuals as being satisfied with existing behaviors and/or unwilling to make any changes (DiClemente, 2003). Moreover, individuals are not considering changes for the foreseeable future, which the author notes is usually a period of six months to one year. Individuals may begin considering change once they experience concern for existing behaviors and/or demonstrate interest in behaviors (DiClemente, 2005). This is known as the contemplation stage. In this second stage, individuals begin evaluating the costs/benefits for existing and potentially new behaviors. If individuals’ costs/benefits evaluations are deemed favorable, they will begin to make decisions for changing existing behaviors and adopting new ones. Walters et al. (2007) suggest individuals who are incarcerated often demonstrate less interest in change during these early stages, even feeling coerced into acting motivated to change.
Once individuals have determined change is foreseeable, they may transition into the preparation stage. In this third stage, individuals begin demonstrating their readiness for change (Prochaska & DiClemente, 2005). They work to develop plans necessary for changing and implementing new behaviors (DiClemente, 2003). Important to the preparation stage is level of commitment. In this stage, commitment refers to the energy and time that is necessary to develop and implement a plan. Once plans have been created, individuals may transition into the action stage. In this fourth stage, individuals begin implementing their change plans (DiClemente, 2005). Change plans may undergo several revisions in order for changed behaviors to remain stable over a period of time. The author notes this is usually for three to six months. As individuals actively work on behavioral changes, they may transition into the maintenance stage. In this final stage, individuals evaluate the conditions that can potentially cause relapse (Prochaska & DiClemente, 1986). As such, individuals must consider alternative coping methods in order to refrain from self-defeating behaviors. Successful maintenance builds on previous stages, and preparation is equally important here as with the action stage.

Early considerations for the stages of change focused on smoking cessation (Prochaska & DiClemente, 1983); however, its application has expanded from general psychotherapy to a proactive treatment of health issues across many populations (Prochaska & DiClemente, 2005). There has been considerable research on the stages of change that focuses on drug and alcohol addiction (see DiClemente et al., 2004). In correctional populations, there is considerable research on motivation to change that focuses on treatment readiness (Day et al., 2009; Ward, Day, Howells, & Birgden, 2004). Studies on motivation to change as it relates to reentry are difficult to find. A qualitative study conducted Gideon’s (2010) examined the importance of motivation in rehabilitation and reentry among a sample of 39 individuals who were incarcerated.
and recovering from drug addiction. Results showed motivation is an important factor for successful reentry and avoiding risks of re-incarceration. Despite these results, generalizations about the effects of motivation on reentry cannot be made.

Importance of Context-specific Conditions

Much of the existing literature on reentry has examined the contributions of context-specific conditions on successful outcomes, and rightfully so. Reentry is a challenging process that poses significant barriers for successful transitions back into community (Lutze, Rosky, & Hamilton, 2014). These barriers to successful reentry create a variety of needs for individuals during their transitions. Binswanger et al. (2011) argue some of the greatest needs upon reentry include securing legal identification, obtaining employment, finding housing. Accordingly, it is important to examine these three context-specific conditions in their relationship to the present study.

One of the greatest challenges for individuals in the reentry process is obtaining legal identification. Most individuals returning to their communities find their previous forms of legal identification have either expired, were lost, or have been damaged during their period of incarcerated (The National Reentry Resource Center, 2016). Obtaining state identification is vital for individuals to access important resources and services that can support the reentry process. More importantly, legal identification is necessary to apply for employment and secure housing upon release, both of which are key factors in successful reentry outcomes.

Finding employment is necessary for successful prison reentry outcomes (Baer et al., 2006). It is associated with decreased risks of reoffending, especially when wages are high (Visher, Debus, & Yahner, 2006). Despite this, individuals who are incarcerated often struggle to find employment upon reentry. While incarcerated, individuals may have limited access to
job skills programming and minimal opportunities to participate in gainful employment experiences. Even if individuals secure work assignments while incarcerated, their jobs and/or skills may not be appealing to employers post-reentry (Solomon, Johnson, Travis, & McBride, 2004). Given the impact of securing legal identification, obtaining employment, finding housing on successful reentry outcomes, it is important to consider possible associations between person-specific and context-specific conditions. For instance, Callander and Schofield’s (2016) study on poverty levels of self-efficacy decreased and levels of poverty increased. Research has also shown an association between socioeconomic status (SES) and optimism over time. Heinonen et al. (2006) examined parent SES in a group of children ages three to six-years-old in 1980, and then again 21 years later. Results showed a significant association between parent SES in 1980 and level of adult optimism 21 years later.

Similar to employment, obtaining housing is often an immediate challenge for individuals during the reentry process (Baer et al., 2006). While some individuals may choose to live with family members, others are challenged by limited housing opportunities. Low-income housing is limited and has strict requirements that make it difficult for individuals in the reentry process. They may be ineligible due to crimes committed, or rental agencies may have policies that prohibit housing to those with incarceration histories. Many individuals are left homeless with limited access to resources and services to support their reentry (Kushel et al., 2005). Consequently, individuals who cannot secure stable housing often return to prison (Metraux & Culhane, 2004).

**Measures Used in Reentry Research**

In order to investigate the construct of reentry readiness and potential underlying factors associated with this construct, it is important to discuss the literature related to the measurement
of the person-specific factors that may be associated with perceived readiness. This includes information regarding to how these constructs have been measured in related studies on reentry as well as their application with mental health populations. Accordingly, the following sections provide a review of the key measures used in the present study.

**Preparedness for Release Scale**

Very few scales exist that measure perceptions of reentry readiness for individuals who are incarcerated. One recent measure of reentry readiness, as developed by Haas and Hamilton (2007) and further reported by Haas and Spence (2017), adopted for this study was the Preparedness for Release (PR) scale. The PR is an eight-item scale that measures readiness based on previously identified barriers to reentry. These barriers include obtaining employment, obtaining housing, returning to families, social support, and understanding the conditions of parole. Examples of items include: “I feel prepared to get a job upon release,” “I know what is expected of me upon release,” and “I have people I can depend on upon release.” The PR is scored on a four-point Likert scale ranging from “Strongly disagree” to “Strongly agree.”

A limitation of using the PR is the lack of evidence for its psychometric properties. Haas and Spence (2017) found preliminary evidence demonstrating a high level of internal consistency for the eight measures with a Chronbach’s alpha of .91. The mean score for the scale was 24.84, which is above the midpoint of the scale (20.0). Further validation of the scale is still needed. Similar considerations for norming procedures are also needed. Initial findings by Haas and Hamilton (2007) and further reported by Haas and Spence (2017) used a sample of 496 individuals who were incarcerated. Demographic breakdowns showed 398 males and 98 females participated. Age of participants ranged from 23 to 60 years and over. The majority of participants were white/Caucasian (n= 444), followed by black/African American (n= 47), and
other (i.e., American Indian, Alaskan Native, or Hispanic/Latino; n= 5). The most serious offense committed by participants was a violent crime (n= 347) and the majority were serving time for their first offense (n= 300).

**General Self-Efficacy Scale**

The General Self-Efficacy (GSE) scale is a self-report assessment of an individual’s belief that he or she can manage any challenge or setback (Schwarzer & Jerusalem, 1995). The GSE is a 10-item measurement that was originally developed in German, but has since been translated across 33 other languages. Responses on the GSE are recorded on a four-point Likert scale using the following format: 1 = not at all true, 2 = barely true, 3 = moderately true, and 4 = exactly true. Accordingly, respondents reach each statement and indicate the extent to which it applies to them. An example of items include: “I can always manage to solve difficult problems if I try hard enough,” and “When I am confronted with a problem, I can usually find several solutions.” No items require reversed coding prior to coding. Each item is summed for a total self-efficacy score. Accordingly, scores can range from 10 to 40; however, higher scores yield higher perceptions of self-efficacy.

Psychometric properties of the GSE’s original version demonstrate high levels of internal consistency across the five samples originally studied with a Cronbach’s alpha ranging from .82 to .93 (Schwarzer & Jerusalem, 1995). Test-retest reliability was examined in a sample of 991 individuals from East Germany over a two-year period. Test-retest reliabilities were .47 for men and .63 for women, demonstrating the GSE is a stable measurement over time. Concurrent validity was assessed between the GSE and conceptually related scales (i.e., self-esteem, internal control beliefs, general anxiety, performance anxiety, and pessimism. Results were fairly modest, with correlations expectedly positive for self-esteem (.52), internal control beliefs (.40),
and optimism (.49). Correlations were expectedly negative for general anxiety (-.54), performance anxiety (-.42), and pessimism (-.28). Results demonstrate the GSE is a fairly reliable and valid measurement of self-efficacy.

Several studies assessing the GSE’s cross-cultural use demonstrate strong support for the universality of the construct. For example, Scholz, Doña, Sud, and Schwarzer (2002) analyzed the psychometric properties of the GSE in a sample of 19,120 individuals across 25 countries. Demographic breakdowns showed 7,243 males, 9,198 females, and 2,679 participants who did not indicate their sex participated in the study. Age of participants ranged from 12 (minimum age advised for the assessment) to 94 years. Internal consistency for the total sample showed a Cronbach’s alpha of .86 with a range of .75 to .91 across countries. Principal component analyses were computed to confirm the unidimensionality of scale adaptations. Results of the Kaiser-Guttman eigenvalue criterion and scree tests demonstrated one-factor solutions for the 25 adaptations of the GSE. Confirmatory factor analysis (CFA) further supported the assumption of multidimensionality with factor loadings generated by the maximum likelihood estimation method for a one-factor solution (adjusted goodness of fit index [AGFI]= .97, normed fit index [NFI]= .97, root mean square residual [RMR]= .03, and root mean square error of approximation [RMSEA]= .05).

The GSE has also been used in a variety of contexts with correctional populations. Specific to mental health, Friestad and Skog Hansen (2005) examined the contributions of self-efficacy, welfare deficiencies, and drug use on mental health symptoms among 225 men experiencing incarceration. Results found significant associations between mental illness, self-efficacy, welfare deficiencies, and drug use. Specifically, individuals with higher mental health issues had lower levels of self-efficacy, and were more likely to have higher levels of welfare
deficiencies and drug use. Moreover, self-efficacy and welfare deficiencies were the only significant contributors to participants’ mental health reports, accounting for 17% of the variance.

Allred, Harrison, and O’Connell (2013) examined changes in self-efficacy among 95 participants incarcerated who participated in dialogic, college-level courses that applied the Inside-Out Prison Exchange model. Participants were housed in either medium or maximum facilities, or in a work-release/reentry program. Self-efficacy was measured at two points during the study (i.e., the beginning and end of a 15-week semester). Results found participants’ level of self-efficacy ranged at the beginning of the semester, with the highest levels found among those who were assigned to a work-release/reentry program. Self-efficacy levels remained almost the same for those individuals at the end of the 15-week semester; however, levels among individuals housed in minimum or maximum facilities saw a significant increase.

**Life-Orientation Test- Revised**

The Life-Orientation Test-Revised (LOT-R) is a self-report assessment of optimism versus pessimism (Scheier, Carver, & Bridges, 1994). The LOT-R is 10-item measurement with three items used to measure optimism, three items used to measure pessimism, and four filler items (not scored). Responses are recorded on a five-point Likert scale using the following format: 0= strongly disagree, 1= disagree, 2= neutral, 3= agree, and 4= strongly agree. An example of an item measuring optimism includes: “In uncertain times, I usually expect the best.” An example of an item measuring pessimism includes: “If something can go wrong for me, it will.” An example of a filler item includes: “It’s important for me to keep busy.” Negatively worded items (i.e., items 3, 7, and 9) are reversed coded prior to scoring. Items 1, 3, 4, 7, 9, and
10 are summed for a total optimism score. Accordingly, scores can range from 0 to 24; however, higher scores yield higher levels of perceived optimism.

