2023

Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in Their Community Reintegration

Daniel Oduro Sem
semx1440@mylaurier.ca

Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in their Community Reintegration

By

Daniel Oduro Sem

BA, BSW, MA, MPhil

Dissertation

Submitted to Martin Luther University College in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Human Relationships

2023

Abstract

Court Diversion Program (CDP) seeks to reduce the criminalization and reoffending among people living with mental illness to ensure their community reintegration (Schneider, 2010). The complex nature of achieving this goal calls for a comprehensive strategy, which requires a collaborative effort of legal, health care, and allied professionals including psychotherapists. However, because most CDP clients frequently receive medication treatment, not much is known about how CDP clients find psychotherapy services even though psychotherapy is effective for addressing mental illnesses and offending behaviors (Feingold & Fox, 2018; Feucht & Holt, 2016), To gain more insight into the issue, this study applied the postmodern framework and adopted a comparative case study design to explore the experiences of 5 CDP clients who received psychotherapy as part of their treatment with other 5 CDP clients who received pharmacotherapy treatment. Specifically, this research investigated why the clients chose their preferred treatment, how they experienced their participation in this form of treatment, and the role their treatment modality played in their community reintegration after encountering the criminal justice system. The researcher used qualitative interview techniques to collect data from the 10 participants who were living in the City of Toronto. Data were analyzed for patterns that revealed group differences in the experience and outcomes of these treatments.

***Key terms*:** court diversion, community reintegration, postmodernism, psychotherapy, pharmacotherapy.

Acknowledgments

I thank the Almighty God for granting me the wisdom and special grace that walked me through every stage of this project.

This dream would not have materialized without the help of my academic advisors and dissertation committee members. I thank my former advisor Rev. Dr. Gyeong Kim, who helped me lay out the structure of my dissertation. I appreciate the relentless effort of Dr. Kate Harper (WLU) who took the mantle and continued with me and provided the necessary steps to the final conclusion of this project. I thank my internal/external advisor Dr. Jennifer Lavoie (WLU) for her guidance and the provision of important literature in the criminal justice field. I am also grateful to other committee members Dr. Kristine Lund and Dr. Daniel Rzondzinski for their invaluable feedback that shaped the final product of the dissertation. Moreover, I am exceptionally pleased with my external examiner Dr. Daryl G. Kroner (SIU), for his insightful feedback to this project.

I also want to express my sincere gratitude to my dear friends and colleagues Dr. Magnus Mfoafo M’Carthy (WLU), Dr. Ben Atekha (DCLM), Dr. James Dzisah (University of Ghana), Dr. Frank Sirotich (CHMA), Pastor Samuel Azu (DCLM), and Mr. & Mrs. Dada (DCLM) for their advice, guidance, and encouragement throughout this research. Last but not least, I am thankful to the research participants for their time; and to the court support workers, as well as other professionals of the court diversion program in Toronto for the amazing work they do.

Dedication

This work is dedicated to Grace Esi Sem and Eliana Adofoa Sem for their love, patience, and forbearance throughout my academic journey.

Table of Contents

Chapter 1: Introduction

Since its inception in the 1980s, Court Diversion Program (CDP) has attracted the interest of researchers from different academic backgrounds. CDP is a program set up for people living with mental health challenges, who come into conflict with the law for minor offenses (Livingston, Weaver, Hall, & Verden-Jones, 2008; Schneider, 2008). To prevent incarceration, reduce recidivism, and connect clients with treatment and support systems, the CDP program is specifically designed for mental health clients to help them take advantage of community treatment options in dealing with their charges instead of going through the regular criminal justice sanctions and trial processes (Livingston et al., 2008).

Much of the research published on CDP tends to focus on the evaluation of the program's success and the factors responsible for that success. Studies that examine the success of the program have concluded that CDP has so far been successful in the United States (Frailing, 2010), Ireland (O'Neill, 2006), and globally (Schneider, 2010). Further studies attribute the success of CDP to various factors including effective case management, medication compliance, probation and parole, participants' regular appearance at court, and the Judge's praise and encouragement to the clients during court attendance (Burns, Hiday, & Ray, 2013; Gottfried, Carbonell, & Miller, 2014; Redlich, Liu, Steadman, Callahan, Robbins, Vessilinov, & Ozdogru, 2010; Ryan, Brown, & Watanabe, 2010).

Not much is known about how psychotherapy may be considered one of the contributory factors for clients' successful completion of the court diversion program and their community reintegration even though psychotherapy is proven to be effective for addressing mental illness and offending behavior (Feingold & Fox, 2018; Feucht & Holt, 2016). Therefore, this study primarily sought to inquire whether there were any clients of the court diversion program who accessed psychotherapy during their enrolment in the program and to hear their experiences of how psychotherapy helped or did not help in addressing their needs when they enrolled in the CDP.

Psychotherapy may be beneficial to CDP clients in two ways—first, to help address their mental health needs, and second, to help control their offending behaviors, which are usually triggered by symptoms of mental illness. Research exists to attest to the potential of psychotherapy for CDP clients. For instance, Feingold and Fox (2018) found that evidence-based psychotherapies are effective in addressing the traumatic experiences of justice-involved clients who receive treatment in community-based settings. Feucht and Holt (2016) also confirmed that contemporary therapists apply CBT to address recidivism and substance abuse issues among both adults and juveniles who are involved in violence and other antisocial behavior.

Though research confirms the effectiveness of psychotherapy for offending behaviors, the researcher's curiosity about this topic was heightened by the proliferation of vast research, which attests to the efficacy of psychotherapy in the treatment of different types of mental illness including psychosis and schizophrenia (Bachar, 1998; Garrett, 2016; Lambert et al., 1994; Seligman, 1995; Warman & Beck 2003). The potency of psychotherapy in the treatment of mental and psychological disorders has been growing over the years. Empirical research confirms the comparable efficacy of psychotherapy and pharmacotherapy for the treatment of depression and/or anxiety disorder (Bachar, 1998; Bibbo, 1999; Cuijpers et al., 2013; Quilty, et al., 2014). Studies show that the psychotherapeutic treatment approach to mental illness is effective in symptom reduction not only for anxiety and mild depression, but also for severe forms of mental disorders including some forms of schizophrenia (Warman & Beck, 2003), psychosis (Garrett, 2016), impulsivity, stillness, addictions, and substance use (Carter & Olshan-Perlmutter, 2015). A study that used 61 meta-analyses on 21 mental health disorders with over 137 100 participants revealed that psychiatric patients respond well to both psychotherapy and pharmacotherapy treatments (Huhn et al., 2014). Since CDP clients are also people living with mental health issues, this current study adopted a comparative qualitative case study design to explore the experiences of CDP clients who received treatment through psychotherapy and those who received treatment through pharmacotherapy as they enroll in the court diversion program and integrate into the community.

Statement of the problem

CDP clients in Toronto currently receive support services arranged by the court to help them complete the diversion program. Though CDP adopts therapeutic jurisprudence principles, it predominantly relies on pharmacotherapy for treating clients with mental illness and offending behavior (MIOB). On the other hand, there are other studies that have also shown that psychotherapy may be effective for the treatment of MIOB (Feingold & Fox, 2018; Feucht & Holt, 2016). A comprehensive discussion of such studies can be found in the literature review section of this study under the theme “psychotherapeutic interventions for justice-involved clients”.

Despite the potential benefits of psychotherapy for the treatment of mental illness and offending behaviors, not much is known about the experiences of clients who receive psychotherapy in the CDP as there are not many of these clients who access psychotherapy services. Indeed, researchers such as Burns et al., (2013); Gottfried, et al., (2014); Redlich et al., (2010); Ryan et al., (2010), attribute the success of CDP to several factors other than psychotherapy.

There is, therefore, a research gap, for little is known about how CDP clients find psychotherapy services in completing diversion and their return to the community upon graduating from the program. While supervision and prescribed medications may help manage the symptoms of CDP clients, the common stressors that usually bring this population into conflict with the law (e.g., oppression, internalized guilt and shame, anger, grief and loss, hopelessness, impulsivity, anxiety, relationship issues, noncompliance with treatment, traumatic experiences, and so forth) may also be handled well through different psychotherapeutic models. Therefore, it is important to investigate how clients who enroll in CDP find psychotherapeutic approaches to treatment.

The Study Objectives

The objective of this study was to compare the experiences of CDP clients who received psychotherapy treatment with those who received pharmacotherapy treatment in their participation in the CDP program as they integrate into the community. This was done with the intention to discover some commonalities and differences among CDP clients' experiences of these two treatments from which some key lessons were drawn to call for collaboration and improvement in service delivery in the mental health and justice field. Hence, the study precisely looked at why clients chose psychotherapy or pharmacotherapy treatment, how they experienced their involvement in their choice of treatment and the impact of their treatment on their community reintegration after encountering the justice system.

Main research question

Why do CDP clients choose psychotherapy or medication for their treatment, and how do they experience their participation in this form of treatment as they re-enter the community after encountering the justice system?

The scope of the study

The focus of this study applied only to adult CDP graduated males with lived experience of mental illness aged 18 years or older, and who were once involved in the justice system and enrolled in the court diversion program in the City of Toronto within the last 5 years, but who were living in the community at the time of the field research. The study was conducted from the scope of psychotherapeutic and community-based case management perspective with an interdisciplinary lens. Literature was drawn from various academic disciplines including, but not limited to, theology, sociology, criminology, philosophy, social work, and other social science and humanities. By connecting ideas and concepts across different disciplines, the researcher was able to deepen his knowledge and learning experience on the subject as it applies to other fields of disciplines.

Significance of the study

Previous studies show the effectiveness of psychotherapy for different kinds of mental illnesses (Garrett, 2016; Warman & Beck 2003). For instance, there is sufficient evidence that psychotherapy is effective in addressing different mental health problems including addictions and substance use (Carter & Olshan-Perlmutter, 2015);

schizophrenia (Warman & Beck, 2003); and psychosis (Garrett, 2016). But not much is known about how mental health clients in CDP experience psychotherapy. An exploration of psychotherapy usage among court diversion clients will shed light on how people living with mental illness and offending behaviors find psychotherapeutic intervention in completing CDP and their re-entry into the community following an encounter with the criminal justice system. In the same context, the study tells how psychotherapists may or may not contribute to the community reintegration of clients with MIOB after their involvement with the justice system.

Also, this study emphasizes the importance of relationship building, empathy for clients, and therapeutic alliance with CDP clients. By this, clinicians from other disciplines may benefit from the contribution of spiritual care and psychotherapy. Moreover, the study has the potential of developing themes and patterns for future research in psychotherapy, mental health and justice, and spirituality. More insight and understanding may be gained about the relationship between the CDP and psychotherapy services.

Additionally, an examination of alternative services (aside from pharmacotherapy) that are deemed useful for clients' successful completion of CDP will strengthen the power of integration and collaboration of community resources for mental health clients who come into conflict with the law. This will increase public safety, reduce the criminalization and the cost of hospitalization of people living with mental illness as they will be supported in the community, and, subsequently, reduce recidivism. Also, both CDP clients and the organizers of the program may benefit from the study as recommended useful strategies and support services are underlined and solutions found to the barriers inhibiting program effectiveness. Most importantly, the findings of this research may also have implications for improvement in healthcare policies and clinical practice at the municipal, provincial, and federal levels in Canada and beyond.

Operational definitions

The term “**clients**" is used several times in this research to refer to people living with mental illness who are involved with the justice system. They may or may not have formal mental health diagnoses. In this study, the term “client” is used sometimes in conjunction with other phrases such as "mental health", “offending behaviors”, and "court diversion".

"**Treatment**" or "**rehabilitation**" in this study involves the process whereby a trained professional or a committed and compassionate person assists with the improvement of clients' mental health condition and other problematic behaviors through a psychotherapeutic process or pharmacotherapy process or a combination of both.

“**Psychotherapy**” is defined by the Psychotherapy Act (2007) as “the assessment and treatment of cognitive, emotional or behavioral disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication” (Psychotherapy Act 2007 Home Page Reference). In addition to this definition, this study emphasizes the need for clinicians to become conscious of clients’ spiritual needs and support them to overcome the negative impact of society’s cultural norms that shape their thoughts and feelings.

The term “**community reintegration**” is used when people return to the community after an extended period of hospitalization or incarceration. While the understanding of the term does not exclude this description, community reintegration in this study goes deeper than a mere return to the community after institutionalization. It also entails clients' involvement and active participation in the community after their release from institutions. The measurement of community reintegration can be complicated since mental health clients have different skills, training, and different functional levels. Notwithstanding, tentative criteria can be used in this research to attempt the measurement of community reintegration. There are common barriers, that returning inmates with serious mental illness face when re-entering the community i.e., homelessness, lack of adequate mental health service, unemployment, treatment relapse, criminal recidivism, and many others (Baillargeon, Hoge & Penn, 2010). When CDP clients make significant changes in overcoming one or more of these barriers, they may be considered to have attained some level of successful community reintegration. From this framework, one could assess the community reintegration of CDP clients if there are signs of one or more of the following: 1) evidence of clinically meaningful reductions in symptoms; 2) reduced reoffending behavior; 3) actively engaged in healthcare or compliance with treatment; 4) engaged in employment; 5) volunteering; 6) enrolled in an education or an apprenticeship program; 8) improved relationship with family members, friends or loved ones; 9) financial/guaranteed source of income, 10) housing stability, and 11) spirituality i.e. religious or a sense of meaning and purpose (Elnitsky, Fisher & Blevins, 2017).

"**Court diversion**" is applied in the same way the term is used in the mental health and justice literature—specialty court programs designed for people living with mental health challenges and/or addictions issues, to help them take advantage of community-based treatment options to address their charges instead of going through the regular criminal justice sanctions and trial processes (Livingston, et al. 2008; Schneider, 2010).

"**Criminality**" and "**criminal behavior**" are also used frequently in this study. The terms include different types of crimes that can be found in the Criminal Code of Canada. However, in this research, the terms criminal activities or behaviors are placed in the context of minor offenses committed by people that society has labeled as "mentally ill persons" who are approved for the court diversion program. Such offenses include, but are not limited to threats, causing a disturbance, public mischief, possession of illegal substances, shoplifting, breaking and entering, and so forth (Adkin et al. 2017).

