Comparing Experiences of Community Reintegration Following Hospitalization Versus Jail Detention During a Mental Health Crisis

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ABSTRACT

BACKGROUND: This comparative qualitative study explores the experiences of individuals transitioning back to the community after institutionalization following an episode of acute suicidality.

METHODS: Semi-structured interviews were conducted with eight individuals who had either been hospitalized (n=4) or incarcerated (n=4) during a mental health crisis that involved acute suicidality. Thematic analysis was conducted first within groups and then between groups.

RESULTS: The findings reveal possible disparities in social determinants of mental health, family dynamics, treatment seeking, and coping mechanisms between groups. Social isolation, barriers to socioeconomic stability, and lack of treatment access were all found to be risk factors for poor outcomes during the vulnerable transition period and were experienced by participants in this limited sample.

CONCLUSIONS: Individuals transitioning from the hospital after a suicide crisis may benefit from increased family involvement, follow-up, and social support at discharge. After a suicide crisis and incarceration, there is a significant need for housing and employment support to allow for mental health treatment seeking. Future research should build on the proof of concept for comparing the experiences of individuals across institutional settings.

KEYWORDS: Mental health, incarceration, qualitative research

INTRODUCTION

In the United States, the criminal-legal system serves as a major point of contact for individuals experiencing a mental health crisis, with jails housing a larger population of people with mental illness than any other institutional setting.[1-8] With psychiatric patients three times more likely to be incarcerated than hospitalized, jails and prisons have become de facto mental health systems, and suicide attempts can result in patients being brought either to the hospital or to jail.[9-11] In contrast to prisons, the majority of people detained in jails are awaiting trial or serving short sentences.[12-15] Both psychiatric hospitals and jails have an average length of stay of 1–2 weeks before individuals are released.[12,15-18]

The transition to the community from a correctional or inpatient psychiatric setting is a highly vulnerable period with an increased risk of mortality and suicide.[19-25] After incarceration, people face obstacles to social and structural determinants of mental health, which may confer additional risk and decreased treatment engagement.[12,26-29] After psychiatric hospitalization, patients face numerous barriers to a healthy transition.[30] However, the ways that patients experience institutionalization during a mental health crisis and what it is like to transition back to the community during this vulnerable period has been highlighted as a critical literature gap, and there is a near absence of research directly comparing the experience of incarceration to inpatient psychiatric treatment.[1,30]

This study addressed a literature gap by exploring the experiences of individuals transitioning to the community after psychiatric or carceral institutionalization following acute suicidality. Utilizing semi-structured interviews, we aimed to understand the unique and shared challenges faced by patients in each setting and inform potential areas of reform to improve the mental health system.

METHODS

Semi-structured interviews were conducted with eight individuals, evenly split between those admitted to pretrial jail detention and those admitted to a psychiatric hospital during a suicide crisis, also referred to as a mental health crisis (**Table 1**). Participants in the current study were recruited from the routine care control arm of one of two randomized-controlled trials to reduce suicidal behavior among high-risk individuals from a Rhode Island jail (NCT #02759172) and a Rhode Island psychiatric hospital (NCT #02313753). These individuals, who had previously provided permission to be contacted for future research, were contacted at least one year after completing the parent trials. To be eligible in either trial, participants were required to be adults (18+ years of age) who had been recently admitted to either the jail or the hospital and had made a suicide attempt or expressed suicidal ideation with intent within 48 hours of admission to be eligible for the hospital trial, or in the past

Table 1. Demographics

ID	Age	Sex	Racial & Ethnic Group	Length of index institutionalization (days)	Number of psychiatric hospitalizations	Number of arrests
J1	32	M	Multi-racial (Black & White), non-Hispanic	14	3	11
	28	M	White, non-Hispanic	45	1	5
J3	29	M	White, non-Hispanic	10	1	5
J4	29	M	Black, non-Hispanic	32	1	5
H1	47	F	White, non-Hispanic	8	2	0
H2	27	M	White, Hispanic	7	1	0
H3	43	F	White, non-Hispanic	5	2	0
H4	32	M	White, non-Hispanic	8	12	1

ID = Subject identifier. J = jail population. H = hospital population. All sex and racial/ethnic information based on self-report.

month (typically prior to arrest) for the jail trial. Additional detail regarding initial eligibility for each study is available in their respective clinicaltrials.gov entries. Participants in the current study were consented under protocols approved by the Institutional Review Boards of both Brown University and Butler Hospital.

Interviews were rooted in the social contextual model, which seeks to understand how individual, interpersonal, and community factors influence health behaviors.[31] Questions were designed to elicit perceptions of factors influencing mental health, individual needs, and experiences of mental health care at three broad timepoints: pre-institutionalization, while institutionalized, and after release. The focus of the current paper is on experiences after release.