Psychometric properties of the LOT-R demonstrated an acceptable level of internal consistency with a Cronbach’s alpha of .78 (Scheier et al., 1994). Test-retest reliability was examined in a sample of undergraduate college students at different time intervals. These intervals included four months (N=96), 12 months (N=96), 24 months (N=52), and 28 months (N=21). Test-retest reliabilities were .68, .60, .56, and .79 respectively, demonstrating the LOT-R is a stable measurement over time. Convergent and discriminant validity was assessed by gender between the LOT-R and conceptually related scales (i.e., neuroticism, self-mastery, self-esteem, trait anxiety, and the LOT). Results were fairly modest, with correlations in men ranging from -.52 (trait anxiety) to -.36 (neuroticism), and correlation in women ranging from .54 (self-esteem) to -.36 (neuroticism). Correlations between men and women in the LOT and LOT-R were high, suggesting both scales measure similar characteristics.

The LOT-R was originally developed in English, but has since been translated across four other languages. Some studies have been conducted to assess the LOT-R’s cross-cultural use. For example, Perczek, Carver, Price, and Pozo-Kaderman (2000) assessed a Spanish version of the LOT-R in a sample of 142 English-Spanish bilingual undergraduate students at the University of Miami. Demographic breakdowns showed 49 men and 93 women participated in the study. Age of participants ranged from 17 to 32 years. Participants responded to both English and Spanish versions of the assessment. Internal consistency for the Spanish version showed a Cronbach’s alpha of .79, which was comparable to its English version (.84). Correlations between the two language versions were high at r=.78. Despite this, ANOVA results demonstrated significant language effects, specifically interactions between language and
language order of administration, $F(1, 138) = 6.59, p < .01$. This demonstrated that when the Spanish version of the LOT-R was administered first, it produced a higher mean than the English version.

Jovanović and Gavrilov-Jerković (2013) assessed the psychometric properties and dimensionality of the LOT-R in a sample of 744 Serbian high school and undergraduate students. Demographic breakdowns showed 348 males and 396 females participated in the study. Age of participants ranged from 15 to 24 years. Internal consistency for the total population on the Serbian version showed a Cronbach’s alpha of .75, and .67 (optimism) and .70 (pessimism) for its subscales. Support for convergent validity demonstrated moderate correlations with similar measures of well-being: hope ($r = .48$) and self-efficacy ($r = .48$). CFA supported a two-factor model of optimism, indicating optimism and pessimism are two moderately independent constructs. Reliability of the LOT-R used in the present study was lower than prior research. Accordingly, a three-item LOT-R scale (i.e., items 1, 4, and 10) was used.

**University of Rhode Island Change Assessment Scale**

The University of Rhode Island Change Assessment (URICA) scale is a self-report assessment of an individual’s motivation to change (McConnaughy, Prochaska, & Velicer, 1983). The URICA is a 32-item measurement that includes four subscales measuring the stages of change: (a) pre-contemplation; (b) contemplation; (c) action; and (d) maintenance. Each subscale consists of eight items for measurement. Items are written in a manner that is relevant to the change of an issue as deemed by the respondent. Responses on the URICA are recorded on a five-point Likert scale using the following format: 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 = strongly agree. An example of an item measuring pre-contemplation includes: “As far as I’m concerned, I don’t have any problems that need
An example of an item measuring contemplation includes: “I think I might be ready for some self-improvement.” An example an item measuring action includes: “I am doing something about the problems that had been bothering me.” An example of an item measuring maintenance includes: “It worries me that I might slip back on a problem I have already changed, so I am here to seek help.” No items require reversed coding prior to coding. The readiness to change score is computed by summing the means of each subscale, then compared to the group means of each subscale to determine which stage of change an individual is in.

Psychometric properties of the URICA in its initial use with adult outpatient psychiatric samples demonstrated acceptable levels for scale composition and theoretical consistency (McConnaughy et al., 1983). Internal consistency was high with Cronbach’s alphas of .88 (pre-contemplation), .88 (contemplation), .89 (action), and .88 (maintenance). Cluster analysis was also performed to classify groups of participants, which yielded nine distinct stages of change profiles. Acceptable levels of the URICA’s internal validity were demonstrated in DiClemente and Hughes’ (1990) study that used a sample of adults in an outpatient alcohol treatment program. Their cluster analysis yielded five clusters (i.e., pre-contemplation, ambivalent, participation, uninvolved/discouraged, and contemplation), and a k-means partitioning method was used to relocate misassigned participants to a cluster. Only 10% of participants needed to be reassigned to a cluster, thus demonstrating stability in the clusters. Internal validity was further verified by including additional participants to examine the clusters’ stability. Results showed each cluster maintained its original profile structure with a fairly even distribution of participants across the clusters (22% joined Cluster 1, 18% joined Cluster 2, 22% joined Cluster 3, 16% joined Cluster 4, and 22% joined Cluster 5).
The URICA was originally developed in English, but has also been translated across several other languages. Some studies have been conducted to assess the URICA’s cross-cultural use. For example, Chan, Chan, and Siu (2007) assessed a Chinese version of the URICA in a sample of 101 individuals in a chronic disease self-management program. Demographic breakdowns showed 14 men and 87 women participated. Age of female participants ranged from 45 to 64 years. Information related to age for male participants was not provided. Internal consistency showed a Cronbach’s alpha range of .65 to .73 across the four subscales. Test-retest reliability using intra-class correlations and their standard error of measurement (SEM) ranged from .63 to .75 across the four subscales. CFA was used to establish structural validity, with the comparative fix index (CFI) used for goodness-of-fit. Results suggested a possible three- or four-factor solution, with a four-factor model selected, and demonstrated a moderate item-to-subscale fit of CFI=.702.

Khalil (2011) assessed the psychometric properties and dimensionality of the URICA in a sample of 175 Saudi Arabian patients at a rehabilitation treatment hospital. Demographic breakdowns showed all participants were male. Age of participants ranged from 18 to 60 years. Internal consistency for the total sample showed a Cronbach’s alpha of .82 with a range of .76 to .89 across the four subscales. CFA was used to examine the data’s fit to the URICA’s proposed factors. The four-factor model (previously established for the scale) demonstrated adequate to reasonable fit indices (goodness-of-fit [GFI]=.89, adjusted goodness-of-fit indices [AGIF]=.91, standardized root-mean square residual [RMSR]=.04, and root-mean-square error of approximation [RMSEA]=.06). These results support the cultural validity of the scale and stage of change model.
Psychometric properties for the URICA have also been examined among correctional populations. For example, Polaschek, Anstiss, and Wilson (2010) examined the URICA among 260 men who were incarcerated. CFA results found the URICA provided support for earlier four-factor structures and the relationships between the factors were consistent. In fact, internal consistency showed a Cronbach’s alpha range of .60 to .90 across the four subscales. Correlations between the URICA factors were also in their expected directions. For example, pre-contemplation scores were negatively correlated with contemplation, action, and maintenance scores. Moreover, contemplation, action, and maintenance scores were all positively correlated as expected. These results support the URICA has factorial validity and reliability when generalize to male incarceration populations.

**Mental Health and Incarceration**

Hall (2015) argues the increased rate of incarceration is a growing problem in the United States. This is especially prevalent for individuals with mental illness (Abracen et al., 2014). The Bureau of Justice Statistics (BJS; James & Glaze, 2006) reported in midyear 2005 that 705,600 incarcerated individuals in State prisons had a mental illness. The BJS reported 78,800 incarcerated individuals in Federal prisons had a mental illness, and 479,900 incarcerated individuals in local jails were also reported to have a mental illness. Further breakdowns of the report show substance use or dependence were prevalent issues for individuals with mental illness prior to incarceration and had lower rates of employment compared to those without a mental illness. Rotter, McQuistion, Broner, and Steinbacher (2005) argue individuals with mental illness and a history of incarceration make up a significant percentage of the mental health population. Accordingly, the increased rate of individuals with mental illness in the criminal justice system is of great concern for mental health professionals (Lamb, Weinberger, &
Several factors have been theorized to explain the presented issue, but none have garnered more attention than the deinstitutionalization hypothesis.

**Deinstitutionalization**

Chow and Priebe (2013) note deinstitutionalization began as a movement that brought forth the mass discharge of individuals in psychiatric hospitals to community-based treatment, some of whom had been institutionalized long-term. Lamb et al. (2004) suggest psychiatric hospitals in the United States were at their highest rates of institutionalizations prior to the deinstitutionalization movement. The authors report 559,000 individuals were admitted in psychiatric hospitals in 1955. The initial release of individuals from psychiatric hospitals began shortly after the end of World War II (Lurigio, Rollins, & Fallon, 2004), and garnered much of its support during the 1960s (Frazier, Sung, Gideon, & Alfaro, 2015). By the 1970s, the process of deinstitutionalization had reached its peak (Petersen-J-Taylor, 2008).

Several arguments supporting the need for deinstitutionalization have garnered significant attention. Csipke et al. (2014) report the deinstitutionalization movement was a direct response to increased concerns for the deteriorating living conditions within psychiatric hospitals. Chow and Priebe (2013) note it was thought that individuals hospitalized experienced a lower quality of life compared to those who had been discharged. The authors argue that the “old-style mental hospitals functioned merely as a custodial care model” (p. 10) prior to the deinstitutionalization movement. Ward and Merlo (2016) note the goal of the deinstitutionalization movement was to help individuals with mental illness live outside of institutions by having access to community-based supports and services. Accordingly, Frazier et al. (2015) suggest the deinstitutionalization movement looked to expand upon the effectiveness of those community supports and services, and to positively change the ways individuals with
mental illness were treated. Subsequently, Lamb and Weinberger (2013) note many hospitals were permanently closed or had significantly reduced the number of hospital beds that we reserved for those with significant mental health issues.

Chow and Priebe (2013) suggest the civil rights movement and the acknowledgement that individuals had the right to receive mental health treatment in non-restrictive ways were major influences behind the deinstitutionalization movement. Likewise, the authors make reference to the advancements made in psychotropic medication and community-based supports and services as potential influences. Despite the advancements made to community-based supports and services at that time, a significant challenge to successful deinstitutionalization was the overall inadequacy and unavailability of these services (Frazier et al., 2015). Consequently, Ward and Merlo (2016) argue the community-based supports and services that were intended to back the deinstitutionalization movement never emerged or they were unable to serve the entire population of individuals with mental illness in their communities. The authors conclude that communities became overwhelmed as a result of the deinstitutionalization movement.

Another criticism of deinstitutionalization, as noted by Lurigio et al. (2004), was its inappropriate execution. The authors make the distinction that transitioning mental health treatment to community-based supports and services had the most severe impact on individuals who struggled to cope with new responsibilities of independent living. Baillargeon, Hoge, and Penn (2010) note many individuals released from psychiatric hospitals were unable to access treatment within their communities. This led to individuals experiencing increased symptoms related to their mental illness in addition to unforeseen barriers caused by homelessness and poverty.
Lamb and Bachrach (2001) note deinstitutionalization has shown drastic reductions in psychiatric hospitals across the United States since its emergence. Torrey et al.’s (2008) report for the Treatment Advocacy Center looked at the availability of public psychiatric beds in an analysis of surveys over 50 years. Results showed in 1955 (prior to deinstitutionalization) 558,239 public (state and county) psychiatric beds were available. Of those beds, approximately 343 were available per 100,000 people. By 2005, those beds had significantly decreased to 52,539. This showed approximately 17 beds were only available per 100,000 people. Over the course of 50 years, the deinstitutionalization movement has seen a 95% decrease of available public psychiatric beds. As a result of this, the criminal justice system has taken greater punitive measures, particularly with the increased rate of individuals with mental illness who are incarcerated (Ward & Merlo, 2016). The authors suggest the shift towards deinstitutionalization also brought shifts to correctional policies “from rehabilitation to a more punitive approach that emphasized accountability for one’s actions,” (p. 29).