The researcher's positionality

It has been observed that a person's educational background, training, profession, social status, political beliefs, and personal values can shape the findings or the outcome of their research (Holmes, 2020). This is not an exception regarding the current study. The researcher of this study is a visible minority, a person of color, and an African descent. The researcher is also an interdisciplinary scholar whose theoretical foundation is informed by his training in philosophy, theology, social work, and psychotherapy. The researcher's ethical convictions can also be traced to his strong belief in African traditional values and Christian principles which are sometimes characterized by adherence to rigorous moral teachings. It took several years of both spiritual and academic training before the researcher began to acknowledge and accept the inclusivist philosophy and multicultural identity.

My immersion in intercultural and client-centered theories in social work, philosophy, and psychotherapy helped me to unlearn some of my own prejudice and biases as a traditional Christian counsellor in different settings. As a social work practitioner, I have worked with clients with mental health/addiction issues and offending behaviors for more than a decade. And I have had the chance to work with other professionals like lawyers, court support workers, crown attorneys, duty counsels, to support individuals with mental illness and minor offending behaviors, who enroll and participate in the Court Diversion Program (CDP) in the city of Toronto. I pursued this research area not only because the goals of the CDP align with my personal values but also because I wanted to know the experiences of psychotherapy clients in the CDP so they can be better supported to re-enter the community after encountering the justice system.

The reflexivity of these experiences is important to help me become unbiased and remain sensitive to data collection, analysis, interpretation, and the general outcome of this study.

Mental health landscape in Canada

The alarming rate of people struggling with mental illness in Canada raises much concern for mental health professionals, researchers, and policymakers in Canada. Less than a decade ago, a published report showed that over 6.7 million Canadians lived with a mental illness, accounting for about 19.8% of the total population (Canadian Mental Health Factsheet, 2016). Currently, over 2 million Canadians aged 15 and older have mental health-related disabilities (Statistics Canada, 2020). Records also show that in any given year, 1 in 5 Canadians experiences a mental illness or addiction problem (Centre for Addictions and Mental Health, n.d [CAMH]). People with mental illness and addictions are more susceptible to dying prematurely than the general population. It is estimated that mental illness can reduce a person's life expectancy by 10 to 20 years (CAMH). Studies also show that by the time Canadians reach 40 years of age, 1 in 2 will have experienced a mental illness (Smetanin et al., 2011). For future projection, Smetanin et al. (2011) estimated that by the year 2041, there would be over 8.9 million Canadians living with a mental illness (i.e., 1.3 times the rate of 2011). Mental illness does not only affect the individual, but it also affects family members, communities, legal, health care systems, and the economy at large. For instance, the yearly economic cost of mental illness to the Canadian government is estimated at $51 billion (CAMH, n.d.).

There are also remarkably high rates of this population having frequent encounters with the police resulting in criminalization in the absence of adequate community treatment and services (Livingston et al., 2008). Mental health clients with offending behaviors become vulnerable when there are not enough community resources to support them. When their families, community members, and the general public give up on them, they often come into contact with law enforcement agents. In both the USA and Canada, police encounter with people with mental illness sometimes result in human rights violations. In a study that reviewed the responses to people with mental illness, Reuland et al. (2009) observed that trained police officers do their best to resolve issues when they receive emergency calls to attend to incidents involving mental health clients, but occasionally the officers' interventions do "involve volatile situations, risking the safety of all involved." (p.v). The types of crimes that bring individuals with mental illness into contact with the police typically involve minor/nuisance/social disorder-related behaviors (Burns et al., 2013; Livingston, et al., 2008). So, if there are enough community resources that the police could easily access, the rate of violence, incarceration, and institutionalization of mental health clients with offending behaviors may be reduced as the clients will receive treatment in the community instead of going to jail. The overwhelming rate of mental health epidemic and its striking socio-legal and economic impact on Canadian citizens call for immediate action.

The need for a collaborative effort

It is projected that the mental health crisis in Canada will escalate by the year 2041 (Smetanin et al., 2011). Not only does the increasing rate of mental health issues in Canada and its socio-economic impact on the Canadian population call for an intervention, but it also requires a response from healthcare and allied professionals and researchers, especially given the complex nature of reintegrating CDP clients into the community. It has long been observed that psychiatrists, social workers, psychologists, and psychotherapists play a similar role in the treatment of mental illness (Seligman, 1995). However, when it comes to CDP, we do not know much about the contribution of psychotherapy to the success of the program. Factors such as case management, clients' regular court attendance, the judge's interactions with clients, probation and parole officers, etc. are considered the main factors responsible for the success of CDP (Burns et al., 2013; Redlich et al., 2010; Ryan, et al., 2010). Therefore, the isolation of psychotherapy from the ingredients necessary for the success of the CDP calls for better collaboration and more research.

The vision of collaboration is not new; it is consistent with the idea that service integration promises a better solution to the problem of recidivism among mental health clients with offending behaviors (Livingston et al., 2008). To successfully address the problem of mental illness and deviance, and to minimize recidivism, a collaborative effort from the legal, health care, and allied professionals including psychotherapists, needs to be strengthened. Collaboration is also in line with the social reintegration philosophy. According to Griffiths et al. (2007), social reintegration is not only meant to support offenders during their reentry into society after imprisonment, but it also includes all intervention strategies “undertaken following an arrest to divert offenders away from the criminal justice system to an alternative measure, including a restorative justice process or suitable treatment.” (p.3). Social reintegration experts thus opine that to succeed in reducing recidivism among offenders of the law, society must provide the necessary resources to ensure their smooth transition into the community. Social reintegration theorists also recommend interventions and collaboration between the justice system, social service, health and other stakeholders, the offender’s close family members, and community-based organizations in order to ensure the overarching goal (Griffiths et al., 2007).

From a theological point of view, Swinton’s (2000) work can be incorporated in the call for collaboration in support of clients inasmuch as it expresses concern about people living with mental illness in the health care system. Swinton’s (2000) assessment of the precarious condition of individuals with mental illness in western countries today is important for the population in this study, for he calls on the Christian community to an important “ministry of liberation and radical befriending” (p, 207) of mental health clients, so we can support them to overcome the injustices perpetrated against them in our society. Moreover, contrary to the assumption that only trained professionals can practice psychotherapy (Jones-Smith, 2016), O’Connor’s & Meakes’ (2014) concept of psychotherapy as a “cure of the soul” also reminds the Christian community that God can use anyone or anything, and anywhere to cure the suffering soul. This means that pastors, clinicians, social workers, physicians, and psychotherapists, who are involved in Christian ministry may all be used by God to bring healing to persons suffering from mental health challenges and offending behavior.

Notwithstanding the call for a robust collaborative strategy, the organizers of the CDP program apply the principles of therapeutic jurisprudence to respond to the issue of Mental Illness and Offending behavior (MIOB) while at the same time relying heavily on pharmacotherapy in serving clients with MIOB (Leroux, 2008). Burns, et al. (2013), however, remind us that it takes a team effort and cooperation to solve the problem of MIOB by way of encouraging clients to follow prescribed treatment protocol and court mandates for behavioral modification “that are designed to alter the underlying problems associated with their criminal behavior”. (p.190).

Since psychotherapy is a proven strategy for resolving MIOB, psychotherapists should be part of this collaboration, primarily because therapists have the skills necessary to address the underlying problems of mental illnesses; they can support clients to gain insight into the causes and triggers of their situation and empower them to overcome some of the barriers to their recovery. It is, therefore, time to explore and test effective ways of addressing the problem of MIOB at a time when there are divergent views about how to respond to the issue of MIOB.

A quick review of the Mental Health Courts (MHCs), which created the CDP will help one understand the goals and philosophies of these two programs; the basic differences between the two, and how they operate in assisting clients with MIOB to receive treatment in the community, will be considered in the next chapter.

Insufficiency of CDP's foundational theory and the necessity of psychotherapy

Court Diversion Programs (CDPs) currently adopt therapeutic jurisprudence and the medical model as theoretical frameworks to address recidivism and the mental health needs of its clients (Leroux, 2008). Commonly applied in the specialty and mental health courts, therapeutic jurisprudence is a framework that perceives the law as a therapeutic agent that needs to prioritize defendants' rehabilitation over their criminalization (Leroux, 2008; Wexler, 2000). Therapeutic jurisprudence can support CDP clients to receive the treatment they need only if its principles are effectively applied by legal experts, and only when court support workers are able to coordinate and collaborate on the available community resources for clients' use.

The medical model, on the other hand, belongs to the field of medical practice and focuses on diagnoses and treatment of illnesses. It operates on the assumption that since mental illness is caused by chemical brain imbalance, it should be treated by medication or chemicals. The medical model framework partly explains why psychiatric referrals, assessment, and prescription drugs play a major role in the operations of CDP.

The prominence of the medical model in addressing mental health issues has a deeper ideological undertone that seeks to undermine the effectiveness of psychotherapy (Prosser, Helfer, & Leucht, 2016). This brain disease framework asserts that mental illness is caused by pathological neural processes, therefore, therapies that directly target these neural processes are necessarily more scientifically valid than that of psychotherapy, which is perceived as psychosocial. It has, however, been argued that the pharmacotherapy/psychotherapy divide is a myth because both treatment models are effective and equally important despite their different methods of delivery (Prosser et al., 2016).

I propose that psychotherapy be considered as a potential treatment model in CDP given that it has been proven to be beneficial for the recovery of clients with mental illness and offending behavior (MIOB). The need for psychotherapy to support CDP clients is not only because of its comparable effectiveness with medication but because the environment and their experiences also alter brain chemistry. But to what extent can psychotherapy make a difference in the court diversion program, whose theoretical foundation has predominantly been the medical model?

Whether or not psychotherapy makes a difference for clients depends on the underlying factors that explain the precarious condition of offenders with mental illness. Persons with mental illness already experience stigma while those with histories of offending also suffer discrimination and oppression (Baillargeon, Hoge, & Penn, 2010; Bromberg, 1941; Goffman, 1963). So, one can imagine the extent to which people with both mental illness and offending behavior may suffer stigmatization, oppression, and discrimination.

Though psychiatric status is not an accurate predictor of criminal activity, CDP clients are stereotyped as perpetrators of violence and aggression by both the police and the general public (Draine et al., 2002). This assumption is reinforced by Labeling theory, which predicts that people will behave the way society has labeled them (Goffman, 1963). Labeling theory has it that negative labels can change one's identity and cause one to perpetrate further deviance. The theory predicts that people will behave exactly the way they have been labeled (Goffman, 1963). Associated with labeling theory is the social stigma, which also explains how people living with mental illness conform to the label given to them by society through internalization (Becker, 1963; Goffman, 1963). Consequently, people living with severe mental illness are prone to becoming offenders within the context of labeling theory and stigma. Because people must put up with what they have been labeled in society, stigma has the power to damage an individual's self-image. Thus, the labeling/stigma theory explains the predictability of recidivism among CDP clients when re-entering the community.

To ameliorate this problem, graduated CDP clients may benefit from additional services like psychotherapy in their recovery journey to help them deal with two main issues—first, internalization of stereotyped behaviors and associated low self-esteem, poor insight, powerlessness, impulsivity, and self-isolation; second, CDP clients may benefit from psychotherapy to help them gain insight into the socio-cultural influence of society within which they find themselves. In this context, CDP clients need social constructionist psychotherapists to assist them to reframe terms such as "criminality", "diagnoses", "punishment" and many others that have placed them under social control and subjugation.

Medication may help reduce symptoms, such as impulsivity, depression, and anxiety, to name only a few, but psychotherapy can support clients to rediscover their purpose, make meaning of their lives and experiences, regain their voice, and achieve their inner self-worth as they become insightful. Since insight can increase compliance (Bromberg, 1941), CDP clients can stay in treatment and become less susceptible to re-offending as they re-enter the community.

Different psychotherapy models accomplish different outcomes. Evidenced-based psychotherapy (EBP) research highlights the effectiveness of CBT for the treatment of mental illness and offending behaviors (Barnes et al., 2017; Feucht & Holt, 2016). However, even though CBT teaches different skills and helps clients improve their thoughts and mood, CBT tends to be individualistic as it focuses on clients' capacity to alter their lives. Thus, CBT may fail to uncover the significant influence of social and environmental factors that often impact an individual's health and well-being in society. By rooting a person's behavioral issues within themselves, the CBT model may also contribute to the labeling of CDP clients. Therefore, social constructionist psychotherapy is needed as an alternative to CBT, not only for addressing the internalization of guilt and oppression of CDP clients but also, to explain the discourses shaping the condition of CDP clients.

Theoretical framework

Society has contributed in no small measure to the suffering of CDP clients living with mental illness and deviant behavior. As mentioned earlier, internalization of oppression, discrimination, shame, and guilt play a large role in the mental state of CDP clients. And this requires the help of a therapist to first, unravel the oppressive force of society behind such shame, and then support CDP clients to liberate themselves from society's emotional torture perpetrated against them through surveillance and control (Foucault, 1987). Therefore, CDP clients need help to gain insight into what is going on around them in the larger society before they can be healed from the pain associated with internalized shame and guilt. Thus, CDP clients need systematic guidance from psychotherapists to trace and identify their feelings, build a healthy view of themselves, gain insight into the systems of power and control, and repair the damage of the shaming messages they constantly receive from the penal system.

Social constructionism and the need for rehabilitation

In exploring how psychotherapy can be incorporated in CDP to support clients' rehabilitation, I applied social constructionism as a postmodern philosophy for this research. As discussed earlier, CDP clients experience blame, shame, and oppression on a daily basis in our society. The social constructionist framework can be used as a tool to deconstruct dominant cultural norms imbibed by CDP clients that constitute blame, shame, and guilt. Social constructionism recognizes the inherent strength of clients. It can therefore be applied as a philosophical foundation of this research in empowering clients to make choices and be responsible for their decisions and actions. With social constructionism, the clients could learn how powerful policymakers in society can sometimes shape their lives through unrealistic expectations administered by the penal system. Gaining insight into the mechanisms of social control will shift the blame away from clients, so they can externalize these and heal.

With its critical reflection on identity, knowledge, truth, abnormality, and reality, postmodernism/ constructivist theory remains crucial to this research. Postmodernism questions today's modern scientific method, which claims the identification of knowledge and objective truth through empiricism, rationalism, and logical reasoning (Jones-Smith, 2016). CDP clients are labeled with different sets of diagnoses and behaviors in the forensic psychiatric system. And it is by this scientific approach that psychiatrists and other health care professionals follow to diagnose and label CDP clients.