All interview recordings were manually transcribed. A reflexive thematic approach was used in coding the transcripts.[32] Each transcript received initial, line-by-line coding, and each code was tagged with a thematic theme. As new themes emerged from subsequent interviews, prior transcripts were re-coded in an iterative process to develop the broadest initial codebook. After the initial coding and thematic tagging of all interviews, codes were reconciled initially within groups, and eventually between groups. The iterative process of constant comparative analysis allowed for identification of thematic saturation, and only recurrent themes that were thoroughly described are included in this analysis.

RESULTS

Demographic information is highlighted in **Table 1**. The hospital sample had a mean age of 37 years (SD: 9.3), compared to 29.5 years (SD: 1.73) in the jail sample. All participants from the jail sample were men compared to half of the hospital sample. The majority of the overall sample was White, although there was more racial diversity among the jail sample. Most participants were familiar with both institutional settings; all members of the jail sample had exposure to psychiatric hospitalization, while one member of the hospital sample had been previously arrested during a mental health crisis.

Three primary themes regarding the transition from institutionalization emerged from the interviews: social determinants of mental health, family and social support, and coping mechanisms and treatment seeking.

I. Social Determinants of Mental Health

Participants leaving jail faced challenges in housing stability, employment, and reintegration due to probation constraints. In contrast, hospital participants experienced more stability and fewer barriers to reintegration. All participants had stable housing at the time of hospital admission and there were no housing concerns after discharge. For those who had been incarcerated, there was ubiquitous housing instability. One participant described being "discharged to the streets," from jail. Another described the process by which he lost his apartment while incarcerated. Every participant required support from family for housing after release. Participants shared the perceived impossibility of legally achieving stability after incarceration, a problem that dovetails with the difficulty of finding both employment and housing with criminal-legal involvement: "I needed to actually get some stability because just trying to build yourself up from the streets, it's like impossible….You can't go paycheck to paycheck and expect to save money when you're homeless. You just can't."

Every participant from the jail sample described difficulty with employment after release. Once employed, the fear of losing work was a barrier to treatment engagement. Participants from the hospital sample had greater employment stability. Those with a job at the time of hospitalization received a medical leave of absence. Others received disability related to their chronic mental health conditions. Others were able to find work when they were ready but did not describe additional barriers due to hospitalization. No hospitalized participants lost their job due to hospitalization or recovery. By contrast, those transitioning from jail were desperate to find employment. Employment was such an important issue that one participant went directly to his former job after release while, "I still smelled like jail," before going home.

The transition to the community for those who were arrested was further complicated by probation and ongoing criminal-legal surveillance. "It's a big stressor knowing that I have that on my back 24/7. One little false move and… you're going to get the three years." One participant spoke about frustration with the "revolving door" of incarceration, in which the burdens of "staying right" in the eyes of the state are nearly impossible to navigate. Most participants who had been jailed referred to the difficulty of navigating probation restrictions, such as the need to maintain housing and employment, or the burden of obtaining transportation and excuses from work to attend meetings with probation officers.

II. Family and Social Support

Compared to the jail sample, participants in the hospital group were more socially isolated and spoke frequently about the lack of family and social ties at the time of hospitalization. Most were living alone or relying on a significant other as their only close relationship: "My support network consisted of my boyfriend and our dogs."

For individuals in the jail sample, family was a source of material stability, emotional support, and purpose. In both groups, there was a feeling that restoring relationships with family was important to long-term recovery, but only in the jail sample was it critical to the initial transition. No hospital participants were parents, but for those with children in the jail sample, repairing relationships with their family was a major motivation in recovery: "My son. I needed to see my kids, drastically. I just needed to be around my family." A common theme in this sample was the importance of being able to provide for one's family as a source of hope and motivation during the transition to the community; however, there were often significant financial, legal, and logistical barriers to regaining custody of children.

III. Post-Release Mental Health: Coping Mechanisms and Treatment Seeking

Multiple participants in the jail sample described worsening of mental health during the initial transition back to the community. One participant described feeling numb when reflecting on the overwhelming emotional burden of his recent experiences in jail and the burdens of life after release: "Usually you're excited that you're getting out of there. Then it gets to the point where it's like wow this really just happened. And you're just too numb to even feel anything. That's what it was, totally numb." Most participants expressed ups and downs in their mental health after incarceration, which culminated for some in exacerbations of underlying depression and suicide risk leading to psychiatric hospitalization.