Deinstitutionalization has been a major contributor to the increased rate of incarcerated individuals with mental illness (Lamb & Bachrach, 2001). Consequently, Ward and Merlo (2016) note the criminalization of mental illness as a result of the deinstitutionalization movement was “an unforeseen consequence” (p. 29). Also referred to as the criminalization hypothesis, Draine and Solomon (2001) suggest deviant behavior associated with severe mental illness has largely been treated by the criminal justice system rather than psychiatric hospitals since the movement began. The authors note that the closing or downsizing of psychiatric hospitals, insufficient community supports and services, and more restrictive criteria for hospital commitment have been major contributing factors to the increased incarceration rates of individuals with mental illness.
Blevins and Soderstrom (2015) argue the criminal justice system, particularly state and federal prisons, have inherited the primary responsibility of treating individuals with mental illness. This presents unique challenges for the criminal justice systems because prisons were never intended to meet the unique needs of individuals with mental illness (Peternelj-Taylor, 2008). Consequently, Lamb et al. (2004) note law enforcement have been forced to increase their roles in the management of mental health crises. Police officers are frequent first responders to mental health crises due to their responsibility to protect the safety of the individual and the community. Palermo (2014) suggests the changes in behavior as a result of fluctuations in mental wellness can lead individuals to break laws and lead to their involvement in the criminal justice system. Unfortunately, minimal treatment is provided to individuals with mental illness who are incarcerated.

**Purpose of the Study**

The purpose of the present study is to examine perceptions of reentry readiness among individuals who are incarcerated. Specifically, the contributions of person-specific conditions on perceived reentry readiness were examined when controlling for demographic variables and accounting for context-specific conditions. Accordingly, this study is guided by three central aims. First, this study aims to examine the characteristics of men who are incarcerated in order to understand their unique perspectives towards reentry readiness. Second, this study aims to understand the person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) that contribute to reentry readiness for individuals who are incarcerated while controlling for demographic variables (i.e., race, age, incarceration history, and length of current incarceration) and accounting for context-specific conditions (i.e., have identification, income, and housing). Finally, this study aims to understand whether mental health status further
contributes to perceptions of reentry readiness. As such, the present study is guided by the following research questions:

1. What are the characteristics of a sample of individuals who are incarcerated in three male state prisons in Pennsylvania? Are there differences in these characteristics based on the presence of mental illness?

2. What are the relative contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness while controlling for demographic variables and accounting for context-specific conditions?

3. Does mental health status effect perceptions of reentry readiness?

**Summary**

In light of the social and economic costs associated with high rates of recidivism among individuals who were formally incarcerated, research related to gaining a better understanding of how to facilitate successful reentry into the community is essential. Previous research in this area has placed a primary focus on context-specific conditions (e.g., income and housing). Few studies have incorporated important constructs from learning theory such as perceived readiness. Perceived readiness is theorized to impact the willingness or capacity for individuals to fully engage in interventions associated with change, such as community reentry programming. The focus of this study is to then incorporate social cognitive theory to gain a better understanding of some of the underlying factors that may be associated with perceived readiness for reentry: self-efficacy, optimism, and motivation to change.
Chapter Three: Methods

Research Design

The present study used survey research methods to assess self-efficacy, optimism, motivation to change, and reentry readiness among a convenience sample of individuals who are incarcerated in state prisons in Pennsylvania. The survey instrument (see Appendix A) was developed in adherence to Dillman, Smyth, and Christian’s (2014) standards for survey methodology using the traditional paper/pencil format as required by the Department of Corrections (DOC). This was due to policies related to safety and security standards that prevent computer access to individuals who are incarcerated. Further design considerations for the survey included use of language and the potential for literacy issues among specific populations (Dillman et al., 2014). This is especially important for individuals who are incarcerated. For instance, the 2003 National Assessment of Adult Literacy Prison Survey (Greenberg, Dunleavy, & Kutner, 2007) found individuals who are incarcerated have lower literacy skills when compared to the general population. As such, this survey and supplemental materials (i.e., recruitment letter and informed consent) were designed in the English language and ensured at least a sixth-grade reading level. Readability levels were verified using scores from the Flesch-Kincaid Grade Level in Microsoft Word.

Procedures

Policies through Pennsylvania’s DOC requires researchers to obtain approval from the Bureau of Planning, Research, and Statistics in addition to approval from the Pennsylvania State University’s Institutional Review Board (IRB). As such, a separate proposal for this study was submitted to the Pennsylvania DOC for review. This study received IRB approval on April 5, 2018 and DOC approval on March 22, 2018 (see Appendices D and E for approval letters).
Upon receiving approval for this study, the chief of research and evaluation at the Pennsylvania DOC assisted with contacting superintendents of the six recommended state correctional facilities to host this study. Three of those facilities responded within the desired timeframe and agreed to host this study.

The researcher coordinated the distribution of surveys with the superintendents’ assistants. Each assistant was given a list of participation requirements for this study and the housing units recommended by the chief of research and evaluation at the Pennsylvania DOC that supported the inclusion criteria. Each survey and supplemental documents (i.e., recruitment letter and informed consent) were folded into a study packet and placed into a white envelope for distribution. Also included was a blank sheet of white paper for participants to use for covering their responses to ensure confidentiality. Surveys were dropped off by the researcher to each participating state correctional facility, and later picked up upon completion. Approximately 1,632 individuals were housed among the three facilities at the time of the study. As such, 650 study packets were distributed among the three facilities based on considerations that inclusion criteria would significantly reduce participant eligibility. Additional study packets were made available for distribution as needed; however, none of the facilities requested them.

The survey instrument was arranged with the demographic questionnaire appearing first. The general directions for this section included: “The following questions will ask you to report your background information. Please read each question carefully and record your responses in the space provided below.” Following the demographic questionnaire, participants continued to the other four instruments used in the survey. The general directions for the scales were altered for considerations of priming literacy. Final versions included: “The following statements aim to understand your feelings of readiness for release from incarceration. Please read each statement
carefully and circle the number (one number per question) that best reflects how you feel” (Preparedness for Release Scale [PR]), “The following statements aim to understand how much you believe in yourself. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel” (General Self-Efficacy Scale [GSE]), “The following statements aim to understand how hopeful you are. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel” (Life Orientation Test-Revised [LOT-R]), and “The following statements aim to understand your motivation to change the behaviors that led to your current incarceration. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel” (University of Rhode Island Change Assessment [URICA]). Written permission to use existing scales was not required for the GSE, LOT-R, or URICA as indicated on the researchers’ respective websites. Permission to use the PR was granted by the first author via e-mail correspondence.

**Recruitment.** Eligible participants were identified using the housing unit lists for each of the three participating state correctional facilities. Study packets were distributed to eligible participants who indicated interest in completing the survey. All eligible participants had the opportunity to read the recruitment letter and informed consent (see Appendices B and C) prior to their participation. Participation in the study was voluntary and posed no reward or threat of punishment for individuals who agreed or declined to be in the study. Completion of the survey was used as an indication of informed consent in lieu of obtaining participants’ signatures. This was a requirement by the Pennsylvania DOC for any researching inquiring about participants’ mental health history. Pennsylvania’s DOC also required participants were aware of additional limitations to confidentiality that are required by law, such as threats to themselves, others, or the
safety/operations of the correctional facility. Safety concerns prevented participants from having the researcher’s direct contact information; however, the researchers office phone number was listed in the informed consent.

**Sampling.** Stratified sampling was used for this study. This involves dividing the populations into strata and choosing the sample from each stratum (Thompson, 2012). The principle of stratification is to divide the population in a manner so that the number of units within each stratum is near equal. Although each stratum may differ from one another, a stratum sample is considered representative of the whole population as long as the desired number of units from each stratum is included. Accordingly, participants in this study were divided into two strata: those who are clinically diagnosed with a mental illness and those who do not have a mental illness. Housing units were used to stratify the sample. Each state correctional facility under the Pennsylvania DOC operates from the same housing unit code for its residents. Participants were stratified from both general population and mental health housing units. It should be noted that both individuals with and without mental illness can be housed within general population so it was important to ensure mental health housing units were used to have an near equal representation in the sample.

**Sample Size.** Tabachnick and Fidell (2012) recommend using the formula $N \geq 50 + 8m$ to calculate a sample size for multiple correlations, where $m$ is equal to the number of independent variables. Three independent variables were used in the present study (i.e., self-efficacy, optimism, and motivation to change). As such, the minimum number of participants calculated was 74. The total number of participants in the present study exceeded this by almost 50%, although a full examination of this will be presented in Chapter 4.

**Participants**
Participants consisted of individuals who are incarcerated and at least 18-years-old, did or did not have a mental health diagnosis, and scheduled for release within 24 months at the time of study. Release could either be due to parole or time served. Pennsylvania has 25 state correctional facilities housing approximately 47,000 individuals as of March 31, 2018. Three state correctional facilities agreed to participate in the study during the desired timeframe. Approximately 6,000 individuals were housed across these three facilities as of March 31, 2018. Men represented the entirety of the sample (n = 164). No participants identified as transgendered or opted to self-identify their gender. The majority of participants were Caucasian/white (50.5%, n = 83), followed by African American/black (29.9%, n = 49), Hispanic/Latino (9.1%, n = 15), and multiracial (4.9%, n = 8). There was a fairly even representation of current mental health status (treatment for mental health 50.6%, n = 83; no treatment for mental health 48.8%, n = 80). Table 3-1 illustrates frequencies of demographic variables.

Table 3-1

Frequencies of Demographic Information for Sample Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18-29</td>
<td>46</td>
<td>28.9</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>45</td>
<td>27.4</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>43</td>
<td>26.2</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>17</td>
<td>10.4</td>
</tr>
<tr>
<td></td>
<td>60+</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>5</td>
<td>3.0</td>
</tr>
<tr>
<td>Race</td>
<td>African American/Black</td>
<td>49</td>
<td>29.9</td>
</tr>
<tr>
<td></td>
<td>American Indian or Alaskan</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td></td>
<td>Asian American/Asian</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td></td>
<td>Caucasian/White</td>
<td>83</td>
<td>50.6</td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino/a</td>
<td>15</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>Native Hawaiian or Pacific Islander</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td></td>
<td>Multiracial</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Self-identify</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>MH treatment</td>
<td>No</td>
<td>80</td>
<td>48.8</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>83</td>
<td>50.6</td>
</tr>
<tr>
<td>MH diagnosis</td>
<td>Missing</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Anger issue</td>
<td>17</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>35</td>
<td>21.3</td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>14</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>BiPolar disorder</td>
<td>21</td>
<td>12.8</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>53</td>
<td>32.3</td>
<td></td>
</tr>
<tr>
<td>Drug and alcohol</td>
<td>22</td>
<td>13.4</td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td>12</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>17</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>20</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>4.3</td>
<td></td>
</tr>
</tbody>
</table>

**Data Collection**

Prior to collecting data, approval of this study was obtained by IRB at the Pennsylvania State University and Pennsylvania’s DOC. Survey packets were dropped off at each of the three participating state correctional facilities. The superintendants’ assistants at each facility assisted with the distribution of survey packets to potential participants who met inclusion criteria for this study. Participants were given a two-week period from time survey packets were received to complete the survey. Completed surveys were returned to the superintendants’ assistants in sealed white envelopes given to them to ensure confidentiality. Participants were notified in the informed consent that any survey collected could be subjected to search policies and procedures as mandated by the DOC before return to the researcher.