But such diagnoses and stereotypes are challenged by postmodernism. Foucault (1987), for instance, discusses the social and cultural conditions in relation to madness. In this work, Foucault (1987) reflects on the influence of medical knowledge on diseases and illnesses, and he perceives medical knowledge as a form of power that exerts illegitimate influence in the determination of what "normality" and "abnormality" are. One core principle of postmodernism that debunks this myth is the importance of human participation in the construction of knowledge, hence the term, *social constructionism.* Social constructionism emphasizes subjective realities and questions the attainment of objective reality. This is because, for the constructivist, reality is not accessible independently of another person's observational processes (Jones-Smith, 2016). Despite this novel observation, forensic experts continue to label CDP clients with one diagnosis or another whilst at the same time various charges are also laid against these clients in the legal system. In my encounter with CDP clients, some of them question the diagnoses given to them by psychiatrists, and many have also told me that they did not do what they have been accused of by the court. It can thus be said that CDP clients tend to be accused of minor crimes where police discretion is at its height, for people with mental illness tend to be charged with more nuisance crimes than non-disordered people (Lyon & Welsh, 2017). They are more likely to have their behavior labeled as deviant and criminalized than the general population (Lyon & Welsh, 2017).

The postmodernism/constructivism framework does not support the idea of labeling individuals with diagnosis and/or criminality because labels are considered social and cultural constructs. In this context, CDP clients can be seen as victims of the history, systems, and norms of society. Psychiatric diagnoses and criminal offense classification in the penal system can thus be critically assessed by the social constructionist paradigm. According to the postmodern framework, a person's health status or condition in life cannot be judged through the lenses of the dominant culture of society. The dominant view or the culture of society is only a particular point of view (subjective), which is far from the objective view of the world. And yet, CDP clients are subjected to and controlled by the decisions of the few powerful people in society who possess the so-called knowledge. In explaining the prison system, Foucault (1978) argues that the persistent surveillance over the everyday life of offenders has become the principal means of social control, which is worse than the physical brutalities meted out to prisoners in the medieval age. Foucault perceived the disciplinary role of prison as very pervasive in social institutions such as schools, hospitals, and factories. Postmodernism seeks to emancipate clients from this institutional dominance by offering alternative discourses.

Postmodernism/constructivism tends to be relativistic in the sense that whom a person becomes, or how an individual's view of the world develops, is shaped by context, language, and relational factors in our environment (Jones-Smith, 2016). In this context, terms such as "criminal", "offender" "psychiatric patient", "depressed" etc. are socially constructed labels for CDP clients, which may or may not be the true representation of reality. Even if CDP clients show symptoms of some of these diagnoses, labels do not define who they are. Thus, postmodern psychotherapy has transformed traditional psychotherapeutic practices in terms of how diagnoses are made, the source of knowledge, how a person is viewed, and the role and relationship between an individual and the therapist (Jones-Smith, 2016). Applying the postmodern/social construction theoretical framework allows clinicians to see a client as an expert and the author of their own life.

Postmodernism asserts that change is possible through an exploration of alternatives. A postmodern/social constructivist clinician collaborates with clients to deconstruct discourses that block change in the therapeutic process (Healey, 2005). In postmodern therapy, attention is paid to the client's strengths rather than deficits. The postmodern therapist views individuals' lives as stories in the sense that they are narratives and the individuals' life are seen as a narrative that can be rewritten (Jones-Smith, 2016; Healey, 2005). Most importantly, Foucault (1987) cautions how therapists themselves may be part of the problem and the solution at the same time even with all their professional training and their good intention to help others. For this reason, postmodern therapists are conscious of their approach when assisting clients.

Narrative therapy: a postmodern psychotherapeutic approach for CDP clients

Narrative therapy was developed by Michael White and David Epston, and it is anchored on the social constructionist philosophy—a belief that the narratives we and others construct about us ultimately shape our experiences, our sense of selves, and our choices in life (Healey, 2005; John-Smith, 2016; White & Epston, 1990). In a unique sense, narrative therapy is based on the basic principle that a person is not the problem, but the problem is the problem. This core principle separates clients from their issues, and it helps therapists to externalize the problems that confront clients in their lives. Unlike some individualistic therapy models which pathologize clients' experiences, narrative therapy maintains that people possess inherent skills and the ability to improve their own lives (Healey, 2005). And by narrating their stories, service users can make meaning of it and reauthor their own stories. Thus, the narrative therapist's role in assisting clients is collaborative and non-directive. The narrative therapist focuses on the stories people tell when they come to therapy as those narratives are the site of intervention. Clinicians applying narrative therapy listen to clients' stories and their experiences in life. They analyze and deconstruct clients' negative internalized labels and then support clients to reconstruct a new discourse.

Healey (2005) discusses three key principles in the practice of narrative therapy. I briefly discuss the three key principles and explain how they can be applied to CDP clients. The first practice centres on the narratives that shape clients' lives. The therapist listens carefully to the story of the person by noting the negative aspects of the narrative. The therapist seeks to transform clients' pathologizing narratives and constructs alternative narratives that recognize and honor the person's capacities to take responsibility for their struggles, such as offending behaviors. This principle can help CDP clients gain insight into their predicament and take responsibility for their offending behaviors including treatment and rehabilitation. But the narrative therapeutic process goes beyond this first principle. The second practice principle separates the person from the problem. Narrative therapists apply this principle through externalizing conversations that give a name to the problem confronted by clients. Here, CDP clients can be supported to construct alternative stories to demonstrate occasions or moments when they effectively resisted offending behaviors. These alternative narratives about the self will contradict the harmful narratives already internalized by CDP clients.

The third practice principle reconstructs the dominant story of the self that weakens and pathologizes a person’s image. According to (Healy, 2005), this reconstruction aims at underscoring stories of the self as “one of survival, courage, responsibility, and active resistance” (p. 208). Healey (2005) reminds us that this reconstruction is not to deny the existence of serious mental illness or violent behavior, but rather a technique that builds on clients’ capacity to make choices in their lives.

In sum, narrative therapy may fit well for CDP clients for various reasons. It will allow CDP clients to share their life experiences in a story form and provide them the opportunity to make meaning of their lived experiences and reauthor the dominant part of their stories in a way that will reduce the harmful effects on their lives. By helping clients develop an alternative story that contradicts the dominant story embedded in clients’ presenting problems, narrative therapy can help externalize the guilt, shame, condemnation, and labeling internalized by CDP clients. Also, CDP clients can have a better sense of themselves as the problems they bring to therapy will be externalized. This will give CDP clients the opportunity to rewrite their stories that reflect their true authentic selves. Moreover, the application of narrative therapy for CDP clients will empower them to regain their voice and play an active role in the therapeutic process since the narrative therapist works in collaboration with clients. With its postmodern philosophy about power, knowledge, and truth, narrative therapy can be a better means of helping CDP clients with many problems. By retelling and reliving the stories that compose a person's life, narrative therapy can help explain the pain, guilt, beliefs, negative feelings, and behaviors that emerged from the events of CDP clients’ stories. It is, however, important to mention that no matter how effective narrative therapy might be (just like any other psychotherapy model) it cannot change life if CDP clients themselves are not motivated.

Chapter 2: Literature review

Given the prevalence of pharmacotherapy in the Court Diversion Program (CDP), this study examined the experiences of graduated CDP clients who received psychotherapy treatment with those who received medication in order to find out how psychotherapy may be accessible to more CDP clients. The first step towards this goal was to explore the experiences of some clients who have received psychotherapy to address their needs—including Mental Illness and Offending Behavior (MIOB) as they enrolled in CDP and reintegrated into the community. Therefore, it was needful to first, review the perceptions of rehabilitation or treatment of clients with MIOB, and examine other key areas such as the mental health courts and the diversion program, the connection between mental illness and criminal behavior, theories attempting an explanation of criminal behavior, and the examination of community-based approach theories that are emerging in the mental health and justice field to address recidivism, decriminalization, and deinstitutionalization of clients with MIOB.

Reactions to clients living with mental illnesses and offending behaviors

Inadequate resources to support the needs of people living with severe mental illnesses after the deinstitutionalization process of the 1960s/70s exacerbated the encounter between people living with mental illness and the justice system as those clients who were released from various institutions began to settle in the community (Ryan, Brown, & Watanabe-Galloway, 2010). The concern around the offenses of mental health clients has attracted the attention of the general public, criminologists, legal experts, and social science researchers. The purpose of this section is to capture a brief overview of the positions held by the general public in responding to the offenders with mental illness about whether these clients should be sentenced to jail, hospitalized, or rehabilitated.

Bull, Cooke, Hatcher, et al. (2010) discuss three different positions held by the public as to how the justice system should handle offenders of the law in general (not just mental health clients). First, some opine that offenders should be punished and not given any consideration at all. A recent study found that factors such as fear of crime, one's educational and vocational background as well as gender differences can make people develop a harsher punitive attitude toward crime (Chen & Einat, 2017). A second conception of how to deal with defendants discussed by Bull et al. (2010) associates criminalities with some psychological or social problem, therefore, they maintain that to prevent recidivism, offenders should be given the opportunity to receive treatment and alter their behavior if only that is reasonable. The advocates of community reintegration of mental health clients (such as Baillargeon, Hoge, & Penn, 2010; Draine, Wolff, Jacoby, et al. 2005; Munetz & Griffin, 2006; Steele, 2017) fit into this second category given their vision of inclusivism and dedicated effort to ensuring that people living with mental illness do not float into the criminal justice system. The third school of thought admits the importance of treatment and rehabilitation of offenders, however, they also attach some strict conditions to offenders' access to rehabilitation, such as the type and seriousness of the offense committed, the number of past convictions, and the degree of harm done to the victim of the crime. Melamed (2010) and Schopp (2012) can be identified with this third school of thought. Schopp (2012) for instance, argued that through different mechanisms, the police have the power to use force on mental health clients for public safety if clients' psychological impairment can harm or endanger others. Melamed (2010) also consistently maintains that mental health clients, especially, those living with chronic schizophrenia should not be granted an "automatic exemption" from responsibility. Melamed (2010) further cautions the need for criminal justice experts to place emphasis on the examination of the relationship between crime and psychotic content.

All three schools of thought are crucial, especially when it comes to public safety. I am, however, convinced that for pragmatic reasons and on compassionate grounds, treatment, and rehabilitation should be prioritized when responding to mental health clients with minor offenses. The psychological pain of people living with MIOB in the corrections and prison systems is a clear indication that harsh punitive measures are not always productive.

Also, through segregation, compartmentalization, marginalization, confinement, excessive scrutiny, and threats by the forensic psychiatric system, society by and large contribute to the suffering of people living with mental illness. Therefore, society should be responsible for ensuring their treatment and rehabilitation. From the legal point of view, the criminal activity of a culpable offender must involve intentional wrongdoing (Ripstein, 2001). It can be inferred that mental health clients, especially those in the diversion program, should not be unduly penalized for their minor offenses if they were not aware or conscious of their actions. Thus, in assessing how to respond to CDP clients who commit minor offenses, the law should prioritize treatment and rehabilitation over other objectives of sentencing.

Within the criminal justice system, a specialized mental health court, (Court Diversion), is one of the programs that determines who among the mental health clients can live safely in the community to receive treatment and who would not. When eligible clients are screened for court diversion programs, they need collaborative support to complete the program. By helping mental health clients to receive treatment, society can cut costs and promote public safety by curtailing long case trials and multiple court appearances of lawyers and court staff. In a clearer tone, Livingston et al. (2008) echo that applying criminal justice interventions to solve the problem of mental health disorders is “inappropriate, ineffective, and expensive” (p. 4). The community treatment option is less costly compared to hospitalization and incarceration as a means of treating people suffering from severe mental illness (Livingston et al., 2008).

An overview of mental health courts in Canada and court diversion programs

Mental Health Courts (MHCs) can be seen as the criminal system’s reaction to people living with mental illness. MHCs are the criminal law courts set up in the various courthouses in Canada to address the charges of people living with mental illnesses and related issues (Adkin et al., 2017). MHCs not only deal with the charges of people with mental illnesses, but they also help address the health needs of people with mental health issues once they enter the criminal justice system by linking them to the healthcare system. A recent report developed by the Provincial Human Services and Justice Coordinating Committee (HSJCC) in partnership with the Canadian Mental Health Association (CMHA) in Ontario, captures some characteristics of MHCs in Ontario and their operation in the province.

Key findings of the provincial HSJCC Mental Health Courts Project report that all designated MHCs have an initiation date when the key founders and stakeholders come together to find a specific space for addressing the needs of people with mental illness and criminal justice issues. The courts have specific days of operation, and most of them have eligibility criteria that are used to assess clients to determine who will be able to participate in the court's processes and programs. These courts have designated legal staff (Judge, Crown, Duty Counsel) and Mental Health Court Support Staff are always available anywhere an MHC is established. CDP is one of the distinguishing factors of MHCs. As Adkin et al. (2017) noted "Mental health diversion is one of the shared elements of designated mental health courts." (p.2). Court diversion is the focus of this study. A brief review of MHCs and their operations will shed some light on the relationship between MHCs and CDPs

The main goals of MHCs

It was by reading the goals of MHC that inspired my interest in this research, for they are consistent with my passion, dream, and motivation for the work I do. MHCs are established for the purpose of improving clients' access to community services and support; promoting the general well-being of clients; ensuring community safety; reducing recidivism; providing alternatives to incarceration; identifying systemic issues faced by people living with mental illness; and reducing stigma (Adkin et al. 2017; Schneider et al, 2007) Most importantly, MHCs are essentially rehabilitative orientated rather than adversarial; they collaborate between the legal, mental health, and social service system to promote the health of people living with mental health issues by linking them to community resources. The courts are also established to reduce or eliminate jail time of the accused people living with mental illness (Schneider, et al., 2007).

Common mental health issues seen in the MHCs

People with all kinds of mental illness do appear at the MHCs, but according to the HSJCC report, common mental health issues that are seen in the MHC include Dual diagnoses, Developmental disabilities, Concurrent Disorders, and Intellectual disabilities (Adkin et al. 2017).