A sense of control over mood and mental health was an important theme expressed by all the participants who experienced incarceration, often described as "getting over it," both during incarceration and after discharge. "You just got to get over it." Another shared, "You're sad, get over it. You're upset, get over it. I wasn't paying attention to what underlying things or causes that there was. I was just living. I was just existing." This was also expressed as, "keeping problems to myself," or another coping mechanism: "forgetting that I had mental problems." When managing his mood in jail, one participant explained, "I kind of just wanted to get over the fact of it. I didn't even want to think about it, just not think about that at all."

In the hospital sample, participants did not speak about needing to "get over" mood symptoms, instead emphasizing the importance of mental health treatment in managing the stress of hospitalization and transition back to the community. All participants sought treatment shortly after hospital discharge. During this period, several participants described feeling overwhelmed and fearful of a relapse, re-hospitalization, and for their own safety. Participants generally had ups and downs after hospitalization with a gradual, positive improvement over time. Important factors in the long-term transition included building a larger social support network, reconnecting with family, engaging in intensive treatment, and finding the right medications and the right therapist. "I definitely needed medication and I needed talk therapy." "The medication for sure once we hit on the right combination of medications; that was a miracle."

In the immediate period after release, no participants transitioning from incarceration felt that mental health treatment was a high priority, despite acknowledging that it would have been helpful in retrospect. There was a consensus that life stressors were major barriers to treatment seeking: "Honestly, I didn't have the time." Unlike the hospital sample, it was more common for participants to begin seeking treatment after six months to a year from release from jail, and all participants eventually engaged in treatment at least once to help manage stressors and to process experiences related to incarceration.

DISCUSSION

The unique challenges faced by individuals leaving jails include the nearly impossible task of achieving stability while navigating the "revolving door" of incarceration.[29,33] Social determinants of mental health, such as housing and employment, pose significant barriers to this group.[29,34-35] Family and social support play a critical role in the transition from jail, serving as an essential source of material and emotional stability in lieu of adequate social services and treatment access.[29,36-38]

In contrast, individuals leaving psychiatric hospitals experience social isolation but may benefit from relatively fewer structural barriers to socioeconomic stability. The degree of social isolation endorsed by participants in this limited study aligns with what has been observed in other studies,

where it has been identified as a significant risk factor for relapse or suicidality after hospital discharge.[25,30] In this population, the lack of meaningful interpersonal bonds was an impediment to achieving positive mental health. All participants described an initial period of isolation, but as they recovered, they made attempts to build stronger relationships with family, friends, social community, and recovery groups. In the long-term transition from hospitalization, social connectedness was both a sign of improved mental health and a cause of improved mood.

Previous research with people transitioning from incarceration has characterized a coping mechanism in which individuals will "push through emotional despair," in a process of "being strong and going on."[34,39] In this study, formerly incarcerated individuals repeatedly stated the importance of having control over mental health, with all participants referring to "getting over" symptoms of depression or anxiety. In this group, there was minimal treatment engagement in the initial stage after discharge. Participants recognized that treatment would have been beneficial, but there were more immediate material concerns. Other researchers have described "a hierarchy in help-seeking activities post-release in which clients' access to treatment services was predicated on their ability to first find sustainable economic and material support."[12] Without stable housing or income, participants in this sample did not seek mental health treatment. This may also explain why those who were hospitalized did not endorse the same need to manage problems on their own. All participants sought mental health treatment in the initial transition period from the hospital, and intensive treatment was a central part of each participant's path to recovery. The access to treatment and relative stability of their material conditions allowed for outpatient treatment seeking upon discharge.

LIMITATIONS

The findings should be taken in light of the study's limitations. The sample sizes were small. Although the jail sample generally reflected the racial demographics within the Rhode Island Department of Corrections, future work will seek to understand the role of race and racism in the experience of each institutional setting. In addition, no individuals from the hospital group experienced involuntary commitment, seclusion, or restraint. Future research should explore how the experience of involuntary commitment in a psychiatric hospital compares to the experience of arrest. The study may have been affected by a selection bias due to the sampling method of recruiting participants who had stable contact information several years after enrolling in their original trial. Coding saturation was determined to be present for all themes presented in this paper, but given the small sample size, there was the possibility of premature saturation.

CONCLUSION

This study sheds light on a current literature gap by demonstrating proof of concept for comparing the experiences of individuals transitioning back to the community after institutionalization following a mental health crisis. The themes provide insights for interventions tailored to the specific needs of each group during a vulnerable period of transition. Considering the heterogeneity of these populations, and the frequency with which individuals who end up in jail during a mental health crisis require inpatient psychiatric care after release, each institutional setting may benefit from the lessons highlighted in these interviews. Ultimately, the insights and recommendations provided by participants offer valuable guidance to policymakers, hospital and jail administrators, social service agencies, and to clinicians who are committed to mitigating the adverse effects of institutionalization and to facilitating more supportive and compassionate reintegration for individuals experiencing a mental health crisis.

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