**Instruments.** The survey consisted of 84 items divided into five areas: (a) demographics; (b) self-perceived reentry readiness; (c) self-efficacy; (d) optimism; and (e) motivation to change. A demographic questionnaire was developed to obtain pertinent information describing the population of interest. Demographic items on the questionnaire were adapted from include age, gender, and race/ethnicity. Such items are consistent with existing studies on reentry readiness (see Wolff & Shi, 2010; Wolff, Shi, & Schumann, 2012). Participants were also asked to report their intended release date to confirm eligibility requirements for this study (i.e.,
scheduled release date within 24 months of the study). Other items included on the demographics questionnaire include history of prior incarceration and length of time served for current sentence. Crime type is an item adapted from Wolff and Shi’s (2012) study. The following question was asked to participants: “What type of offense were you sentenced for?” Participants may choose all that apply from the following list: (a) drug distribution; (b) drug possession; (c) property offense; (d) fraud, embezzlement, or identity theft; (e) rape, sexual assault, or molestation; (f) eluding; (g) violent offense; or (h) other. Individuals who chose “other” were given space to report their offense.

Existing scales were used to measure perceived reentry readiness (i.e., PR), self-efficacy (i.e., GSE), optimism (i.e., LOT-R), and motivation to change (i.e., URICA). The reliability of these scales was consistent with previous studies with the exception of the LOT-R. Accordingly, a three-item version of the LOT-R was used. Table 3-2 illustrates the reliability of the scales used in the present study.

Table 3-2

<table>
<thead>
<tr>
<th>Scale</th>
<th>Chronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reentry Readiness</td>
<td>.85</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>.88</td>
</tr>
<tr>
<td>Optimisma</td>
<td>.71</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>.82</td>
</tr>
</tbody>
</table>

a Three-item version of the LOT-R

**Variables**

Four independent variables and one dependent variable were used to address the research questions guiding the present study. Several demographic variables and context-specific conditions were also used to control for any potential influence on the dependent. The following
literature outlines the methods used to measure the following variables: self-efficacy, optimism, motivation to change, and reentry readiness.

**Independent Variables.** Subjective feelings of self-efficacy, optimism, and motivation to change were self-report predictor variables in this study. Self-efficacy was measured using the GSE scale. The GSE is a 10-item self-report measure of confidence. Responses are recorded on a four-point Likert scale ranging from “Not at all true” to “Exactly true.” There is no cut-off score for self-efficacy as it is meant to be continuous. Higher scores on the GSE equate to higher perceptions of self-efficacy. Optimism was measured using the LOT-R (Scheier et al., 1994). The LOT-R is a 10-item self-report measure. Responses are recorded on a five-point Likert scale ranging from “Strongly Disagree” to “Strongly agree.” Similar to the GSE, there is no cut-off score for optimism as it is also meant to be continuous. Higher scores on the LOT-R equate to higher perceptions of optimism. Motivation to change was measured using the URICA scale. The URICA is a 32-item self-report measure. Responses are recorded on a five-point Likert scale ranging from “Strongly disagree” to “Strongly agree.” Similar to the GSE and LOT-R, there is no cut-off score that distinguishes a level on a particular stage as it is also meant to be continuous.

Mental illness was a self-report demographic variable in this study. This was used to address the potential for additional contributions to the dependent variable, which is discussed in subsequent sections. Participants were asked the following question: “While in prison, have you been treated for a mental health disorder?” Participants could choose one item, either “Yes,” or “No.” Participants who marked “Yes” could then check off the type(s) of mental health issues they have been treated for, which include: (a) anger disorder; (b) anxiety disorder; (c) ADHD; (d) Bipolar disorder; (e) depression; (f) drug/alcohol use; (g) panic attacks; (h) PTSD; (i)
schizophrenia; and (j) other. Individuals who chose “Other” were given space to report the programs they participated in.

Dependent Variables. Reentry readiness was a self-report dependent variable in this study. Reentry readiness was measured using the PR scale. The eight-item scale measures perceptions of how prepared individuals feel for release. Responses are recorded on a four-point Likert scale ranging from “Strongly disagree” to “Strongly agree.” Higher scores on the PR equate to higher perceptions of self-efficacy.

Control Variables. Several items were used as control variables in the present study. First, given that the overrepresentation of racial minorities in the criminal justice system has been thoroughly documented in the literature (for current statistics, see Carson, 2018), race was controlled for to mitigate any influence on perceptions of readiness. Age and length of incarceration have also been linked to perceptions of reentry readiness. For instance, Wolff and Shi (2010) found evidence in their study suggesting younger individuals were more likely to report feeling ready to reenter than older individuals. In a separate study, Visher and O’Connell (2012) found number months served decreased perceptions of optimism individuals feel to reenter their communities. Similarly, Wolff, Shi, and Schumann (2012) found that on average, individuals were more likely to feel ready to reenter if they had served short-term sentences. Moreover, those individuals were more likely to report having access to the context-specific conditions (i.e., housing and identification). Also, because high recidivism rates demonstrate a significant challenge to the reentry process (Hunter et al., 2016) incarceration history was also identified as a control variable.

Covariates. Context-specific conditions have also been linked to challenges in the reentry process (see Baillargeon, Hoge, and Penn 2010; Frazier et al., 2015; Hall, 2015; Pope et
The present study adapted 12 items from Wolff and Shi’s (2010) study to assess this, including access to an identification card, driver’s license, birth certificate, Social Security card, transportation, source of income, medical insurance, stable housing, mailing address, phone access, food, and one-month supply of medication. Participants were instructed to report the extent to which they would have access to those items as either, “Yes,” “No,” or “Unsure.” Having access to a source of income and housing showed significant correlations with self-efficacy, optimism, and perceived reentry readiness (see Table 3-3 presented at the end of the chapter), thus warranting inclusion as covariate variables. Having identification is theorized to have a significant contribution to perceived reentry readiness given it is often required to obtain employment, housing, and access to other supports and services (The National Reentry Resource Center, 2016).

**Subscale Scoring**

Items were coded in adherence to the coding instructions for each instrument. Responses on the PR and GSE were summed to obtain a total score for reentry readiness and self-efficacy. The LOT-R required recoding for three items (i.e., items 3, 7, and 9). Items 2, 5, 6, and 8 were filler items and not scored, thus only six items (i.e., 1, 3, 4, 7, 9, and 10) were summed to obtain a total score for optimism. As previously mentioned, initial reliability checks for the scale were lower than previous studies. Accordingly, items 3, 7, and 9 were removed, leaving items 1, 4, and 10 to represent level of optimism. The URICA has two options for scoring depending on the researcher’s desired outcome. For example, a profile score could be obtained in order to understand the different patterns participants fit in according to the stages of change. The present study aimed to calculate a readiness score. This requires summing the individual score on items specified for each stage of change (i.e., pre-contemplation, contemplation, action, and
maintenance) and then calculating the mean. Each stage of change has one item omitted from the score so calculating the mean for each stage requires dividing by seven, not eight. Once the means are calculated, the means for contemplation, action, and maintenance are summed. The mean for pre-contemplation is then subtracted from that total, resulting in a readiness score.

**Data Analysis**

Data was analyzed using the Statistical Package for Social Science (SPSS) 24. Several analyses were used to answer the three research questions guiding the present study: (1) What are the characteristics of a sample of individuals who are incarcerated in three male state prisons in Pennsylvania? Are there differences in these characteristics based on the presence of mental illness? (2) What are the relative contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness? (3) Does mental health status further contribute to perceptions of reentry readiness? The sample size exceeded the recommended number of participants to further support conclusions made. The following literature outlines the application of the data analysis methods used to answer their respective research questions.

**Descriptive Statistics and Frequencies.** Obtaining descriptive statistics provides important information for initial interpretations of data (Antonius, 2003). They are used to produce measures of central tendency, dispersion, and position. Frequencies were then used to obtain the descriptive statistics for all categorical variables in the present study (Pallant, 2010). They provide the overall characteristics of the sample that is used to determine how participants respond to items in a study. These analyses were further used in the present study as an initial indication of participants’ responses based on their mental health status.
Chi-Square Test for Independence. The chi-square test for independence is used to examine the relationship between two categorical variables (Pallant, 2010). It compares the observed frequencies or proportions from all cases in each category. An assumption for this analysis is that the categorical variables to have at least two or more categories, which cannot have less than five responses. The Pearson Chi-Square value is used to determine whether the relationship between the two variables is significant (p < .05).

Independent Samples T-Test. An independent-samples t-test is used to compare mean scores between two different groups or conditions (Pallant, 2010). It explains whether there is a statistically significant difference in mean scores between two groups. Moreover, it tests the probability that two sets of scores come from the same population. This analysis requires two variables: one categorical, independent variable and one continuous, dependent variable. An independent t-test was run with a nominal variable that had two categories. Participants reported themselves either not having been treated for a mental health issue (Group 1) or having been treated for a mental health issue (Group 2). Prior to conducting the analysis, assumptions for parametric statistics were tested, as noted by Pallant (2010). Assumptions for normality were already tested prior to conducting MLR, which determined this was violated. As such, data transformation on the dependent variable (i.e., reentry readiness) was performed using a power transformation (i.e., cubed). The assumption of homogeneity of variance was then tested, which verifies samples are used from populations with equal variances. This was tested in using Levene’s test for equality of variances. Pallant (2010) notes a non-significant result (i.e., p > .05) is necessary. Results of the Levene’s test showed p = .262, demonstrating the assumption had been met.
Accordingly, the present study applied independent t-tests to determine whether there were differences in self-efficacy, optimism, motivation to change, and reentry readiness scores based on mental health status.

**Multiple Regression Analyses.** Hierarchical regression was used in the present study to examine the change in contributions of the predictor variables on the dependent variable (Petrocelli, 2003). This method allows the researcher to enter predictor variables in the regression model as blocks in a predetermined order (Pallant, 2010). The order used in the present study was guided by existing literature and theoretical understandings of the variables. Because demographic variables were controlled for to mitigate any potential effect on the dependent variable, the author recommended entering all control variables in the first block in order to “force” (p.163) them into the analysis. Once all other predictor variables are added into their respective blocks, the effect of the control variables is removed and the amount of remaining variance determines what is explained by the predictor variables.

**Data Cleaning**

The presented study distributed 650 surveys to individuals experiencing incarceration across three state prisons in Pennsylvania, yielding 274 surveys received, or a return rate of 42%. Initial review found 26 surveys were returned as blank and therefore removed from the sample (N = 248). Inclusion criteria required eligible participants to have a scheduled release date within 24 months. Accordingly, 81 participants were removed for not meeting this criterion (N = 167). Frequency tables were inspected for each item to ensure all responses were accounted for based on an N = 167. Minimum and maximum values were also inspected to ensure responses were not entered outside their respective range. Error in values were identified and corrected. Further procedures were used to address issues of missing data.
**Missing Data.** One of the greatest challenges in research is missing data (Graham, 2009). There are three types of missingness often described in research: (a) missing completely at random (MCAR), (b) missing at random (MAR), and (c) missing not at random (MNAR). Data that is MCAR is said to be missing completely by chance, meaning a study has an equal chance for missing data across all its variables (Sterner, 2011). It is recommended that researchers using large data sets analyze MCAR using the SPSS Missing Value Analysis (MVA) Expectation Maximization (EM; Little’s MCAR test). This analysis uses a chi-square test for this, but results cannot be statistically significant (i.e., $p > .05$). This recommendation was followed in the present study and it was determined data was MCAR. There are several methods that can be used for addressing data MCAR, though Graham (2009) discussed a modern approach using the EM algorithm. This produces maximum likelihood estimates, meaning the best guess for any missing value is used based on the regression-based imputation for a single independent variable in the model. Demographic variables could not be corrected using the EM algorithm; however, they did not have a significant impact on data analysis aside from the mental illness variable. No data was missing for this, but all other missing data on the demographic questionnaire was coded as “999.”

**Outliers.** An outlier is best described as a score that significantly differs from others in the data (Fields, 2013). Failure to address outliers could produce biases in the results. One method used for identifying outliers in the present study was by examining a box plot, which showed five possible cases. Standardized residuals, which are residuals converted to $z$-scores, were then examined to determine if values ranged outside $+/- 3$. The author notes values outside of this range is concerning because an average sample should never be that high. It was determined three standard residual scores in the present study exceeded -3, which were two cases
less than the number of outliers examined through a box plot. To resolve this issue, Tabachnick and Fidell (2007) suggest removing extreme outliers in the data as one method. As such, this method was used given the sample size would still remain quite large for the analyses (N = 164).