Eligibility process in the MHCs

Clients enrolled in the MHC may come from different sources. Though the referral process may vary, the Mental Health Court Support Worker is ultimately responsible in most courts for processing referrals. Mental health court support staff routinely uses screening tools to assist with determining eligibility for the court. Sometimes the court support workers work hand in hand with the Crown Attorney during the screening and eligibility process (Adkin et al. 2017). The decision of other stakeholders such as Duty Counsel and Psychiatrists may also count during this eligibility screening process (Adkin et al., 2017). Thus, the Crown, Duty Counsel, Psychiatrist, court support workers collaborate to discuss how best to manage complex cases as a team. Sometimes the setting of the court may involve the use of technology such as video links, especially during fitness assessments when a psychiatrist is not available in person (Adkin et al. 2017). To prevent removing individuals from their communities unnecessarily, the Kenora court, for instance, uses Ontario Telemedicine Network (OTN) for the intake and assessments of indigenous populations (Adkin et al., 2017).

Differences and similarities between MHC and diversion

The similarities between MHC and CDP are so close that sometimes it is not easy to distinguish between the two. While both MHC and diversion take care of the offending behaviors of people living with mental illness, MHC is an institution of its own accord whereas diversion is a program run by the court. Diversion is one of the decisions made by a Judge or the Crown when dealing with the offenses of people living with mental illness. A judge might not necessarily have to be in a designated MHC before screening a mentally ill accused person for diversion. At times, judges in different courthouses may refer a client to an MHC when they observe psychiatric symptoms. The diversion programs may take place in any court—be it MHC or otherwise. In Toronto for instance, there is only one MHC (i.e., Court Room 102) located at the Old City Hall. And yet, the diversion program is established in other courts in the City of Toronto including the College Park court, the Scarborough court, the 1000 Finch Avenue West court, and the 2201 Finch Ave West court. Also, whereas MHC provides services to clients both in and out of custody, diversion clients are mostly out of custody, and clients do live in the community (houses, shelters, on residential programs). Moreover, all accused persons living with mental illness can participate in the MHCs regardless of the nature of the crime they are accused of, but only clients with minor offenses are screened for CDP. Another difference between MHC and CDP is determined by a client's responsibility for participation. For instance, Schneider et al., (2007) note that "in the Toronto system diversion is voluntary, whereas participation in the mental health court is obligatory until the accused is found fit to stand trial." (p.100). CDP can be distinguished from MHCs because CDP is just one of the functions or operations of the MHC in Toronto. CDP targets mental health clients with charges that are less serious in nature.

What is Court Diversion Program (CDP)?

CDP is a unique program set up in the courthouses to screen eligible clients with MIOB and offer them the opportunity to receive treatment in the community. Within the justice system framework, CDP is specifically designed only for mental health and/or concurrent disordered clients to help them take advantage of community-based treatment options to deal with their charges instead of going through the regular criminal justice sanctions and trial processes (Livingston, Weaver, Hall, & Verden-Jones, 2008; Schneider, 2010).

Court diversion process

Not all individuals living with severe mental illness get diagnosed through the healthcare system. Some clients get diagnosed only after they have come into contact with the criminal justice system. Sometimes people living with severe mental illness come into the psychiatric system through the police before they get assessed, hospitalized, and/or treated. Police officers may get calls from friends, professionals, public servants, and family members of clients, to assist with an unusual behavior exhibited by people suffering from mental illness. Such behaviors may be misconduct, inappropriate gestures, signs of depression including isolation and withdrawal from normal daily activities, violations to some norms and so forth. When the police encounter clients in a crisis situation, their response, by and large, depends on their level of training and knowledge of community resources (Munetz & Griffin, 2006) on the one hand, and the nature of the offense or behavior of the accused on the other. Police officers have the option of sending clients who are in a crisis situation to jail or connect them to community resources (Munetz & Griffin, 2006). Clients who are charged with minor offenses (e.g. shoplifting, minor Assault, Mischief, etc.) may qualify for court diversion when they are brought to the court upon the Crown Attorney's approval for the diversion program. The assumption here is that the person's behavior was impacted by their mental health condition, therefore, they need help to connect with community resources for their recovery.

Court support workers are also present in the MHCs, and they assist the Crown Attorney in determining the suitability of the accused for the court diversion program. Though only the Crown Attorney determines what set of charges can be diverted, court support workers also help screen clients' eligibility for the diversion program (Human Services & Justice Committee, 2017). However, since the program itself is voluntary, clients also have the right to refuse enrolment if they are not interested. If a client accepts to complete the diversion program, they or their lawyer will attend court and advise the Crown Attorney and the Court that they are ready to complete diversion within a reasonable time frame. It takes approximately six months to one year for a client to complete court diversion depending on one's cooperation with their care plan, the nature of one's offense, and whether or not one has previous charges. During this period, the client will periodically report to a designated mental health court and work with a court support worker and sometimes a community case worker for ongoing support. The court will adjourn the matter each time the client reports until the day of graduation.

From my experience working with mental health court professionals in Toronto, the success of CDP is frequently measured in terms of clients' performance in court attendance, their response to treatment, their cooperation with court support workers, etc. — from the time of their enrollment in the program till the time they graduate from the program. Prior to their graduation, CDP clients are usually asked to provide a letter from their physician to attest to their health condition, which is meant to be their treatment compliance. Thus, psychiatric referrals and other medical referrals by court support workers and case managers play an important role in the CDP.

Two models of diversion

There are several diversion models developed by many countries including Canada. The models may, however, be broadly grouped under two main categories--prebooking or precharge diversion programs, and postbooking diversion programs (Sirotich, 2009). Prebooking programs divert clients immediately when encountered by the police before charges are laid (Sirotich, 2009). On the contrary, postbooking diversion programs seek to divert clients after they have been arrested and detained in jail or after they are charged with a criminal offense (Sirotich, 2009).

The goal of diversion

Whatever type and jurisdiction diversion is established, the desired goals of the program include prevention of the client's involvement with the criminal justice system, decrease in incarceration, connecting offenders with treatment and support systems, reducing recidivism, increasing treatment compliance, reducing symptoms, improving quality of life, reducing hospitalizations, and decreasing the costs of justice administration (Livingston et al., 2008).

Divertible offenses in CDP/MHCs

Divertible offenses under CDP include shoplifting, causing a disturbance, possession of illegal substances, threats, public mischief, breaking and entering, etc. Clients who commit serious crimes such as murder, sexual assault, and manslaughter, are usually not considered for court diversion. Several factors may be considered when clients are being screened for admission into the program, but according to studies, the most influential factor is participants' willingness to enroll in CDP (Human Services & Justice Committee, 2017). Though there are other professionals involved in the assessment of a client's eligibility for CDP (e.g. court support workers, psychiatrists, the judge, defense counsel, and duty counsel) it is only the Crown or the prosecutor who determines what kind of offense may get approved for diversion (Human Services & Justice Committee, 2017). Clients who voluntarily enroll on diversion and are able to complete the program successfully, have their charges dropped or stayed by the prosecutor. Although clients, friends, family members, and the Crown play an active role in CDP, Mental Health Court Support Workers are mainly responsible for developing the court diversion plans (Adkin et al., 2017). The Mental Health Court Support Workers most often conduct the initial screening and then develop the plan in collaboration with the client as well as other service providers where necessary.

Court attendance and opting out of CDP

The frequency of a client's court attendance depends on each court and the circumstances of the client. Clients who have a history of noncompliance are likely to attend court more often than those who are not. Clients may opt out of the diversion program for various reasons such as lack of insight into their mental health status, preferring court trials, or the feeling that diversion takes too long to complete (Adkin et al., 2017). Not all clients are able to complete their diversion. According to Adkin et al., (2017), this happens because of non-compliance with treatment plan, uncooperative with medication regimen, and relocation. However, experience shows that hospitalization and incarceration may also be other contributory factors.

Rewards and sanctions are key features of the CDP. Rewards include praise from the Judge and the Crown, a certificate of completion, and other incentives such as gift cards. Sanctions often used by the court also include expulsion from diversion or diversion revoked and charges not withdrawn (Adkin et al., 2017).

The qualitative comparative case study approach

Since this study employed the qualitative comparative case approach to analyze the data, it was deemed necessary to include some studies which have used a similar technique in the literature review.

Bates et al. (2018) employed the comparative case study methodology to study three convicted fathers of African American descent. The study aimed to examine the experiences of these fathers and in particular, the impact of the incarceration on the fathers themselves and how their relationship with their children was affected upon re-entering the community. The authors used semi-structured interviews, observation, and document viewing to collect data. The data were analyzed using the thematic approach. Through comparative case analysis, the study revealed that incarceration negatively affects the relationship between fathers and their children upon their return to the community. The study further pointed out that it is increasingly difficult for fathers to find decent jobs due to their criminal records. Hence, they encounter financial difficulties and become discouraged in life. One of the study's key implications is that incarcerated African American fathers need a strong support system when re-entering the community.

In his dissertation, Jones (2020) also used the comparative case study technique for his qualitative research. Jones (2020) observed the recent mass shootings in black colleges and universities in the USA. He, therefore, sampled three of these black colleges and used secondary data analysis to examine the similarities and differences in these cases. The study unraveled two major problems that partly account for the shootings. One, unequal funding for public and privately operated black state universities and colleges; and two, the poor and crime-driven locations of these schools contributed in no small measure to the multiple shootings and deaths in the colleges/universities selected for the study. The study, therefore, made several recommendations including adequate funding for historically black universities and colleges, social activities and training for students and staff, measures to promote safety on the campus, and many others.

The connection between mental disorders and criminality

Though some studies find a weak relationship between psychiatric symptoms and criminal behavior at the group level (Peterson et al., 2014), the overrepresentation of mental health clients in the criminal justice system (Draine et al., 2002; Gill & Murphy, 2017) calls for a closer look at the connection between mental disorder and crime in general. Lyon and Welsh, (2017) have noted the search for evidence of this link has produced three outcomes. One, there are higher rates of psychiatric disorders among convicted offenders compared to those without psychiatric disorders. Second, studies show that the arrest and conviction rate among people with mental disorders is higher than the rate among the general population. Third, the community study sample also shows that people with mental health issues exhibit higher rates of violent and criminal behavior than those without. From these reports, Lyon and Welsh (2017) admit that some relationship does exist between mental disorders and crime especially if mental disorder coexists with substance use. It is, however, important to note that most people with a major mental disorder do not commit serious criminal or violent acts. In fact, most crimes and violence in society are perpetrated by those who do not live with a major mental illness (Lyon & Welsh, 2017). It has been theorized that people with mental health issues are not more likely to commit crimes, but they are more likely to be arrested and placed into custody than others who engage in similar behavior (Lyon & Welsh, 2017).

Theories of criminal behavior

There are various hypotheses as to why people commit a crime. Theorists usually point to biological, physical, economic, environmental, and sociological factors to explain criminal behavior. Classical biological theorists hinted that the main determinants of human behavior are constitutionally or genetically based. In the latter part of the 19th century, Cesare Lombroso was said to have committed himself to studying the physical differences between normality and abnormality to detect who is a criminal and who is not (The Scottish Centre for Crime and Justice Research, n.d.). Lombroso measured the bodies of executed and deceased offenders and examined living inmates and assigned a variety of bodily features, such as large teeth, ears lacking lobes, long arms, and lots of body hair, as predictive signs of criminal people. For Lombroso, the physical shape of the head and face will tell who was born a criminal. Lombroso drew inspiration from Charles Darwin's theory and concluded that criminals were "evolutionary throwbacks", whose minds are maldeveloped (The Scottish Centre for Crime and Justice Research, n.d.). Lombroso's theory did not gain much currency, but it laid the foundation for modern biological theories such as neurophysiological conditions, genetic inheritance, and theories of abnormality (The Scottish Centre for Crime and Justice Research, n.d.).

Constitutional Theories, on the other hand, owe their origin to William Sheldon (1898-1977), who used body measurement procedures to associate specific body types with personality. Sheldon itemized three basic body types to connect temperaments and personalities, which are: 1) Endomorphic (fat and soft) who are usually sociable and relaxed. 2) Ectomorphic (thin and fragile) who are introverted and restrained, and 3) Mesomorphic (muscular and hard) who tend to be aggressive and adventurous. In

Sheldon’s correlational study, he discovered that many offenders were mesomorphic, and they were far from being ectomorphic (The Scottish Centre for Crime and Justice Research, n.d.).

Psychological approaches to delinquency have some basic common features—they pay attention to early life experiences; they tend to be much more individualistic, and they are most useful in treatment settings (The Scottish Centre for Crime and Justice Research, n.d.). Freudian psychoanalysis traces the cause of human behavior to the unconscious or instinctual aspect of humankind with an emphasis on the conflict between the id, ego, and superego. Low IQ, for instance, has been used to explain why offenders break the law, but it is not certain whether low IQ is inherited or influenced by one’s environment. The list of theories that attempt an explanation of offensive behaviors continues and on, yet experts have not yet been able to predict exactly who will be antisocial and/or break the law and who will not (The Scottish Centre for Crime and Justice Research, n.d.).

Besides Goffman's (1963) labeling and stigma theory that was discussed earlier, another sociological theory of criminal behavior deemed necessary for this research is the Social Control Theory (SCT) by Travis Hirschi (1969). The distinctive feature of the social control theory is that it does not purport to address the causes of a crime, rather it seeks to explain why people obey the law (The Scottish Centre for Crime and Justice Research). The social control theory was used as one of the sources of reference in this project. The rationale for this is provided in other sections of this research.

While the factors responsible for deviant behavior may be applicable to the general public, the disproportion of people with mental illness in the criminal justice system compared to those who do not suffer from any mental illness makes one wonder about the relationship between mental health challenges and criminality. In an article, ***Mental Illness and the Prison System*,** Dr. Sandy Simpson of the CAMH echoed this disparity when he wrote: "Mental illness rates are about 4 to 7 times more common in prison than in the community". (par. 2). Gill and Murphy (2017) discuss some hypotheses that explain the cause of offending behaviors. One such hypothesis is that mental illness or its related conditions elicit behaviors that bring people into contact with the law. The term "criminalization" of people with mental illnesses was coined to describe this hypothesis—a situation where people with mental illness are placed into jail for committing criminal offenses when they become symptomatic, whereas ideally, such symptoms should have kept them in the hospital for treatment if there were enough hospital beds and support, or they could have been prevented entirely with access to timely mental health supports.

A second theory related to the first maintains that the perceived factors predictive of criminal behavior among people with mental illness are similar to that of everyone else, except that people with mental illnesses have a higher rate of risk factors and, with a section of folks, there is a high potential of criminal behavior and violence depending on symptoms and type of diagnosis (Gill & Murphy 2017). Clients struggling with psychosis involving threat/control-override delusions, for instance, may have a false belief that someone is trying to harm them or that they cannot control their thoughts or actions. Consequently, a person suffering from severe paranoid delusion may become aggressive if they do not receive help at the right time. But such isolated cases do not collapse into a sweeping generalization that people with mental health conditions are violent. Mental illness is an umbrella term that subsumes a broad range of conditions and symptomologies. Indeed, experience rather shows that the rate of crime at the societal level reduced at the time when mentally ill people were deinstitutionalized. It could, therefore, be inferred that mental illness alone does not typically explain why people are involved in criminal behavior, for nonclinical risk factors (e.g., psychopathic traits, economic need, impulsivity) may also play a huge role when it comes to criminality (Draine et al., 2002; Gill & Murphy, 2017).

The review of the foregoing theories presupposes that there may be one or more factors accounting for deviant behavior. But as far as this study is concerned, the focus will be on mental health issues, though the study will also look at how some external factors may exacerbate or predispose people with mental illness to break the law. Regardless of the cause of their criminal behaviors, experience shows that sometimes clients do recover when clinicians show them love and compassionate care. People with disruptive behaviors engendered by their mental health issues can be supported collaboratively to receive treatment, and those whose criminality is caused by nonclinical factors can also receive help to learn pro-social behaviors to replace criminal actions after gaining insight.

But how do we intervene in the offending behaviors of people struggling with severe mental health issues? The justice system has tried to establish the jail or court diversion program, which assists with the mental health and behavioral issues faced by CDP clients. Studies that examine the success of the program have concluded that the program has so far been successful in the United States (Frailing, 2010), Ireland (O'Neill, 2006), and globally (Schneider, 2010) in the areas of symptom management and community reentry. But this success usually ends on the clients' graduation day as some of these clients recidivate and return to the justice system. This is partly because the clients have inadequate resources and skills to help sustain them in the community. Sometimes, it may also be a result of societal failure to show them love, empathy, and the compassionate care they deserve. It is for this reason that one needs to explore how psychotherapy may be used as an additional intervention strategy to help graduated CDP clients as they re-enter the community.

Psychotherapeutic interventions for justice-involved clients

Psychotherapy is a proven strategy for addressing mental illness and offending behaviors. The following are a few selected evidence-based research that attests to this assertion. Feingold et al., (2018) noted that individuals with serious mental illness (particularly, those living with PTSD) usually deal with aggravated psychiatric symptoms, a higher risk of homelessness, and recidivism. Feingold et al., (2018) therefore adopted a quantitative research strategy to examine the effectiveness of evidence-based psychotherapies (EBPs) for trauma-related distress in treating mental health patients diverted from jail to receive community-based treatment services. The study looked at 97 individual participants who were referred to the trauma-informed division of the St. Louis City Jail Diversion Program between the years 2011–2015. The authors reported that seventy-two participants began treatment and received Cognitive Processing Therapy (CPT; 53%), Cognitive-Behavioral Therapy (CBT; 39%), and Motivational Interviewing (MI; 8%). The study further revealed that while treatment completers did not differ from non-completers, there were significant decreases in symptoms of PTSD and depression throughout the course of treatment for both completers and non-completers. The authors confirmed that evidence-based psychotherapy is effective for trauma-related distress especially when delivered in an outpatient setting to people with mental health issues who come into conflict with the law.

In their assessment of the efficacy of psychotherapy for clients involved in the justice system, Mitchell et al. (2011) also developed a cognitively based intervention and tested it on adolescents with diverse kinds of mental health issues in different security settings. They then compared the results with a control group. Although this was a small-scale study, the authors reported no discovery of any remarkable differences in outcomes for the two groups. The authors observed that the recruitment of research participants and retention rate in therapy were both great, and potential candidates did not get disqualified because of learning challenges or co-morbidity. According to the authors, this study shows the feasibility of administering cognitive-oriented intervention therapy for mental health clients who share common characteristic features in secure settings.

Out of curiosity, Feucht and Holt (2016) examined what evidence talks about using CBT in criminal justice. They reviewed and tabulated fifty different programs and eight practices at the crimesolution.gov website. CrimeSolutions.gov is US National Institute of Justice Department website that uses research to rate the effectiveness of programs and practices to determine whether such programs are “Effective,” “Promising” or “No Effects”. Feucht and Holt analyzed their research to investigate how CBT is rated for each of the categories of juveniles, adults, or both. Feucht and Holt (2016) reported that five programs that targeted juveniles or both juveniles and adults tend to be rated “Effective” more than programs targeting only adults. And seven CBT programs serving only adults received a “Promising” rating, but only one was found to be “Effective.” The researchers provided a reason for the slight differences in the outcome—that because adults may have acquired profound maladaptive cognitive processes, which takes some time to change, CBT tends to be more effective for juveniles than adults. Moreover, Feucht and Holt (2016) noted that CBT appears to be effective in helping offenders deal with trauma. And in a supervised prison facility, using CBT in a therapeutic community can reduce the risk of recidivism. Feucht and Holt (2016), however, cautioned that in this analysis, CBT does not work for treating sex offenders nor could it prevent domestic violence reoffending. Nonetheless, since serving adults in the justice system with CBT looks "Promising" according to this study, clinicians may merge CBT with some postmodern psychotherapy such as narrative therapy to support CDP clients deal with their unique experiences in the community.

CBT as a model of psychotherapy might look general and somewhat complicated for beginners to learn and apply, especially with the justice-involved population. An effort to make things relatively lighter for therapists and to encourage practitioners to focus on some aspects of strategies they have found useful is crucial in psychotherapy practice. Perhaps, it is against this background that Gannon (2016) selected a specific key technique of CBT referred to as Behavioral Experiment (BE), studied it, and showed how it could be an effective technique for making changes in the offenders' problematic cognitions. Gannon (2016) examined current conceptualizations of cognition in mainstream forensic psychology and various treatment techniques commonly used by clinicians to effect cognitive change. From Gannon's (2016) analysis, she realized something important was still missing in the approaches adopted by contemporary forensic psychologists, so she felt the need to emphasize an essential component of CBT strategy i.e., BE, to generate effective cognitive change among offending populations. To improve CBT-based forensic psychological practice, Gannon (2016) recommends that clinicians apply BE to treat offenders' problematic beliefs as assumptions or hypotheses to be proven, to be tested, or to be verified in order to instill change in such beliefs that cause problematic behaviors.

Barnes et al. (2017) also experimented with a classroom-based 14-week CBT program called "Choosing to Think, Thinking to Choose," in a community correctional setting and examined the program's impact on the recidivism of high-risk offenders on probation. The research showed that the CBT group candidates were significantly less likely to re-offend.

Morgan, Kroner, Mills, Bauer, and Serna (2014) are of the view that persons with mental illness involved in the justice system should receive anti-social and mental health treatment simultaneously because treating mental illness alone does not address criminal recidivism. With that premise, Morgan et al. (2014) designed and evaluated a comprehensive treatment program specifically tailored to tackle the problem of both mental illness and criminality. They recruited forty-seven incarcerated males in a residential treatment facility as participants. Thirty-one out of the forty-seven actively participated, did their homework, and completed the program. The authors used different techniques (four-tired assessment strategy, magnitude of effect sizes, reliable change indices, pre-post significance testing, and clinical cutoffs) to examine change. Morgan, et al. (2014) reported that their findings "showed evidence of strong therapeutic alliance and treatment program satisfaction, as well as symptom reduction and some evidence for reduced criminal thinking." (p.902).

In an earlier study that assessed the effectiveness of services to offenders with mental illness, Morgan, et al. (2012) further discovered that treatment strategies that target the psychiatric and criminal justice needs of this population often result in positive outcomes such as improved behavior, development of life coping skills, and a remarkable reduction in mental health symptoms. Significant to this meta-analytic research is the light shed on the effectiveness of the practice of homework which program planners incorporated in their admission requirements and treatment plans.

Age, culture, and gender may certainly influence CBT effectiveness for clients with criminal involvement. But it has also been shown that whether or not CBT will be effective for offending populations depends on other factors. For instance, comprehensive CBT training received by therapists, treatment of high-risk criminals, and CBT programs designed specifically for research or demonstration purposes (as opposed to regular practice programs) are listed as having the potential of yielding greater effects (Lipsey & Landenberger, 2005). Lipsey and Landenberger (2005) believe that CBT treatment program results may also differ depending on the content and combination of elements put together. When a program is tailored to capture cognitive skills teaching and other topics such as relapse prevention, interpersonal problem solving, anger management, and moral reasoning, results are more likely to be effective in addressing recidivism (Lipsey & Landenberger, 2005).

While effort is being geared toward social and community-based techniques for addressing recidivism, there are studies that are heading in the other direction. Some believe that diversion program supervised by legal experts has great potential as well (Gill & Murphy, 2017). In their five-year study which assessed the effectiveness of jail diversion in addressing offending behaviors, Gill and Murphy (2017) acknowledged the important role of housing, mental health, and community-based supports, but they concluded with an assertion that completion of a jail diversion program supervised by a prosecutor's office can lower recidivism and the number of days a person is incarcerated. However, it appears the major problem confronting society today is not who supervises or organizes a program for clients with mental health challenges and offending behaviors, but it is how the proven, effective, and evidenced-based resources can be well coordinated to help change lives for the population in question.

Assimilative integrated psychotherapy

Assimilative integration is when a therapist focuses on one principal therapy approach while blending or incorporating other systems of psychotherapy into their practice. As described by Jones-Smith (2016), therapists of the assimilative integration orientation "use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems." (p.698). Most CDP clients appear at the court with diverse needs (emotional, physical, mental, spiritual, psychological, social, and material), which suggests that CDP clients would most likely benefit from an assimilative integrated psychotherapy model of treatment more than a single therapeutic model.

Other relevant theories for this research

Travis Hirschi's (1969) Social Control Theory (SCT) is another sociological theory that is relevant for this research due to its unique way of explaining delinquent behavior. The SCT was useful in understanding the experiences of CDP clients and their community reintegration process after encountering the justice system. According to

Hirschi (1969), an individual's strong bonds to social institutions such as family, school, education, and employment do "control" or restrain them from deviant or delinquent behavior. In the review of theories on the causes of youth delinquency, Pratt et al. (2011) present how Hirschi's SCT is unique from all other criminological theories. According to the authors, Strain theory, for instance, sees the disconnection between the pressures of expectation that social norms place on youths and their inability to use legitimate means to reach their goals in life, as the main motivation for their offensive behavior. Pratt et al. (2011) also discuss other criminological theories which perceive values and techniques of criminal behavior as something that has to be learned through socialization. Contrary to the above two explanations of criminal behavior, Pratt et al. (2011) further note that Hirschi's SCT starts from the opposite direction. Hirschi does not believe that a person needs to learn to offend, for every human being possesses inner selfishness that may drive them to offend. Hirschi adds that most people try to control these natural urges in order to restrain themselves from committing a crime. Hirschi's theory thus, stands out from other theories, for while other criminal theorists try to explain why offenders flout the law, Hirschi (1969) says we should rather ask the question: what should restrain people from committing a crime since they are already prone to it?

Pratt et al. (2011) tell us that for Hirschi, people do not do what their natural urges want them to do because of "the bonds they form to prosocial values, prosocial people, and prosocial institutions." (p.58). These bonds help one to control themselves when they are tempted to offend. The bonds are of four different but interconnected types: 1) *Attachment,* 2) *Commitment*, 3) *Involvement,* and 4) *Belief*.

1) ***Attachment****:* this refers to the emotional and psychological affection that youths have for their prosocial person (such as parents) or prosocial institution (such as school). Youths who have a greater affection for their parents and their school tend to have greater levels of social control than those who do not. The more children are attached to their parents there is the likelihood that they will conform to the norms of society and desist from delinquent behaviors. The opposite is true for those who are less attached to their parents or guardians.

2) ***Commitment:*** the social relationships that one already holds and tries to maintain actually help one to avoid criminal offenses as their involvement in criminal activity may threaten or jeopardize the already established social networks in the society. So, for instance, to avoid the risk of losing one's prosocial relationships and status in society in the area of associations, friendships, marriages, employment, etc. they may refrain from criminal activities that may threaten their status in these prosocial relationships.

3) ***Involvement****:* Involvement touches on the opportunity cost of spending one's time on something else apart from crime. Here, Pratt et al. (2011) report that Hirschi must have drawn inspiration from the old adage: "idle hands are the devil's workshop". When youths spend their time studying or if they involve themselves in sports or other prosocial activities, there is less tendency to spend time stealing, doing drugs, or destroying properties. This does not imply that youths cannot commit evil things before or after being involved in prosocial activities. According to Hirschi (1969), what this implies is that when people are committed to prosocial activities, they cannot use the same time for delinquency.

4) *Belief*: Belief as causation of delinquency is contested in criminology. Though SCT does not perceive beliefs as positive causes of delinquency, it is, however, consistent with the principle that some beliefs engender criminal behavior while others prevent it. If a person is convinced that spending time in jail allows them to flee social responsibilities, then they will care less about committing criminal activities and going to jail. Conversely, one will avoid delinquency if one believes that the time spent in jail can be used in doing something productive in the community. This implies that the extent to which a person conforms to the law correlates with the nature of their attitude/beliefs and the values they hold in the society where they live. Prosocial attitudes, beliefs, or behaviors constrain criminality more than problematic ones.

Rarely is a theory propounded without limitations. One of the criticisms leveled against the SCT is that sometimes people with strong social bonds or connections still do commit crimes. Certainly, one theory cannot answer all questions about why people commit a crime. The SCT remains intuitively convincing, as it can help explain what people with mental health issues need for their community reintegration. As Pratt et al. (2011) noted, the most important aspect of Hirschi's SCT lies in its indirect influence on our lives, for once the prosocial bonds are formed, they keep one's behavior in check anytime and anywhere and it helps one continue to be a law-abiding citizen.