Assumptions Testing

Many statistical analyses require researchers to test assumptions for variables used in their studies (Osborne & Waters, 2002). Violation of these assumptions could produce Type I or Type II error, or inaccurate estimations of effect size. As such, results could be biased. The authors identify several assumptions that are not “robust” (p. 1) to violation, but that can be dealt with by the researcher. Accordingly, the following assumptions were tested in the present study: (a) normality, (b) linearity, and (c) homoscedasticity.

Normality. Osborne and Waters (2002) identify several methods for testing the normality assumption, such as the visual inspection of data plots, skewness and kurtosis, and P-P plots, or Kolmogorov-Smirnov tests. Skewness and kurtosis were used to test the normality of the dependent variable (i.e., reentry readiness) in the present study. Tabachnick and Fidell (2007) note violation of this assumption results if the skewness value of the variable of interest divided by the standard error of skewness is greater than the absolute value of two. It was determined that normality was violated in the present study based upon review of these items, thus requiring transformation of data. The authors recommend conducting power transformations for negatively skewed data as opposed to logarithmic transformations. As such, a cubed power transformation was used to meet assumptions for normality and keep the direction of correlations between variables the same.

Linearity. It is important to check the assumption of linearity in order to truly estimate the relationship between the dependent and independent variables (Osborne & Waters, 2002).
Violation of the linearity assumptions results in the under-estimation of the variables’ relationship, thus increasing the likelihood of Type I or Type II error. The authors recommend examining residual plots to determine a linear relationship. Results of this showed no presence of a curvilinear relationship between the dependent and independent variables post-transformation. As such, there was evidence to support this assumption was met.

**Homoscedasticity.** Testing the assumption of homoscedasticity was achieved through the examination of bivariate scatterplots. No evidence suggesting violation of this assumption could be seen. Moreover, Tabachnick and Fidell (2007) note variables are homoscedastic if they do not violate the normality assumption. Although initial analysis showed elevated skewness, this significantly dropped after data transformation.

**Multicollinearity.** Calculating bivariate correlations were used to test the assumption for multicollinearity. This occurs when two variables have very strong correlations with each other. The cut off point for correlations between two variables that are multicollinear is greater than or equal to .90 (Tabachnick & Fidell, 2007). The authors note one of the two variables must be deleted if this assumption is violated. None of the correlation values between variables exceeded this limit, thus supporting the assumption of multicollinearity was met. Tolerance values were also very high for each variable, further demonstrating the assumption of multicollinearity had been met (Pallant, 2001). Table 3-3 illustrates the correlation matrix of the variables used in the present study.
### Table 3-3

**Correlation Matrix of Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>.167*</td>
<td>.149</td>
<td>-.131</td>
<td>.152</td>
<td>-.170*</td>
<td>-.038</td>
<td>-.153</td>
<td>-.028</td>
<td>-.006</td>
<td>.164*</td>
<td>-.137</td>
<td></td>
</tr>
<tr>
<td>2. Race</td>
<td>.077</td>
<td>-.094</td>
<td>-.047</td>
<td>-.015</td>
<td>.030</td>
<td>-.027</td>
<td>-.048</td>
<td>-.146</td>
<td>.076</td>
<td>-.017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mental health status</td>
<td>-.037</td>
<td>-.064</td>
<td>-.069</td>
<td>-.046</td>
<td>-.101</td>
<td>-.102</td>
<td>-.082</td>
<td>.063</td>
<td>-.136</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. First time incarcerated</td>
<td></td>
<td>.070</td>
<td>-.093</td>
<td>-.015</td>
<td>.122</td>
<td>.044</td>
<td>.118</td>
<td>-.045</td>
<td>-.006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Length of incarceration</td>
<td>.031</td>
<td>-.088</td>
<td>.070</td>
<td>.030</td>
<td>.009</td>
<td>-.192*</td>
<td>-.043</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. ID</td>
<td></td>
<td>.113</td>
<td>.145</td>
<td>-.039</td>
<td>.058</td>
<td>-.020</td>
<td>.005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Income</td>
<td></td>
<td></td>
<td></td>
<td>.33**</td>
<td>.197*</td>
<td>.155*</td>
<td>-.012</td>
<td>.440**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.178*</td>
<td>.247**</td>
<td>-.011</td>
<td>.600**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Self-efficacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.480**</td>
<td>-.016</td>
<td>.423**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Optimism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.010</td>
<td>.271**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Motivation to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.025</td>
</tr>
<tr>
<td>12. Reentry readiness a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at the .05 level.
** Significant at the .01 level

*a Cube Transformation
Chapter Four: Results

**Research Question 1**

Findings are reported in response to three research questions guiding the present study. Because initial assumptions checks showed data was skewed, a cubed transformation was applied to the dependent variable. All analyses completed used the cubed transformation of the dependent variable. Manikandan (2010) recommends that researchers report their findings before and after data transformation, which is adhered throughout the chapter. As such, the first research question asked, “What are the characteristics of a sample of individuals who are incarcerated in three male state prisons in Pennsylvania? Are there differences in these characteristics based on the presence of mental illness?” To answer this question, descriptive statistics were first obtained to provide summaries for the sample and measures used. Table 4-1 illustrates the descriptive statistics for the independent and dependent variables in the present study.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-efficacy</td>
<td>30</td>
<td>32.39</td>
<td>4.82</td>
<td>-.72</td>
<td>.90</td>
</tr>
</tbody>
</table>
Further examination of the sample’s characteristics was achieved using frequencies. To determine whether mental health status was associated with differences among the sample’s characteristics, a Chi-square test for independence was used. Yates’ Correction for Continuity values were applied for all 2 by 2 tables to account for overestimations of chi-square values (Pallant, 2010). Results are reported by the following major categories below.

**Incarceration History and Crime Type**

Results from the present study indicated a fairly even representation of individuals who were experiencing their first incarceration (48.1%) as opposed to those who were not (51.9%). Moreover, 44.7% of individuals reported having served three or less years incarcerated at the time of the study, while 45.3% reported having served three to 10 years. The majority of participants identified “other” as the crime they were sentenced for (42.3%), followed by “violent offense” (25.8%). Table 4-3 presents the frequencies for information related to incarceration history and the crime for which participants were currently sentenced. Results indicated no significant associations between mental health status and incarceration history or crime sentenced for.

Table 4-3
### Frequencies of Incarceration History and Crime Type by Mental Health Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>N (MH)</th>
<th>N (No MH)</th>
<th>Chi-test and df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First time incarcerated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>44</td>
<td>40</td>
<td>.095*</td>
<td>.758</td>
</tr>
<tr>
<td></td>
<td>.519</td>
<td>.272</td>
<td>.247</td>
<td>df = 1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>78</td>
<td>38</td>
<td>40</td>
<td>.481</td>
<td>.272</td>
</tr>
<tr>
<td></td>
<td>.235</td>
<td>.247</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current incarceration length</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3 years</td>
<td>71</td>
<td>41</td>
<td>30</td>
<td>5.420</td>
<td>.067</td>
</tr>
<tr>
<td></td>
<td>.447</td>
<td>.258</td>
<td>.189</td>
<td>df = 2</td>
<td></td>
</tr>
<tr>
<td>3-10 years</td>
<td>72</td>
<td>29</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.453</td>
<td>.182</td>
<td>.270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>16</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.101</td>
<td>.063</td>
<td>.038</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime: Drug offense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>143</td>
<td>77</td>
<td>66</td>
<td>3.095*</td>
<td>.079</td>
</tr>
<tr>
<td></td>
<td>.877</td>
<td>.472</td>
<td>.405</td>
<td>df = 1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>6</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.123</td>
<td>.037</td>
<td>.086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime: Property</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>133</td>
<td>67</td>
<td>66</td>
<td>.008*</td>
<td>.928</td>
</tr>
<tr>
<td></td>
<td>.816</td>
<td>.411</td>
<td>.405</td>
<td>df = 1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30</td>
<td>16</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.184</td>
<td>.098</td>
<td>.086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime: Rape/sexual assault</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>134</td>
<td>70</td>
<td>64</td>
<td>.269*</td>
<td>.604</td>
</tr>
<tr>
<td></td>
<td>.822</td>
<td>.429</td>
<td>.393</td>
<td>df = 1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>13</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.178</td>
<td>.080</td>
<td>.098</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime: Violent offense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>121</td>
<td>60</td>
<td>61</td>
<td>.159*</td>
<td>.690</td>
</tr>
<tr>
<td></td>
<td>.742</td>
<td>.368</td>
<td>.374</td>
<td>df = 1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
<td>23</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.258</td>
<td>.141</td>
<td>.117</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The majority of individuals reported participating in some form of programming during their current period of incarceration (86.3%), with drug and alcohol programming being most reported (47.8%). Most individuals also reported obtaining paid employment within the correctional facility (90.5%). Table 4-4 illustrates the frequencies for programming information and the context-specific conditions that participants anticipate having upon reentry. A Chi-square test for independence indicated a significant association between mental health status and participating in mental health programming, $\chi^2 (1, n = 163) = 13.210, p = .000, \phi = .300$. Further results indicated a significant association between mental health status and having food upon reentry, $\chi^2 (1, n = 163) = 5.068, p = .024, \phi = -.193$, and having medication upon reentry, $\chi^2 (1, n = 163) = 15.197, p = .000, \phi = .305$.

Table 4-4

*Yates’ Continuity Correction*

**Programming and Context-Specific Conditions**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>N (MH)</th>
<th>N (No MH)</th>
<th>Chi-test and df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program participation</strong></td>
<td></td>
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*Note: df = degrees of freedom
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* Yates’ Continuity Correction

**Person-Specific Conditions**

To test whether scores for self-efficacy, optimism, motivation to change, and reentry readiness were significantly different based on mental health status, independent samples t-tests were performed. Assumptions of homogeneity of variances were tested and satisfied using Levene’s F test for self-efficacy, $F(161) = 1.116$, $p = .292$, optimism, $F(161) = 2.319$, $p = .130$, motivation to change, $F(161) = 1.941$, $p = .165$, and reentry readiness, $F(161) = 1.519$, $p = .220$. Similar results were found for reentry readiness after cubed transformation, $F(161) = 1.267$, $p = .262$. In terms of self-efficacy, individuals with mental illness ($N = 83$) did not have a statistically significant difference in score ($M = 31.90$, $SD = 4.93$), $t(161) = 1.304$, $p = .194$. In
terms of optimism, individuals with mental illness did not have a statistically significant difference in score \((M = 7.81, SD = 2.35), t(161) = 1.045, p = .298\).

In terms of motivation to change, individuals with mental illness did not have a statistically significant difference in score \((M = 59.77, SD = 11.56), t(161) = -.804, p = .422\). In terms of reentry readiness, individuals with mental illness did not have a statistically significant difference in score, \((M = 26.28, SD = 4.85), t(161) = 1.647, p = .102\). This is further examined after cube transformation \((M = 19893.85, SD = 9115.25), t(161) = 1.737, p = .084\). Thus, self-efficacy, optimism, motivation to change, and perceptions of reentry readiness were not significantly different based on mental health status. Results are further illustrated in Table 4-5.

Table 4-5

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<th>p-value</th>
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* Cube Transformation

**Research Questions 2**

The second research question asked, “What are the relative contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness?” Following Cohen and Cohen (1983), hierarchical regression analysis was used. In Model A, the person-specific conditions were entered with the demographic control variables to determine their contributions to perceived reentry readiness while statistically controlling for any impact of the demographic variables. This contribution provides a baseline comparison for the other models. Accordingly, perceived reentry readiness was regressed on the
demographic control variables (Block 1) and explained 0.1% of the variance. Adding the person-specific conditions (Block 2) resulted in 15.5% of the variance explained, which was an increase of 16.8% in Model A as shown in Table 4-6.