Some of the serious problems which mentally challenged people to face on a day-to-day basis include difficulties in accessing training and/or education, unemployment, lack of affordable/descent housing, poverty, social isolation, etc. (Baillargeon et al., 2010; Livingston et al., 2008; Swinton, 2000). In their analysis, Levingston et al. (2008) also summarized the essential needs of incarcerated mentally ill persons in their bid to re-enter the community:

> The basic needs of persons with mental disorders are the same as anyone: safe and adequate housing; sufficient financial resources to meet reasonable food, clothing, transportation, hygiene and health needs; social interactions; and the opportunity to both participate in their own life planning and to contribute to society, (p.9)

It is in this context that the application of Hirschi's SCT makes unique sense. The basic tenet of SCT is that the more people are *attached*, *committed, involved, and believed* in these social institutions the lesser the tendency for them to commit a crime. This theory provides insight into the key areas therapists and other professionals need to be conscious of when supporting clients with MIOB.

Summary of observations from the literature review

The reviewed literature has presented an overview of CDP, its goals, principles, and philosophies as well as the relationship between the mental health court and the CDP. Two research studies that used the qualitative comparative case study approach have been reviewed. The literature has also expounded on the connection between mental illness and criminal behavior as well as some of the theories that attempt an explanation of criminal behavior. This chapter also reviewed community-based approach theories that are emerging in the mental health and justice field to address recidivism, decriminalization, and deinstitutionalization of clients with MIOB. Though much has been said in the review about the effectiveness of psychotherapy in the treatment of mental illness and offending behavior, there is still not much known about how CDP clients experience psychotherapy in their community reintegration endeavors.

Moreover, a critical review of the activities of the justice system reveals that though diversion run by the court may have accomplished some goals because the court also holds individuals accountable for their actions, this legalism seems to shake the foundation of therapeutic jurisprudence. The structure of the court system, the presence of the police and security guides, the judge, the crown, and the duty counsel at the court sometimes appear very intimidating to CDP clients. In that context, CDP clients are prone to accept the pharmacotherapy treatment recommended by their court support workers. This has the effect of limiting CDP clients' right to freely choose from the various community-based services to support themselves no matter how effective those services might be. The structure, operations, and the process of the court seem to undermine the main rationale of diversion—the idea that treatment should be preferred to criminal justice processing, a principle that Livingston et al. (2008) have powerfully explained:

> Treatment is more appropriate than criminal justice processing. At the core of diversion is the idea that persons with mental disorders should be provided with opportunities for services and supports in the mental health system, rather than being processed and punished through the traditional criminal justice channels. The use of criminal justice interventions is perceived as an inappropriate, ineffective, and expensive manner for dealing with mental disorders (p. 4).

It thus behooves on theologians, clinicians, therapists, and other allied professionals outside the justice system to work collaboratively in support of CDP clients in their community reintegration endeavors.

It is also important to note that a greater portion of the reviewed literature attests to the efficacy of CBT. But as pointed out earlier, because CBT tends to be individualistic and it sometimes overlooks the negative influence of the oppressive power structure of society on clients, narrative therapy should be considered. Narrative therapy might also work well in combination with other therapy models. Assimilative integration allows therapists to blend their specialized model of therapy with other theories of psychotherapy. So, to help reduce the internalization of stereotyped labels and their negative effect— damaged self-image and deviance, CDP clients may also benefit from other psychotherapy models such as solution focus, spiritually integrated therapy, existentialism, humanism, and so forth.

Chapter 3: Methodology

The procedure of the project

This study set out to explore and compare the experiences of CDP clients who received psychotherapy and those who received pharmacotherapy as a treatment plan to address their mental health needs as they enrolled in CDP and reintegrated into the community. Before stepping into the field to conduct an interview for this study, a preliminary search was done to avoid duplication of scientific research. To achieve this, the researcher did an extensive database search for about three years. The sources of this search include Google Scholar, Academia.ca, ProQuest, PsycINFO, and government websites including reports and keynote speeches by important diplomats, professionals, and academic scholars. Themes, keywords, and common phrases in the mental health and justice field were mainly used for the database search. The researcher also attended conferences and occasionally, presented on this topic in different academic cycles including psychology, spiritual care and psychotherapy, social work, and theology. A thorough search was also made to look into published books and online journals to find out themes that come close to this current study. Despite this effort, the researcher did not find any similar topic associated with this study though there were somewhat related topics around the same area of research. All the works that the researcher found useful to the topic have been cited and acknowledged accordingly in the reference list.

Qualitative research design

Research design is one of the important aspects of knowledge building. It influences the reliability of the researcher’s data. According to Yegidis and Weinbach (2006), a research design is a plan for conducting a proposed research question or hypothesis after the researcher has done an extensive literature review. Qualitative research design, as noted by Creswell and Poth (2017) "begins with assumption and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem" (pp. 40-41). Qualitative researchers further recommend studying such problems in a natural setting using different sources of data and to remain sensitive to the people and place where the study is being conducted (Brown, 2008, Creswell & Poth, 2017; Merriam, 2009; Yin, 2013, 2014, 2018). There are various types of qualitative research designs such as ethnography, case study, grounded theory, phenomenology, narrative method, historical model, and so on. This dissertation adopted the case study design for reasons discussed later in this chapter.

The description and core features of case studies

Though experts who attempt the definition of the case study methodology differ in their academic orientations, their descriptions share many things in common. For instance, Kaarbo & Beasley, (1999), defined case study research as "a method of obtaining a "case" or a number of "cases" through an empirical examination of a real-world phenomenon or the context" (p.372, emphasis in original). This definition does not only classify the case study methodology as a practical approach that is used to investigate an event or a phenomenon, but it also underlines the two main types of case study research—single case and multiple case study. Yin (2018) also defined the term as "an empirical method that investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident." (p. 15). Yin's definition also describes a case study as an experiential method that examines practical life issues in a contemporary setting as opposed to studies on an imaginary phenomenon. Just like Yin, Merriam (2009) also defines the term as "an in-depth description and analysis of a bounded system" (p.40). Merriam (2009) points out that modern case study research has its roots in social sciences particularly sociology, anthropology, and psychology. Finally, Goodrick (2014) describes a case study as "an in-depth examination, often undertaken over time, of a single case – such as a policy, programme, intervention site, implementation process or participant." (p.1).

The above definitions capture the case study methodology as a research strategy that involves an in-depth investigation of a phenomenon or a case. Goodrick's definition throws some light on the nature or types of case study research as he highlights policy, implementation process, program, intervention site, or participant. However, not all case study experts agree that policies and events fit the case study designation. Stake (2006), for instance, notes that in qualitative research some may consider events, situations, and instances as case studies. However, because Stake (2006) perceives a case study as a noun, he argues that for a phenomenon to qualify as a case, it should be an "integrated system", an "organic systemicity" or a "specific thing", meaning an entity on its own (p.2). In the qualitative case study design, a case is studied in its context and in a real-life setting (Merriam, 2009; Stake, 2006; Yin, 2018). This dissertation fits many of the case study descriptions by the above experts, for it is an in-depth examination of a group of participants (graduated CDP clients) and their experiences of psychotherapy treatment in the court diversion program as they integrate into the community. In the context of Stake's description, the entity this research is focusing on is graduated CDP clients in

Toronto who are eighteen years and above and who received psychotherapy or medication treatment in the court diversion program. This group of participants can be seen as a bounded system, an entity, and an integrated body with common unifying factors.

A case study methodology may be either qualitative or qualitative (Bhatta, 2018; Goodrick, 2014; Remenyi 2013; Yin, 2014). While both Bhatta (2018) and Merriam (2009) do not dispute this fact, they also believe that the case study method is decidedly a qualitative research approach. In drawing the distinction between a case study and other forms of qualitative methods, Merriam (2009) argues that it is the freedom of the researcher to choose ‘what’ to be studied, i.e., the “bounded system” or the “unit of analysis” that makes a given methodology a case study. Merriam (2009) pointed out:

> If the phenomenon you are interested in studying is not intrinsically bounded, it is not a case. One technique for assessing the boundedness of the topic is to ask how finite the data collection would be, that is, whether there is a limit to the number of people involved who could be interviewed or a finite time for the observation. If there is no end, actually or theoretically, to the number of people who could be interviewed or to observations that could be conducted, then the phenomenon is not bounded enough to qualify as a case. (p.41)

Again, the unit of analysis of this dissertation is limited, bounded, and finite. This study adopted a comparative case study design and focused on 10 adult male graduated court diversion clients in Toronto (18 years or older) who completed their diversion program within the last 5 years and were still living in the community at the time of the study.

Anyone who did not meet these criteria was excluded from the study. This is one way by which the data collection of this study was bounded.

A qualitative case study is further characterized by being “particularistic, descriptive and heuristic” (Merriam, 2009, p. 43). According to Merriam (2009), a case is *particularistic* when it is designed to investigate a specific research problem of a phenomenon, program, or event; a case study is *descriptive* when the research outcome is rich, exploratory, holistic, and in-depth; and thirdly, a *heuristic* case study helps readers to gain insight into the phenomenon that is being investigated. This study fits Merriam’s *particularistic* description of a case study because it tries to gain an understanding of why not much is known about the use of psychotherapy in the court diversion program. This study also fits the *descriptive* feature because it is exploratory, and through interviews this dissertation pays attention to the participant’s experiences and the meaning they make to their experience as they enroll in the court diversion program and participate in psychotherapy treatment. This dissertation adopts Merriam’s (2009) *heuristic* case study designation, for it attempts to bring “the discovery of new meaning, extend reader’s experience, or confirm what is known” (p.44).

The theoretical/philosophical underpinning of qualitative case study

One way to pin down the theoretical foundation of the case study research is by looking at the philosophical and epistemological orientations of the prominent experts of this design. Case study researchers are many but Merriam (2009), Stake (1995, 2006), and Yin (2013, 2014, 2018), are said to be the three main influential figures in the qualitative case study research design (Brown, 2008). These three prominent case study researchers have somewhat different philosophical orientations. And since their training and epistemological background have shaped the planning, evaluation, and implementation of the case study design, it is often said that the theoretical foundation of the case study research is sometimes confusing or unsettling (Bhatta, 2018; Brown, 2008; Harrison et al., 2017).

Bhatta (2018) notes that the seeming versatility of the case study theoretical foundation stems from the fact that both positivists and non-positivists have contributed to the development of the case study design. According to Harrison et al., (2017), the effectiveness of case study research and the ubiquitous of its application and development by professionals with diverse philosophical perspectives may have contributed to differences in the theoretical foundation of the case study design. For instance, because Robert Yin applies a systematic scientific approach to strengthen the case study research outcome, he is dubbed a *realist and positivist*; Sharan Merriam is regarded as a *pragmatic constructivist* while Robert Stake is described as *relativist* and *constructivist* or *interpretivist* (Brown, 2008; Harrison et al., 2017). Under Merriam's pragmatic constructionist case study framework, the investigator takes the stance that reality could be constructed intersubjectively through socialization, meaning making, and experience (Merriam, 2009). Just like Merriam's pragmatic approach, Stake (1995) also contends that when applying a constructivist knowledge-building paradigm, the main mission of the case study researcher is to interpret, clarify, and describe vividly a complex phenomenon. Brown (2008) analyzed the philosophical and theoretical variation between Merriam, Stake, and Yin so well and concluded: "Qualitative case study research is supported by the pragmatic approach of Merriam, informed by the rigour of Yin and enriched by the creative interpretation described by Stake" (p.9).

The researcher's perspective

Because CDP clients who experience mental illness and offending behaviors suffer discrimination, systemic oppression, and are usually blamed by society (Baillargeon, Hoge, & Penn, 2010; Bromberg, 1941; Goffman, 1963), this study adopted the social constructionist paradigm as a theoretical framework to help reframe this perception. Through the reconstructionist paradigm, the therapist supporting CDP clients can help externalize this blame through empathy and human validation as CDP clients share their experiences and make meaning of them. In this context, the theoretical framework of this dissertation resonates well with both Merriam's pragmatic reconstructionist case study approach and Stake's relativist/constructivist or interpretive case study design more than Yin's scientific methodological positivist model, which he usually applies for policy consultancy.

As a racialized person, a theologian, a social worker, and mental health therapist, I agree with Brown (2008) that "there are multiple realities through which one can make sense of the world, and I construct my reality from my experiences, and my standpoint on my reality is valid" (p.1). This fundamental conception of the world is located in the qualitative case study paradigm, which I have chosen for this dissertation. Among the various qualitative methods, I have selected the case study as the preferred research strategy to explore how CDP clients enroll in court diversion programs and participate in psychotherapy as they integrate into the community.

Single and multiple cases studies

There are two types of case study design— single and multiple case design (Merriam 2009; Remenyi 2013; Yin, 2018). This means that case study research may be categorized under 1) a study that concentrates on a single individual/event/phenomenon; or 2) a study that focuses on multiple cases with common unifying factors (Merriam, 2009, Stake, 2005; Yin, 2018). Researchers who try to gain more insight into a phenomenon and develop a robust theory usually choose a multiple case study approach rather than a single case study. Merriam (2009) used the following key terms interchangeably to refer to a case study method that involves more than one case: “collective case studies; cross-case; multicase, or multisite studies; or comparative case studies” (p. 49).

The choice between the single or multiple-case design also depends on the research question and the investigator’s intention for the project (Merriam, 2009; Remenyi, 2013; Yin, 2018). This dissertation adopted the comparative case design because my research question explores the experiences of graduated CDP clients who received psychotherapy or medication treatment as they integrated into the community. My intention in this project was to gain more insight into the experiences of these clients’ involvement and their participation in the choice of treatment they received when they enrolled in the court diversion program.

Data collection sources of a case study

Stake (2006) holds the view that in case study research, the investigator has questions that they are looking answers to. And because sometimes one must rely on others for some evidence that happened in their absence, the most important data collection methods for the case study research are direct and indirect observation. Most case study researchers, however, have noted that the case study data may be gathered through multiple instruments such as interviews, artifacts, documents search, observations, etc. (Goodrick, 2014; Kaarbo & Beasley, 1999; Merriam, 2009; Remenyi, 2013; Terrell, 2016; Yin, 2018). While Kaarbo and Beasley (1999) do not disagree with the multiple sources of data collection, they contend that it is not always required of the researcher "to use multiple sources or types of evidence in order to perform a case study." (p.373). Due to Covid-19 restrictions only the qualitative interview technique was employed by the researcher to gather data for this dissertation.