Table 4-6

Model Summaries Before and After Data Transformation

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* Cube transformation

In Model B, the person-specific conditions were entered with the demographic control variables followed by an additional block including the context-specific covariates (i.e., identification, income, and housing). The context-specific conditions were treated as covariates since it is theorized they are correlated with person-specific conditions and perceived reentry readiness. Accordingly, perceived reentry readiness was regressed on the person-specific conditions and demographic control variables (Block 1) and explained 15.5% of the variance. Adding the context-specific conditions (Block 2) resulted in 48.5% of the variance explained, which was an increase of 32.4% in Model B as shown in Table 4-7.

Table 4-7

Model Summaries Before and After Data Transformation

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The final research question asked, “Does mental health status further contribute to perceptions of reentry readiness?” Keeping with Cohen and Cohen’s (1983) methods for hierarchical regression, the mental health status variable was entered into the model to assess whether any further contributes to perceived reentry readiness is made when statistically controlling for demographic variables and accounting for context-specific covariates. In Model C, the person-specific conditions and demographic control variables were entered together in Block 1 followed by the context-specific covariates in Block 2. Adding mental health status was (Block 3) resulted in 0.1% of the variance explained. Mental health status made no significant contribution to the variance in perceived reentry readiness. The full model (Model C) explained 48.3% of the variance in perceived reentry readiness as shown in Table 4-8.

Table 4-8

* Model Summaries Before and After Data Transformation

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* Cube transformation
Chapter Five: Discussion

Discussion of the Results

The purpose of the present study was to examine the contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceived reentry readiness when controlling for demographic variables and accounting for context-specific conditions (i.e., have identification, income, and housing upon reentry). As such, three research questions were used to guide the study: (1) What are the characteristics of a sample of individuals who are incarcerated in three male state prisons in Pennsylvania? Are there differences in these characteristics based on the presence of mental illness? (2) What are the relative contributions of person-specific conditions (i.e., self-efficacy, optimism, and motivation to change) on perceptions of reentry readiness when controlling for demographic variables and accounting for context-specific conditions? (3) Does mental health status further contribute to perceptions of reentry readiness?

While there are a few notable studies that have examined reentry readiness, most do not consider the contributions of person-specific factors on perceived reentry readiness. In response to the three research questions, findings in the present study make several contributions to the reentry literature. First, findings showed some differences among individuals with and without mental illness with regards to the type of programs they have participated in while incarcerated as well as the context-specific conditions they anticipate having upon reentry. Second, context-specific conditions showed the greatest contribution to perceived reentry readiness, although person-specific conditions also made contributions. In particular, self-efficacy made the greatest contribution. Finally, mental health status showed no contribution to perceived reentry readiness.
Characteristics of the Sample and Differences Based on Mental Health Status

This study helps to understand the various characteristics of individuals who incarcerated. Several demographic areas of interest were examined, including incarceration history, length of incarceration, programming, and access to context-specific conditions that promote readiness. Given the overrepresentation of individuals with mental illness in the criminal justice system, it was important to examine differences in these characteristics based on mental health status. Mental illness has been identified as a potential risk factor recidivism (Abracen et al., 2014; Lurigio, Rollins, & Fallon, 2004), therefore it was expected to see a difference in the sample’s incarceration history based on mental health history. As expected, results show individuals with mental illness had slightly more experiences with prior incarcerations in comparison to individuals without. This is consistent with existing reentry research that focuses on mental illness in correctional settings (see James & Glaze, 2006; Palermo, 2014); however, caution should be made when trying to make any generalizations of the present study.

Prisons offer a variety of programming options to individuals experiencing incarceration, including education, job training or work assignments, drug and alcohol, mental health and wellness to name a few. Participation in these programs have been linked to successful reentry outcomes among individuals who are incarcerated (Pompoco et al., 2017); however, concerns regarding availability and low participation rates for men have been made (Crittenden & Koons-Witt, 2017). Accordingly, it was anticipated the sample used in the present study would indicate lower levels of participation in prison programs. Surprisingly, the majority of participants reported being involved in prison programming at some point during their current period of incarceration. In particular, drug and alcohol programs, education programs, and “other” programs not listed on the survey were most reported. Only a small percentage of individuals
receiving mental health treatment reported participating in mental health programming. This could be contributed to the fact that other specific forms of mental health treatment (e.g., counseling, case management, or medication) were not accounted for in the present study. In general, no major differences in program participation were found based on mental health status.

Challenges to successful reentry have been associated with limited access to context-specific conditions (i.e., employment, housing) for individuals who are incarcerated (see Baer et al., 2006; Visher & Travis, 2003). Overwhelming, the majority of participants in the present study reported they would have access to context-specific conditions upon reentry regardless of the presence of mental illness. In general, participants were more likely to report “no” or “unsure” with regards to their access to income and insurance, which further highlight the challenges in obtaining employment or accessing benefits upon reentry (Pager, Western, & Sugie, 2009). Only anticipated access to food and medication upon reentry were associated with mental health status. The difference in access to food was surprising considering access to income or other income-required conditions were not associated with mental health status. Not surprising was the association between access to medication and mental health status; however, nearly half of the mental health population in this present study anticipated not having or being unsure if they will have medications upon reentry. This further raises concerns for mental health as a risk factor for unsuccessful reentry. Given that most people with mental illness do not receive effective mental health treatment in the community, they are susceptible to engaging in behaviors that can lead to incarceration (Palermo (2014).

The present study also examined differences in levels of self-efficacy, optimism, motivation to change, and perceived reentry readiness based on mental health status. Prior studies have found negative correlations between self-efficacy and mental health distress
(Andersson et al., 2014; Rabani Bavojdan, Towhidi, & Rahmati, 2011). Similar results have also been found with optimism (Hirsch, Conner, & Duberstein, 2007). As such, it was expected to see noticeable differences among the sample used in the present study; however, no differences were seen. Levels across the person-specific conditions and perceived reentry readiness were similar regardless of the presence of mental illness. Accordingly, results in the present study raises concerns for risk factors of unsuccessful reentry. While the literature has identified mental illness as one possible risk factor (see Abracen et al., 2014; Lurigio, Rollins, & Fallon, 2004), individuals in the present study may not consider mental illness as a potential barrier to their reentry readiness.

**Contributions of Person-Specific Condition on Perceived Reentry Readiness**

In review of reentry literature, Wolff, Shi, and Schumann (2012) note context-specific conditions (i.e., income and housing) have a significant role in successful reentry outcomes. Alternatively, Bahr, Harris, Fisher, and Harker (2010) and Forste, Clarke, and Bahr’s (2011) research found evidence that lower self-efficacy is associated with unsuccessful reentry and staying away from trouble among individuals who are incarcerated. Accordingly, it was important for the present study to consider the contributions of these conditions to perceived readiness. Results showed person-specific conditions contributed 15.5% of variance in perceived reentry readiness when controlling for demographic variables and accounting for context-specific conditions. Specifically, self-efficacy was the strongest contributor in comparison to optimism and motivation to change. This challenges Visher and O’Connell’s (2012) notion that optimism is an important determinant of post-reentry behaviors.

One possible explanation is the challenge to distinguish optimism from self-efficacy. Although the present study found no concerns with multicollinearity between the two variables,
they may still have similar representations as person-specific conditions. This distinction can be further examined supported by the social cognitive framework. For instance, Bandura’s (2006) social cognitive theory notes the role self-efficacy has in determining whether individuals will possess optimistic versus pessimistic attitudes. Moreover, whether individuals will be motivated and willing to make behavioral change. Based on this framework, self-efficacy may be the greatest contributor over all other possible person-specific conditions. Surprisingly, the present study did not find a significant relationship between self-efficacy and motivation to change. It is possible that self-efficacy may demonstrate a relationship with the individual change profiles; however, this was not captured given motivation to change was represented as a total readiness score.

**Contributions of Context-Specific Conditions on Perceived Reentry Readiness**

Much of the existing literature on reentry has examined the contributions of context-specific conditions on successful outcomes. Several barriers to successful reentry have been identified in the literature, which include securing legal identification, obtaining employment, and finding housing (Binswanger et al., 2011). Accordingly, it was important for the present study to consider the contributions of these conditions to perceived reentry readiness. Results showed context-specific contributed the majority of variance in perceived reentry readiness when controlling for demographic variables. Specifically, anticipation of having an income and a home were the strongest contributors.

The contributions of context-specific conditions on perceived reentry readiness are consistent with expectations based on existing reentry literature. Despite this, one cannot ignore that both person-specific and context-specific conditions contributed a combined total of nearly half of the variance in perceived reentry readiness. Accordingly, the present study’s findings
suggest neither person-specific nor context-specific factors alone contribute to perceived reentry readiness. Surprisingly, the anticipation of having access to legal identification upon reentry did not have a significant contribution to perceived reentry readiness despite its importance for individuals to obtain employment and find housing upon release.

**Contributions of Mental Health Status on Perceived Reentry Readiness**

It was also important for the present study to examine the extent of the relationship between mental illness and perceived reentry readiness given mental illness has been identified as a possible risk factor for unsuccessful reentry among individuals who are incarcerated (Abracen et al., 2014; Lurigio, Rollins, & Fallon, 2004). Current mental health status was examined as a separate contributor to perceived reentry readiness in the regression model after all other variables were accounted for in the models. Results showed the presence of mental illness did not make any additional contributions to perceived reentry readiness among participants in this sample. In fact, the variance accounted for in the final model decreased less than 1% from the previous models.

There are two possible explanations that could support the conceptualization of model’s outcome once contributions from mental illness were made. First, it is possible that mental health treatment received during incarceration increases perceptions of readiness. This would be consistent with research on self-efficacy and optimism that shows in which higher levels of mental health wellness are associated with higher perceptions of self-efficacy and optimism (Andersson et al., 2014; Rabani Bavojdan, Towhidi, & Rahmati, 2011). Second, there is concern among prison research regarding the overestimation of abilities, or even an underestimation of potential challenges experienced during reentry (Dhami, Mandel, Loewenstein, & Ayton, 2006).
This could have some indications for why the majority of the sample used in the present study consistently reported higher perceptions of reentry readiness.

**Implications**

Much of the existing literature on prison reentry has examined the impact of context-specific conditions (i.e., employment, housing,) that promote successful reentry among individuals who are incarcerated. Accordingly, the present study aimed to direct attention to the person-specific factors that contribute to perceived reentry readiness. Specifically, the contributions of self-efficacy, optimism, and motivation to change were examined. Findings demonstrate the need for further examination of the person-specific factors that contribute to perceived reentry readiness. There is preliminary evidence supporting self-efficacy is a contributor to perceived reentry readiness in a small sample of individuals who are incarcerated; however, results further support existing contributions of context-specific conditions on reentry. As such, there are several important implications the present study holds for the counseling profession.

In terms of person-specific conditions, counselors working in correctional settings and/or supporting clients in the community during the reentry process should consider incorporating interventions that promote person-specific conditions, particularly self-efficacy. Given existing research, and even the present study, have demonstrated support for the need of context-specific conditions for successful reentry, counselors should consider how this might contribute to lower levels of person-specific conditions and connect clients to gaining the proper services to support their reentry. Rehabilitation counselors could have a significant role with this given they possess additional training to assist individuals with addressing housing, employment, education, and several other context-specific needs. Moreover, they are trained to work with clients who have a
variety of disabilities, not just mental health. Although mental health was of primary interest in the present study, it does not account for presence of other disabilities that could impact perceptions of reentry readiness.