Comparative case studies

According to Kaarbo and Beasley (1999), "*The comparative case study* is the systematic comparison of two or more data points ("cases") obtained through use of the case study method." (p.372, emphasis in original). A more compelling description of a comparative case study that addresses one of the criticisms leveled against the case study design (the generalizability problem) is offered by Goodrick (2014): "Comparative case studies cover two or more cases in a way that produces more generalizable knowledge about causal questions – how and why particular programmes or policies work or fail to work" (p.1). While Goodrick's comparative case study definition applies to quantitative research it is not out of context for qualitative researchers to seek ways that can strengthen the supposed limitations of this design.

There are potential benefits accrued to multiple or comparative case studies. Compared to a single case study, multiple case studies can be lengthy and time-consuming, however, it seems to have some advantages over a single case study. This is because multiple case study allows a researcher to compare cases for similarities and differences; it allows researchers to study cases across sites and scales; and it enables the investigator to compare cases on vertical, horizontal, and transversal axes (Bartlett &

Vavrus, 2017). It is also likely that the findings and evidence derived from multiple case studies may be stronger and more reliable than that of a single case study. Remenyi (2013) does not only discuss the benefits of multiple case design, but he also provides some guidance on how many cases are enough for the doctor's dissertation that adopts the comparative case study strategy:

> Two or more observations i.e. case studies allow the researcher to indulge in some comparative analysis (using both similarities and differences) which can produce some useful insights into the nature of the circumstances being studied. But in general two cases are often considered not to be sufficient. A doctoral degree candidate would be better advised to select three or four cases and sometimes perhaps even five. In academic research the cases are required to be in depth and more than five cases would be considered by many supervisors and examiners as more than enough work to undertake in the space of a 3 or 4 (full-time) to 6 (part-time) year doctoral degree. With multiple case studies it is necessary to employ a multiple case study design with a technique for cross case study analysis… (pp 491-493).

In exploring how graduated CDP clients in Toronto experienced their mode of treatment in the CDP, the researcher adopted a multiple case study design and selected five psychotherapy clients and five medication clients for data collection and analysis, with the goal of comparing their experiences in these groups. In Merriam's parlance, this approach is a cross-case or comparative case study.

To distinguish an embedded single case study from a comparative case study in a multisite, Merriam (2009) pointed out that the latter involves gathering and analyzing data from various cases. Merriam (2009) further affirms that the comparative case study strategy enhances cross-case analysis and generalization. But whether the benefits of generalization and cross-case analysis can be achieved or not depends on the cases a researcher chooses for their concentration in terms of comparison. The selection process in a comparative case study design, therefore, needs to be guided as well.

Selecting cases for the comparative design

To select cases for comparison purposes in the comparative case study design, one needs to be meticulous in the choice of cases one wants to focus on. It is recommended that the researcher selects a collection of cases that are identical or cases with common characteristics and features or cases that can be bounded (Kaarbo & Beasley, 1999; Merriam, 2009; Stake, 2006). If the goal is to analyze similarities and differences among a collection of cases, Stake (2006) reminds the case study designer that: “For multicase research, the cases need to be similar in some ways” (p.1). This implies that cases selected for discussion in the comparative case study design may be similar but might also differ in some respects. Just like Stake, Kaarbo and Beasley (1999) do acknowledge the importance of comparability for all scientific research (not only case studies), but they also contend that unless the theoretical foundation and the research question posed in a given study require exact similar cases for comparison, case study researchers need not bother themselves with an effort to select cases that are entirely and completely similar for their analysis. In their additional information in the footnotes, Kaarbo and Beasley (1999) provided the necessary condition for deciding comparable cases:

> A prerequisite for choosing comparable cases is to define what a “case” or the unit of analysis is for the investigation. Thus, choosing comparative cases directly

> follows from the first step of focusing the research question and identifying the class of phenomena that the question addresses. (p.380)

As mentioned earlier, the "case" or the unit of analysis of this research are the five graduated adult male clients in Toronto (18 years or older) who received psychotherapy treatment within the last five years and were still living in the community at the time of the study. The research question posed to investigate this study was: Why do CDP clients choose psychotherapy, and how do they experience their participation in this form of treatment as they re-enter the community compared to other CDP clients who receive treatment as usual (pharmacotherapy)? Thus, a comparison of the experiences of both psychotherapy and pharmacotherapy clients is not just an accident, it is anchored to the theoretical framework of this study, and it is also embedded in the research question which was posed from the beginning of this project.

The rationale for the case study

When I decided to explore CDP clients' treatment experiences in the court diversion program, the first qualitative design that came to mind was phenomenology. After a cursory review of the work of Edmund Husserl (2017), one of the primary founders of phenomenology, I initially thought that there is no need to consider any other qualitative method. Husserl's main mission for his phenomenology was to save the world from the influence of the scientific method, positivism, numbers or quantity, and the belief in cause-effect, which philosophers and researchers applied to explain events and the world. For Husserl (2017), one cannot deduce the source of human knowledge from the external world. On the contrary, Husserl rather perceived something common with all human beings, which he called the "essence". Thus, to know the world, or to be able to explain the nature of things and human experiences, Husserl taught that we must first know ourselves. There is no single view of reality, but rather multiple forms of reality through human interpretation. For this reason, interpretation requires suspension of or bracketing out of one's presuppositions to become objective. Phenomenology can thus be understood as the philosophical foundation of all qualitative research (Merriam, 2009).

Even though I applied some aspects of the phenomenological philosophy in this dissertation I did not choose it as the main methodology or design for my research, first, because the goal of this study was not to discover the universal essence of receiving psychotherapy treatment in the court diversion program. The aim of this study was to gain an in-depth understanding of why CDP clients choose psychotherapy, how they participate in this form of treatment, and the impact (if any) of psychotherapy on their community reintegration after encountering the justice system. This is more exploratory research to study people in a real-life context in a natural setting (Merriam, 2009, Remenyi, 2013; Stake, 2005; Yin, 2013, 2014, 2018). Such an objective could best be achieved through the comparative case study design whereby participants are purposively selected for the study's goals.

Also, after many years of supporting clients to go through the court diversion program in the City of Toronto, I hardly encountered clients who were receiving psychotherapy treatment in the CDP. Therefore, when I discovered during the preliminary inquiry part of this research that a few CDP clients have accessed psychotherapy as a treatment, I decided to explore what their experiences might be like. This initial discovery fits into Terrell's initial research methodological screening for the case study approach. Terrell (2016) illustrates when case study research can begin by providing a guideline statement that potential research students should be able to complete: "*If I could discover what actually occurred and was experienced during one single lived event in a specific location I would want to know…"* (p.158, emphasis in original). From Terrell's problem statement, a case study may begin when the researcher encounters an event that is out of the ordinary. The researcher begins the case study as an observer, develops interest, and then becomes an inquisitor or an investigator, or an explorer desiring to learn more about the phenomenon and find out what makes the case unique that can be shared with the research community. Not much is known about clients receiving psychotherapy in the CDP. Recent discoveries about a few of these clients who are accessing psychotherapy are intriguing. To explore more about this unique trend, the case study design was preferred compared to other qualitative designs.

Moreover, compared to other academic disciplines, psychology has an extensive history of case study research (Yin, 2018). Yin (2018) further noted that regardless of one's academic orientation the case study is always helpful when the goal is to gain insight into "complex social phenomena" (p.5). The case studies approach is versatile in nature, for according to Yin (2018), it offers an opportunity for the researcher to examine themes of a *case* and helps "to retain a holistic and real-world perspective—such as in studying individual life cycles, small group behavior, organizational and managerial processes, neighborhood change, school performance, international relations, and the maturation of industries." (p.5) Moreover, according to Yin (2018), the case study research method is recommended when (1) the main research questions one is investigating are "how" or "why" questions, (2) when one has limited control over behavioral events, and (3) when the focus of the research is a recent or contemporary phenomenon. The research question of this dissertation asked why and how questions. The researcher did not have control over any participant's behavior or the treatments they received. The study was conducted in its natural setting. Also, this dissertation concentrated on a contemporary phenomenon, i.e., participants who have recently graduated and are sharing their experiences of treatment in the court diversion program and their community reintegration.

This project did not aim at using a quantitative strategy to prove or disprove established theories. Among the five major qualitative strategies, the case study was selected because it allows the researcher to have "an in-depth inquiry into a specific and complex phenomenon" (Yin, 2013, p. 321) in the mental health and justice system. Moreover, in this study, it was crucial for the researcher to develop a rapport and engage in a fair and respectful manner with clients, court support staff, and the managers who supervise the three mental health and justice programs in the organizations providing court diversion services in the City of Toronto. In qualitative case study research, mutual trust and relationship building between the researcher and the respondents is necessary before data collection can occur (Terrell, 2016).

There are other reasons for choosing a case study as a qualitative design. For Terrell (2016), it is the need for close interaction and the relationship between the researcher and the parties involved in data collection that calls for a case study as a qualitative design. Other research experts suggest a case study for a different reason(s). For instance, Mayer (2001) may opt for a case study rather than other qualitative designs such as ethnography and grounded theory because of the former's key distinctive requirement before research begins. For Mayer (2001), the key difference between a case study and other qualitative designs is that case studies are "open to the use of theory or conceptual categories that guide the research and analysis. In contrast, grounded theory or ethnography presupposes that theoretical perspectives are grounded in and emerge from firsthand data." (p.331). Thus, in the case of grounded theory or ethnography, a theory is formed through the collection of data whereas the case study researcher may already have a theoretical framework as their research base before data collection is carried out.

The beauty of innovative research is its ability to contribute to knowledge. A case study, as a qualitative methodology, helps fulfill this role by uncovering hidden areas that quantitative research would have made difficult or impossible to explain or uncover. The case study methodology is used when researchers try to understand and report on an event that really happened to an individual or a group of people in a single unit (Terrell, 2016). In this study, the researcher tried to understand the experiences of the selected participants who received treatment in the court diversion program. Compared to other qualitative strategies, Meyer (2001) also notes that a case study is useful when researchers try to explore new processes and behaviors or when little is known about a given subject matter, or when there is a lack of information about an area of research. Yegidis and Weinbach (2006) also note that a case study is appropriate when certain conditions prevail— i.e. when little is known about the area of investigation; when the area of research has some restrictions due to illegal behaviors; and when it is impossible to get a representative sample of the population. As stated earlier, people living with mental illnesses who are involved in the criminal justice system may have experienced psychotherapy, but not much is known about the experiences of those who are specifically registered in the court diversion program. Since not much is known, the case study design is more appropriate than other qualitative methods.

It is important for researchers to be able to predict the success of a particular research design they plan to use for a given project based on the aim of the study. In this context, experts of the case study methodology suggest that a case study is preferred, and it is also effective especially when a researcher is investigating *why* and *how* questions on a contemporary issue (Brown, 2008; Goodrick, 2014; Merriam, 2009; Meyer, 2001; Yin, 2013, 2018).

In sum, a case study design was preferred in this research because the goal of the study— to gain an in-depth understanding of why CDP clients choose psychotherapy, how they participate in this form of treatment, and the impact (if any) of psychotherapy on their community reintegration after encountering the justice system. I did not choose phenomenology as the main method for this research because my primary interest was not to discover the "essence" of psychotherapy treatment for CDP clients but to gain a deeper understanding of how and why CDP clients enrolled in psychotherapy and the outcome of their participation in this treatment.

Second, the researcher had to establish a respectful and fair relationship with the proposed participants of the project (Terrell, 2016). Third, the researcher investigated the *why* and *how* questions in this project (Brown, 2008; Goodrick, 2014; Merriam, 2009; Meyer, 2001; Yin, 2013, 2018). Fourth, from the reviewed literature, little is known about the use of psychotherapy in the CDP (Yegidis & Weinbach, 2006). Fifth, potential participants of this study were ex-offenders of the law, so the researcher was confronted with some legal restrictions as to how much information he could access from the court.

Sixth, I did not choose to do grounded theory as my methodological research approach because the aim of this study was not to build a “substantive theory” (Merriam, 2009). This case project already had theories guiding the study (Meyer, 2001). This study was guided by postmodern/social constructionist psychotherapy, labeling and stigmatization theory, and social control theory.

Sampling and recruitment process

Recommended as the most useful methods for comparative case studies, purposive and stratified sampling were used in this research (Goodrick, 2014). The researcher used purposive sampling to select 5 CDP clients who received psychotherapy treatment and used stratified sampling for the other set of 5 CDP clients who received pharmacotherapy treatment. Purposive sampling was chosen for the psychotherapy group because there seemed not to be many CDP clients who had accessed psychotherapy. On the other hand, since most CDP clients receive medication as part of their treatment plan, the researcher adopted a stratified sampling method in selecting 5 participants who had received pharmacotherapy.

There are three organizations offering CDP in Toronto—Fred Victor Centre, whose court diversion programs were located at the Old City Hall court (60 Queen St West) and the College Park court (444 Yonge Street). The second organization is the Canadian Mental Health Association (CMHA), whose diversion programs were located at 1911 Eglinton Avenue East, Scarborough, and 2201 Finch Avenue West Court. The third organization is COTA, whose diversion program was also located at 1000 Finch Avenue West. While COTA has only one site, CMHA, and Fred Victor Centre have two sites each. Thus, in total, there were five sites of diversion programs in Toronto at the time of this research. And the stratified sampling of pharmacotherapy clients was made based on site. All 10 clients (psychotherapy and pharmacotherapy) were selected from Toronto because it is the city, where the largest mental health court in Canada is located, and where the researcher was also located.

The primary source of research participants' recruitment was the court support workers, community workers, and case managers who received the research information from the managers of the three organizations, which run the court diversion programs in Toronto. At the time of the research, there were 17 court support workers who work from the three organizations working in the court diversion programs in different sites within the City of Toronto.