In terms of context-specific conditions, employment has been found to be a significant barrier for individuals during the reentry process. While the majority of participants in the present study reported being employed at their current correctional facility, researchers have raised concerns regarding whether the skills individuals acquire will translate into gainful employment post-reentry. In fact, Solomon, Johnson, Travis, and McBride (2004) suggest the work assignments during incarceration are not always appealing to employers post-reentry. They note the majority of individuals are often assigned custodial work assignments that support the operations of the correctional facility, but do not increase their marketability for gainful employment. Participation in job skills programming has been linked to obtainment of employment post-reentry (Visher, Debus, & Yahner, 2008). Surprisingly, only 24.2% of individuals in the present study reported participation in job skills programming. There are a variety of possibilities that could contribute to a lack of participation in these programs (e.g., conflicts with other commitments, number of openings). Moving forward, correctional facilities should consider the efficacy of their programs and ensure all individuals experiencing incarceration are aware of and have access to these programs.

Counselor Educators play a significant role in the education and training of counselors-in-training to become competent and ethical professionals in the field. It is important for counselors-in-training to possess the knowledge and awareness for working with culturally diverse clients, yet very few programs specifically address methods for supporting clients who have been impacted by incarceration. Although generalizations cannot be made in the present
study, there is some indication that characteristics among individuals who are incarcerated may vary according to mental health status. Given the prevalence of mental illness in the criminal justice system coupled with challenges presented by mass prison reentry, the likelihood of counselors supporting clients during the reentry process is likely. As such, counselor educators adopt methods into their programs that will assist future counselors with addressing the unique needs of this population.

**Limitations of the Study**

As with all research, there are several limitations that warrant discussion in the present study. In terms of population, only male participants were included in the sample so results may not be generalizable to the female population. Wolff, Shi, and Schumann (2012) suggest there may be gender differences for females in terms of familial supports outside of prison due to childcare responsibilities. The presence of additional supports outside of incarceration could affect females’ perceptions of readiness. Another limitation to the population was assessing the presence of mental illness. Although participants currently treated for mental health issues were included, history of mental illness was not considered. It is possible that participants that were not identified as currently receiving mental health treatment could have experienced prior mental health issues. Also, due to confidentiality concerns, participants’ current diagnostic information could not be obtained. Type of mental illness was a self-report item on the survey, therefore actual diagnoses could not be verified. The present study also did not account for the severity of symptoms, which could make important distinctions about perceived reentry readiness.

Limitations to studies involving populations experiencing incarceration also exist. These individuals face added vulnerabilities due to restrictions in their autonomy, privacy, and freedoms (Johnson, Kondo, Brems, Ironside, & Eldridge, 2016). The added stigmatization of
mental illness further increases the need for securing participants’ confidentiality and privacy. Participants in this study were provided an additional white sheet of paper to cover responses; however, they were informed that completed surveys could be subjected to search upon return to the researcher as part of institutional policy. This could not only impact the number of individuals willing to participate, but also the honesty of their responses. Issues regarding coercion to participate may also exist. Although eligible participants for the present study were informed their participation was voluntary and had no risk of reward or punishment, Dugosh, Festinger, Croft, and Marlowe (2010) found evidence suggesting individuals who are incarcerated have perceptions that research participation will help their court cases and make them look better to the judge.

Survey methodology is also subjected to several limitations (Dillman et al., 2014). First, surveyors must carefully plan any skip patterns that will be used. Paper surveys lack the technology that would automatically respond to skip patterns like those found in web surveys. As such, skip patterns were not used in the survey; however, the demographic questionnaire did ask participants to expand on any items marked “other.” Authors note further challenges with paper surveys include participants’ ability to scan the entire survey before beginning, or at any point during administration. This gives participants an idea for the general length of the survey and the topics discussed, which can lead to priming. Moreover, participants may answer items outside of their intended order. Since this survey did not use skip patterns, answering questions outside of their intended order was less of a concern; however, it does produce issues for missing data. There are also limitations to the use of self-report methods, such as faulty recall or participant bias (Wolff et al., 2012).
There are also limitations to consider with regards to any generalizations made. First, the present study was exploratory in nature, therefore any conclusions made should be done with caution. While a return rate of 42% was achieved (N = 274), only 60% of those surveys met inclusion criteria (N = 164). With regards to the analysis, another limitation was that the demographic variable (i.e., perceived reentry readiness) required data transformation due to being negatively skewed. Most methods available for data transformations are aimed at positively skewed results. Some of the most well-known and researched data transformations can be applied to negatively skewed data, but after a reflection is first applied. Unfortunately, this approach altered the direction of variable correlations that were not consistent with existing literature or expectations for the present study. Accordingly, the power transformation used to address skewed data could have an impact of the model’s results and overall findings in the study.

**Recommendations for Future Research**

The present study is one of a few that have examined person-specific conditions that contribute to perceptions of reentry readiness among individuals who are incarcerated. Specifically, the contributions of self-efficacy, optimism, and motivation to change were examined. Results of the present study would be strengthened with replication across various correctional settings using samples that are representative of the general population of individuals experiencing incarceration. Further research is necessary to understand connection between person-specific conditions and perceived reentry readiness in order to improve the development of effective strategies for reentry planning and programming.

Given the issue of high recidivism rates challenging the reentry process, one future recommendation for research should examine the relationship between perceived reentry
readiness and reentry outcomes post-release. While the present study found the majority of participants had higher perceptions of reentry readiness, there is no indication of whether readiness will translate into successful outcomes and a reduction in recidivism over time. Given the present study found strong support for the contributions of context-specific conditions to perceived reentry readiness, it would be important for future research to consider the long-term relationship between person-specific and context-specific conditions in reentry outcomes.

Further directions in research on reentry readiness should also be aimed at developing valid and reliable instruments used to measure the construct. The Preparedness for Release (PR) scale used in the present study is one of a few measures that have been developed for this purpose; however, the PR focuses more on the extent individuals feel they will have access to context-specific conditions associated with reentry readiness. Only two of its items really capture the person-specific conditions of reentry readiness. As more research is conducted on factors that promote readiness, it will be important to further develop scales like the PR that take into account both person-specific and context-specific conditions to best measure the construct. Moreover, issues concerning individuals’ unrealistic perceptions about readiness should be addressed. It is recommended that measures to assess true perceptions of reentry readiness should be implemented in any future research to ensure reliable and valid assessments of the construct. Dhami et al. (2006) developed measures to assess unrealistic optimism and self-enhancement that are consistent with prior research. Accordingly, use of these measures with other scales should be considered.

Finally, future reentry research examining differences among individuals with and without mental illness should be consistent with current diagnostic criteria. For instance, the present study adopted existing mental health items for use on the demographic questionnaire.
Participants had the option to report receipt of treatment for anger issues despite anger is not specifically identified as a mental health disorder as per the *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* (DSM-5, American Psychiatric Association, 2013). Although it is not uncommon for individuals to work on potential anger issues while incarcerated, it may not fully represent potential underlying mental health issues that could be valuable for future understanding. Other research could also examine differences in perceived reentry readiness across mental health disorders. For this, it is recommended that researchers obtain participants’ mental health information through official documentation if permissible by the Department of Corrections approving of the research. The present study utilized self-report mental health data, which is subjected to a variety of limitations that may not accurately identify differences across types of disorders.
References


Khalil, M.S. (2011). Reliability and confirmatory factor analysis of the Arabic version of the University of Rhode Island Change Assessment (URICA). *Alcohol and Alcoholism, 46*(2), 138-142. doi: 10-1093/alcalc/agr003


Appendix A

Background Information

The following questions will ask you to report your background information. Please read each question carefully and record your responses in the space provided below.

What is your age (in years)? ________

What is your gender identity? [Please check one]

___ Male        ___ Female          ___ Transgender    ___ Self-identify: ____________________________

What is your race/ethnicity? [Please check one]

___ African American/Black   ___ Hispanic/Latino/a
___ American Indian or Alaskan Native   ___ Native Hawaiian or Pacific Islander
___ Asian American/Asian   ___ Multi-racial
___ Caucasian/White   ___ Self-identify: ____________________________

Is this the first time you have been in prison? [Please check one]

___ Yes          ___ No

If you checked no, how many times have you been in prison? ____________________________

What crime(s) were you sentenced for this time? [Please check all that apply]

___ Drug distribution   ___ Drug possession
___ Property offense (e.g., theft, burglary)   ___ Fraud, embezzlement, identity theft
___ Rape, sexual assault, molestation   ___ Eluding
___ Violent offense (e.g., battery, assault, murder)   ___ Other

If you checked other, please write your response here: ____________________________

How long have you been in prison this time? ____________________________

Months     Years

When will you be released? ____________________________

Month     Year

While in prison, have you been treated for a mental health issue? [Please check one]

___ Yes          ___ No
If you checked yes, what you were treated for? [Please check all that apply]

___ Anger disorder  ___ Depression  ___ Schizophrenia
___ Anxiety disorder  ___ Drug/alcohol use  ___ Other
___ ADHD  ___ Panic attacks
___ Bipolar disorder  ___ PTSD

If you checked other, please write your response here: ___________________________

___________________________________________________________________________

Have you been in any programs while in prison this time? [Please check one]

___ Yes  ___ No

If you checked yes, what types of programming have you been in? [Please check all that apply]

___ Job skills
___ Education (e.g., GED)
___ Drug and alcohol (e.g., AA, NA)
___ Mental health or emotional support (e.g., coping skills, trauma, anger management)
___ General health or nutrition
___ Other

If you checked other, please write your response here: _______________________

___________________________________________________________________________

Have you been given a job in the prison that pays you? [Please check one]

___ Yes  ___ No

Upon release, will you have…

ID card  ___ Yes  ___ No  ___ Unsure
Driver’s license  ___ Yes  ___ No  ___ Unsure
Birth certificate  ___ Yes  ___ No  ___ Unsure
Social Security card  ___ Yes  ___ No  ___ Unsure
Transportation  ___ Yes  ___ No  ___ Unsure
Source of income  ___ Yes  ___ No  ___ Unsure
Medical insurance  ___ Yes  ___ No  ___ Unsure
Stable housing  ___ Yes  ___ No  ___ Unsure
Mailing address  ___ Yes  ___ No  ___ Unsure
Phone access  ___ Yes  ___ No  ___ Unsure
Food  ___ Yes  ___ No  ___ Unsure
One-month of medications  ___ Yes  ___ No  ___ Unsure

Do you feel ready to support yourself once you leave prison? [Please check one]
___ Yes     ___ No

Overall, how would you rate your readiness for living on your own? [Please check one]

___ Excellent     ___ Very good     ___ Good     ___ Fair     ___ Poor

The following statements aim to understand your feelings of readiness for release from incarceration. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. I feel prepared to get a job upon release.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I feel comfortable going back to my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I am comfortable with my housing situation upon release.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I know where I’m going to live when I leave here.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I know what is expected of me upon release.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. It will be easy to pay my bills after release</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. It will be easy to find a good place to live when I leave here.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I have people I can depend on when I am released.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The following statements aim to understand how much you believe in yourself. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel.

<table>
<thead>
<tr>
<th></th>
<th>Not at all true</th>
<th>Hardly true</th>
<th>Moderately true</th>
<th>Exactly true</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. I can always manage to solve difficult problems if I try hard enough.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. If someone opposes me, I can find the means and ways to get what I want.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
3. It is easy for me to stick to my aims and accomplish my goals. 1 2 3 4
4. I am confident that I could deal efficiently with unexpected events. 1 2 3 4
5. Thanks to my resourcefulness, I know how to handle unforeseen situations. 1 2 3 4
6. I can solve most problems if I invest the necessary effort. 1 2 3 4
7. I can remain calm when facing difficulties because I can rely on my coping abilities. 1 2 3 4
8. When I am confronted with a problem, I can usually find several solutions. 1 2 3 4
9. If I am in trouble, I can usually think of a solution. 1 2 3 4
10. I can usually handle whatever comes my way. 1 2 3 4

The following statements aim to understand how hopeful you are. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In uncertain times, I usually expect the best.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. It's easy for me to relax.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. If something can go wrong for me, it will.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I'm always optimistic about my future.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I enjoy my friends a lot.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. It's important for me to keep busy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I hardly ever expect things to go my way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I don't get upset too easily.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
9. I rarely count on good things happening to me. 0 1 2 3 4
10. Overall, I expect more good things to happen to me than bad. 0 1 2 3 4

The following statements aim to understand your motivation to change the behaviors that led to your current incarceration. Please read each statement carefully and circle the number (one number per question) that best reflects how you feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As far as I am concerned, I don’t have any problems that need changing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I think I might be ready for some self-improvement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am doing something about the problems that had been bothering me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. It might be worthwhile to work on my problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I’m not the problem one. It doesn’t make much sense for me to consider changing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. It worries me that I might slip back on a problem I have already changed, so I am looking for help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am finally doing some work on my problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I have been thinking that I might want to change something about myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have been successful in working on my problem, but I’m not sure I can keep up the effort on my own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. At times my problem is difficult, but I am working on it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Trying to change is pretty much a waste of time for me because the problem doesn’t have to do with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
12. I’m hoping that I will be able to understand myself better.

13. I guess I have faults, but there is nothing that I really need to change.

14. I am really working hard to change.

15. I have a problem, and I really think I should work on it.

16. I am not following through with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.

17. Even though I’m not always successful in changing, I am at least working on my problem.

18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.

19. I wish I had more ideas on how to solve my problems.

20. I have started working on my problem, but I would like help.

21. Maybe someone or something will be able to help me.

22. I may need a boost right now to help me maintain the changes I’ve already made.

23. I may be part of the problem, but I don’t really think I am.

24. I hope that someone will have some good advice for me.

25. Anyone can talk about changing; I am actually doing something about it.

26. All this talk about psychology is boring. Why can’t people just forget about their problems.

27. I am struggling to improve myself from having a relapse of my problem.

28. It is frustrating, but I feel I might having a
recurrence of a problem I thought I had resolved.

29. I have worries, but so does everyone.  
   1  2  3  4  5

30. I am actively working on my problem.  
   1  2  3  4  5

31. I would rather cope with my faults than try to change them.  
   1  2  3  4  5

32. After all I had done to try and change my problem every now and again it comes back to haunt me.  
   1  2  3  4  5

This is the end of the survey.

Thank you for your participation!
Appendix B

Dear Participant,

My name is Lindsey Fullmer and I am a doctoral student in the Counselor Education and Supervision program at Penn State University. I am writing to ask you to be in a study about readiness to leave prison. You are able to be in this study because you are at least 18-years-old.

If you want to be in this study, you will be given a survey that will ask you questions about your feelings of readiness to leave prison, the belief you have in yourself to achieve, your feelings of hopefulness, and your motivation to change. This study takes about 45-60 minutes to do. You will have 14 days to finish the survey once it is given to you.

You can choose to be in the study or not. You will not be in trouble if you do not want to be in the study. If you have any questions about the study, you may call me at 814-863-2418.

Thank you very much for your consideration!

Sincerely,

Lindsey Fullmer
Appendix C

CONSENT FOR RESEARCH
The Pennsylvania State University

Title of Project: Reentry Readiness: The Relationships Between self-Efficacy, Optimism, and Motivation to Change as Individuals Who Are Incarcerated Prepare for Release

Principal Investigator: Lindsey Fullmer

Address: 141 CEDAR Bldg, University Park, PA 16802

Telephone Number: 814-863-2418

Advisor: Dr. Liza Conyers

Advisor Telephone Number: 814-863-6115

We are asking you to be in a research study. This form gives you information about the research.

Whether or not you take part is up to you. You can choose not to take part. You can agree to take part and later change your mind. Your decision will not be held against you.

Please ask questions about anything that is unclear to you and take your time to make your choice.

1. Why is this research study being done?
   We are asking you to be in this research study because you are at least 18-years-old. This study is being done to find out how much your belief in yourself to achieve, your feelings of hopefulness, and your motivation to change impact your readiness to leave prison. About 400 people in Pennsylvania state prisons will be in this study.

2. What will happen in this research study?
   You will be asked to read statements and report your feelings. You may skip questions that you do not want to answer. You will have 14 days to finish the survey once it is given to you.

3. What are the risks and possible discomforts from being in this research study?
   There is a risk of loss of confidentiality if someone other than the researchers obtains your information or identity. Steps will be taken to keep this from happening that is allowed by law. The DOC requires that your confidentiality be broken if there is risk to your health or safety. It will also be broken if there is risk to the health or safety of someone else, or to the safety or operations of any state prison or jail. Your survey could be inspected upon return to the researcher as part of DOC policies and procedures for outgoing mail. You should not put any information specific to you in the survey. The confidentiality of your electronic data created by you or by the researchers will be kept to the degree allowed by the technology used. Absolute confidentiality cannot be guaranteed.

4. What are the possible benefits from being in this research study?
   4a. What are the possible benefits to you?
There are no benefits for being in the research study. Taking part in this research study will not improve your housing or correctional program assignments. Your taking part in this research study will not improve your chance of parole or release.

4b. What are the possible benefits to others?
If you take part in this research study, you have the chance to give helpful input to understand feelings of readiness to leave prison.

5. What other options are available instead of being in this research study?
You may decide not to participate in this research.

6. How long will you take part in this research study?
If you agree to take part, it will take you about 45-60 minutes to complete this research study.

7. How will your privacy and confidentiality be protected if you decide to take part in this research study?
Efforts will be made to limit the use and sharing of your personal research information to people who have a need to review it. No identifiable information to you will be collected in this research study. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared. Your data will be stored on a password-protected computer. The paper copy of your survey will be stored in a locked file. This will be shredded once your data is entered in the computer.

We will do our best to keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people may find out about your participation in this research study. For example, the following people/groups may check and copy records about this research.
- The Office for Human Research Protections in the U.S. Department of Health and Human Services
- The Institutional Review Board (a committee that reviews and approves research studies)
- The Office for Research Protections.
- Pennsylvania Department of Corrections

Some of these records could contain information that personally identifies you. Reasonable efforts will be made to keep the personal information in your research record private. However, absolute confidentiality cannot be guaranteed.

8. What are your rights if you take part in this research study?
Taking part in this research study is voluntary.
- You do not have to be in this research.
- If you choose to be in this research, you have the right to stop at any time.
- If you decide not to be in this research or if you decide to stop at a later date, there will be no penalty or loss of benefits to which you are entitled.

9. If you have questions or concerns about this research study, whom should you call?
Please call the head of the research study (principal investigator), Lindsey Fullmer, at 814-863-2418 if you:
- Have questions, complaints or concerns about the research.
- Believe you may have been harmed by being in the research study.
You may also contact the Office for Research Protections at (814) 865-1775, ORProtections@psu.edu if you:
- Have questions regarding your rights as a person in a research study.
- Have concerns or general questions about the research.
- You may also call this number if you cannot reach the research team or wish to offer input or to talk to someone else about any concerns related to the research.

INFORMED CONSENT TO TAKE PART IN RESEARCH

Your participation implies your voluntary consent to participate in the research. Please keep or print a copy of this form for your records.
Appendix D

Office for Research Protections
Vice President for Research
The Pennsylvania State University
205 The 330 Building
University Park, PA 16802

Fax: 814-865-8699
orp@psu.edu
research.psu.edu/orp

APPROVAL OF SUBMISSION

Date: April 3, 2018
From: Lindsay Kowalski, IRB Analyst
To: Lindsey Fullmer

Type of Submission: Initial Study

Title of Study: Reentry Readiness: The Relationships Between Self-Efficacy, Optimism, and Motivation to Change as Individuals Who Are Incarcerated Prepare for Release

Principal Investigator: Lindsey Fullmer

Study ID: STUDY00008672

Submission ID: STUDY00008672

Funding: Not Applicable

IND, IDE, or HDE: Not Applicable

Documents Approved:
• Fullmer- Recruitment Letter.docx (3), Category: Recruitment Materials
• Fullmer- Survey.docx (2), Category: Data Collection Instrument
• HRP-589 - ORP Consent Form (Waiver of Written Documentation of Consent).pdf (5), Category: Consent Form
• HRP-591 - Protocol for Human Subject Research.pdf (5), Category: IRB Protocol

Review Level: Committee

IRB Board Meeting Date: 3/22/2018

On 3/22/2018, the IRB approved the above-referenced Initial Study. This approval is effective through 3/21/2019 inclusive. You must submit a continuing review form with all required explanations for this study at least 45 days before the study’s approval end date. You can submit a continuing review by navigating to the active study and clicking ‘Create Modification / CR’.
If continuing review approval is not granted before 3/21/2019, approval of this study expires on that date.
To document consent, use the consent documents that were approved and stamped by the IRB. Go to the Documents tab to download them.

We would like to know how the IRB Program can better serve you. Please fill out our survey; it should take about a minute: https://www.research.psu.edu/irb/feedback. ID26

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within CATS IRB (http://irb.psu.edu). These requirements include, but are not limited to:

- Documenting consent
- Requesting modification(s)
- Requesting continuing review
- Closing a study
- Reporting new information about a study
- Registering an applicable clinical trial
- Maintaining research records

This correspondence should be maintained with your records.
Appendix E

March 22, 2018

Lindsey Fullmer
Pennsylvania State University
812 Southgate Dr.
State College, PA 16801

Ms. Fullmer,

I am pleased to inform you that the Department’s Research Review Committee (RRC) has approved your research study titled “FACTORS THAT PREDICT REENTRY READINESS FOR INDIVIDUALS WITH MENTAL ILLNESS.” This approval gives you authorization to survey inmates as discussed in your proposal.

Please note that approval of your proposal is contingent upon the following conditions:

- Receipt of your institution’s Internal Review Board (IRB) approval.
- Participation by inmates in the study is purely voluntary. If individuals choose not to participate, they cannot be required to participate and may withdraw from the study at any time.
- All participants must receive an informed consent briefing in accordance with your IRB’s guidance.
- Inmates may not receive any incentives or compensation for their participation in this study.
- Prior to proceeding with research, please sign and return the attached “Research Ethics and Policy Guidelines and Conditions.” Your signature will imply your acceptance of the terms and conditions of the Department’s Research Policy. This signed form will be maintained in our files for the duration of your project.

Upon receipt of your IRB approval and signed ethics form, we will begin coordinating with the SCI’s. If you have further questions, you may contact me at (717) 728-4085.

Sincerely,

Michele Hester
Chief, Research and Evaluation
Chair, Research Review Committee

Encl

cc  Dir. Bucklen  File 2017-22
Lindsey Fullmer, M.Ed., CRC
lnf5001@psu.edu

EDUCATION
Doctor of Philosophy- Counselor Education and Supervision
The Pennsylvania State University
Defended June 2018

Masters of Education-Rehabilitation Counseling
The Pennsylvania State University
May 2015

Bachelors of Arts-Journalism
The Pennsylvania State University
May 2008

CERTIFICATIONS
Certified Rehabilitation Counselor
Commission on Rehabilitation Counselor Certification
April 2016-present

TEACHING EXPERIENCE
The Pennsylvania State University
Introduction to Counseling as a Profession
Fall 2017-Spring 2018

Introduction to Disability Culture (online and residential)
Fall 2017-Spring 2018

SELECTED CO-TEACHING EXPERIENCE
The Pennsylvania State University
Applied Testing in Counseling
Spring 2018

Supervised Internship: Prison Education Program
Fall 2017

Introduction to Rehabilitation Counseling
Fall 2016

SELECTED PROFESSIONAL EXPERIENCE
CEDAR Clinic Supervisor
August 2015-May 2018

Strawberry Fields, Inc.
Lead Psychiatric Direct Support Specialist
July 2011-August 2015

SELECTED CONFERENCE PRESENTATIONS