Upon getting the approval letter from the Research Ethics Board (REB), the researcher first contacted the managers/supervisors of the court support workers via email and phone calls for permission to contact their staff. When the consent was granted, the researcher then sent the information about the project to all the court support workers of the three organizations via email, who then contacted their graduated adult male clients to find out if they wanted to participate in the research. Seven graduated CDP psychotherapy clients initially responded to the recruitment flyer. In the process, one of them relocated to another province and changed his phone number, so we lost contact. Among the remaining six clients, the researcher conducted pre-screening and purposively selected five out of them who had accessed psychotherapy during their enrollment in the CDP. The sixth person was found unsuitable for the study due to some behavioral issues.

On the other hand, the stratified sampling method based on site was also used to select 5 graduated CDP clients who received medication treatment during their enrolment in the court diversion program.

Participants (Inclusion/exclusion criteria)

Participants of this study were graduated court diversion male clients; 18 years or older; who completed their program in Toronto within the last five years; used either psychotherapy services or medication for treatment during their enrollment in the court diversion program; and were currently living in the community at the time of the data collection. Clients who met the inclusion/exclusion criteria and were deemed eligible to enter the study following the screening process were selected, and the researcher scheduled the time to explain the purpose and the goals of the research to them. They were given the opportunity to ask questions before they were asked to confirm and sign their consent.

Data Collection

Semi-structured interview questions were used as a guide to help elicit responses from the participants after the purpose of the study had fully been explained to the participants. The researcher also gave ample time to answer every question bothering the participants' minds about the research. Those who met the study's criteria signed the informed consent and participated in the study. Each interview took about sixty to ninety minutes to complete. While some of the participants were brief and straight to the point in responding to the interview questions, there were few of them who took the time to chat about other experiences in their lives that were not directly relevant to the current study. The researcher respectfully listened to their opinion and appreciated the additional contribution they made to enrich the data. All the participants agreed to the voice recording. After each interview, the researcher transcribed the audio-recorded voices of the participants and read through them repeatedly (Goodrick, 2014; Merriam, 2009). Some of the participants were contacted again during the transcription for clarity of certain statements in their responses. The researcher then organized, categorized, and coded the data considering the research question, the objectives of the study, and the relevant theories of this study. As Merriam (2009) has noted, qualitative study analysis requires that the researcher patiently underlines the "recurring patterns or themes supported by the data from which they were derived. The overall interpretation will be the researcher's understanding of the participants' understanding of the phenomenon of interest." (pp. 23-24).

In following the Public Health's mandate regarding the COVID-19 pandemic, the researcher collected the data through phone interviews. When it became necessary to contact those who did not have access to a computer and scanning machine for the return of the signed consent forms, the researcher wore his full Personal Protective Equipment (PPE) and met them face-to-face for the signed consent form.

Instruments and procedures for data collection

Noting that data could sometimes be difficult to collect, the researcher relied on some useful tips and suggestions from experts in the qualitative sources of data. For case study sampling, it is recommended that researchers use interviews, observations, documents, and artifacts for data collection (Goodrick, 2014; Merriam, 2009, Remenyi, 2013; Stake, 2005; Terrell, 2016; Yin, 2013, 2014, 2018).

For this current study, however, the investigator used an interviewing strategy for primary data collection due to Covid-19 restrictions. Published articles including keynote addresses on the mental health court diversion program as well as theories of community reintegration of clients with MIOB were some additional sources used to assess the primary data. This research was also enriched by the researcher's previous knowledge about the operations of the diversion program prior to the beginning of this study. After receiving the Research Ethics Board's approval, the researcher initially contacted the court diversion site managers, who then shared the research information with the court support workers. The court support workers helped the researcher in the recruitment process of the research participants. The participants contacted the researcher via emails and phone calls for recruitment. The researcher used a semi-structured interview technique to elicit responses. The semi-structured questions mainly explored the participants' general perception and experiences of psychotherapy/pharmacotherapy during their enrolment in CDP, how they accessed psychotherapy/pharmacotherapy services, and whether they benefitted from it and how. Upon receiving their responses, a follow-up interview was scheduled to give the participants the opportunity to discuss and explain their responses in detail. The participants also provided their demographic information after confirming their participation and signing the informed consent. The interviews were audio-recorded by an electronic device after the clients had authorized the researcher to do so when they signed the informed consent.

Qualitative Comparative Analysis

The researcher analyzed and synthesized the data to look for similarities, differences, and patterns across the cases in terms of common goals, successes, accomplishments, or barriers. To achieve this, the researcher described the specific features of each case prior to the presentation of the data (Goodrick, 2014; Merriam, 2009). In establishing a strong analytic framework for cross-case comparison, cases that the researcher wanted to focus on were carefully selected and linked directly to the key research questions that this study aims to investigate (Goodrick, 2014; Kaarbo & Beasley, 1999; Stake, 1995). With the audiotaped information, the researcher wrote, analyzed, and coded it under words, clustered under themes and phrases, and grouped under thematic categories (Merriam, 2009). The process of analysis was done for each side of the two groups of the study (i.e., psychotherapy clients and pharmacotherapy clients). This strategy helped the researcher to find patterns and allowed him to synthesize, theorize, and develop propositions that enhanced a comparison with the reviewed literature for consistency and variations.

Ethical considerations

From the proposal stage to the time of the publication of this dissertation, the researcher was bound by the ethical standards of the Wilfrid Laurier University Research Ethics Board. This helped to ensure the data security and confidentiality of the participants. In compliance with the Research Ethics Board’s framework, the researcher had it as a duty and was committed to protecting participants’ information from unauthorized access, use, disclosure, modification, loss, or theft. As discussed earlier, participants were selected through recommended ethical standards without any compulsion. Those who met the inclusion criteria received answers to their questions and they understood the goal and the purpose of the research before they signed the informed consent.

Participants who consented to be recorded were audiotaped. To avoid a breach of confidentiality, the recorded data was stored on a USB mass storage and kept in the researcher’s secure briefcase. All audio devices and papers of this research were securely kept in the researcher’s briefcase during the data collection process. No participant made a specific request to not have their names mentioned in the report, therefore, none of them was identified in the report or in any presentation of the study. Qualitative research designs usually go hand in hand with the use of direct quotations. However, to maintain confidentiality and anonymity, only pseudonym names have been used for direct quotations. Participants who requested to vet their personal quotes before publication were contacted and they did authorize their direct quotes to be included in the report. The researcher’s laptop for data collection was password keyed and the information will permanently be deleted after ten years.

The researcher also acknowledges how his training, background, values, biases, and assumptions, may impact the outcome of the study. Prior to becoming a student of psychotherapy, the researcher had been working as a community support worker in the mental health and justice field providing support in different capacities to mental health and justice clients. The researcher had spent over twelve years working with other professionals in the mental health court in Toronto. He spends much of his time in the court diversion room and performs main activities including, but not limited to, conducting intake assessments, escorting clients to the mental health court, and aiding clients during their graduation from the diversion program. The researcher also provided psychotherapy to clients with mental health and addiction issues under the supervision of a certified medical practitioner. Besides, the researcher provides spiritual care and counseling to a local congregation in Toronto. The researcher believes that these experiences could enhance his knowledge and sensitivity to the research being conducted. Although all efforts were made to ensure objectivity, the researcher's own idiosyncrasies and biases may have influenced his views about the data collection and its interpretation. It is for this reason that the researcher deeply committed himself to bracket out his own assumptions and presuppositions throughout the process of this project.

Summary

In determining the most appropriate methodological approach for this study, this chapter first echoed the mission of this project— i.e., to explore and compare the experiences of CDP clients who received psychotherapy and those who received pharmacotherapy for treatment in the court diversion program as they integrate into the community. Before stepping into the field to conduct an interview for this study, the researcher conducted a preliminary search to avoid duplication of scientific research. Given the nature of the research question, the sampling size, the background of the participants, the researcher's philosophical perspective, and several other factors, the researcher deemed a qualitative comparative case study strategy appropriate for the design of this research.

This chapter relied on case study experts such as Brown, (2008), Goodrick, (2014); Kaarbo and Beasley, (1999) Merriam, (2009), Terrell (2016) Yin (2013, 2014, 2018), who suggested some useful tips for qualitative data collection. For case study sampling, these experts recommend interviews, observations, documents, and artifacts. This current study utilized only an in-depth interviewing technique for primary data collection. However, the study was enriched by the knowledge and experience of the researcher.

Though there were still some Covid-19 restrictions in place during the data collection, the researcher continued to witness the activities, processes, and hearings of the clients in the diversion program via video. The researcher used semi-structured interviewing questions to explore the participants' general perception and experiences of psychotherapy/pharmacotherapy during their enrollment in CDP, how they accessed these services, and whether they benefitted from it and how.

Though a comparative case study can be time-consuming, it proved to be effective in the description, interpretation, and explanation of the experiences of the participants. Through the comparative case study design, the researcher was able to analyze and synthesize the data for similarities, differences, and patterns across the cases in terms of common goals, successes, accomplishments, or barriers (Goodrick, 2014). To achieve this, the researcher described the specific features of each case prior to the presentation of the data (Goodrick, 2014; Merriam, 2009; Stake, 1999). Importantly, the whole process of this research—participant recruitment, data collection, data analysis, presentation of data, and report of the findings, followed Wilfrid Laurier's Research Ethics Board's ethical framework as well as the prescribed directives of the APA Publication Manual on qualitative research.

Chapter 4: Findings

The objective of this field research was to explore how graduated Court Diversion Program (CDP) clients experience psychotherapy as they integrate into the community. The exploration aimed at comparing the experience of CDP clients who received psychotherapy services with their counterpart graduated CDP clients who did not have psychotherapy but treatment as usual (i.e., medication). The researcher's professional experience and training as a community support worker already offered him an opportunity to conduct an extensive observation of the mental health court diversion program in Toronto at different sites prior to Covid-19. During Covid-19 restrictions, the researcher continued talking to the court support workers and observed the court process remotely through videos and telephone conferences, listening to and watching how clients enroll in the CDP program, the services they received, and their participation in the program, and their graduation process. Through the interactions with key CDP planning staff such as Crown Attorneys, court support workers, and other stakeholders, the researcher was also able to gain much insight that added value to the data through interviews and observation.

Encounter with CDP program planners

One of the common assumptions among service providers and even some health care professionals is that psychotherapy is mainly for a few privileged individuals who suffer from minor mental illnesses such as depression and anxiety. For such people, a study aimed at exploring the use of psychotherapy among CDP clients may seem pointless. Therefore, before this study began, it was deemed necessary for the researcher to conduct a preliminary investigation from the Toronto Court Support Consortium (a network of court support programs in Toronto) to find out if there be any clients who have or did receive psychotherapy in the court diversion program.

During this preliminary inquiry, the researcher had an opportunity to interact with two Crown Attorneys in Toronto to discuss this research. The Attorneys were receptive to the researcher and answered all his questions pertaining to the treatment of CDP clients when they enroll in the court diversion program. Though the meetings with both Attorneys occurred at different court sites and at different times, their responses were similar—that the court is much more concerned about the treatment of CDP clients than what treatment they receive. The Crowns confirmed that CDP clients may receive psychotherapy treatment if that is what they agree to work on with their Court Support Workers (CSW). The Attorneys' response prioritized the role of the CSW in the diversion program.

The researcher's preliminary inquiry from the CSWs also confirmed the declaration of the Crown Attorneys. During the preliminary inquiry, the researcher was able to meet with one CSW who had a client on their caseload that was receiving psychotherapy support at the time of the meeting. However, this evidence was not consistent across all court diversion sites as far as psychotherapy in CDP is concerned. And it was during the data collection that the researcher encountered a couple of CSWs whose knowledge of and experience with CDP clients and psychotherapy services was different. Contrary to the first CSW's view, these latter two CSWs believed that it is difficult to find CDP clients receiving/have received psychotherapy because most CDP clients appear at the court showing severe symptoms of mental illness, therefore, they would rather recommend medication for them instead of psychotherapy. These workers also believed that psychotherapists would probably not accept CDP clients because of their involvement in the justice system. The researcher continued the recruitment process until he found other court support workers who had worked with CDP clients who have received psychotherapy treatment.

Graduated CDP clients share their own experiences

The in-depth interview provided a platform for the researcher to hear CDP clients' own lived experiences of psychotherapy or medication as part of their treatment plan when they were charged and came to court. Semi-structured interview questions were used to explore the reasons graduated CDP clients chose psychotherapy, how they experienced their participation in this form of treatment and how they perceived psychotherapy to shape/did not shape the aspects of their well-being and community reintegration after encountering the criminal justice system. Five psychotherapy clients were screened and purposefully selected using the inclusion/exclusion criteria for this study (see Appendix C or D). A stratified sampling method was also used to select five graduated CDP clients who received medication treatment during their enrolment in the court diversion program. All ten participants were selected from the City of Toronto. The semi-structured questions were used as a guide to help elicit responses from the participants in a natural setting after the purpose of the study had been explained to them and all their questions answered for the participants. Those who met the study's criteria signed the informed consent and participated in the study. Each interview took about sixty to ninety minutes to complete. After each in-depth interview, I transcribed the audio-recorded voice of the participants and read them over and over again as recommended by Goodrick (2014). Some of the participants were contacted again during the transcription for clarity of certain statements in their responses. I then organized, categorized, and coded the data in light of the research question, the objectives of the study, and the relevant theories of this study. With the advice of my supervisor, the data were analyzed using thematic analysis as discussed by established authors such as Brown, (2008), Creswell and Poth (2017), Goodrick, (2014), Kaarbo and Beasley, (1999), Merriam, (2009), Terrell (2016), and Yin (2013, 2014, 2018). A combination of the work of these two authors helped the investigator to follow the path of the Qualitative Comparative Analysis (QCA) approach, which suggests that in order to bring rigor to qualitative data, researchers using the qualitative study method should focus on patterns but not necessarily on the outcome.

Before presenting the findings of this study, it is important to provide a brief description of each of the 5 psychotherapy clients who partook in the research. The table below (Figure 1) is to assist the reader to have an idea of the background of the 5 psychotherapy clients who were interviewed. To maintain the confidentiality of the participants, their specific ages and charges are vaguely reported, and their names are also replaced by pseudonyms in the data presented in the table.

Figure 1: Demographics of CDP psychotherapy clients

Participants	Age	Gender	Education	Ethnicity	Place of residence	Diagnosis	Offense	Graduation Year	Mode of therapy	Recidivism?
Ray	50s	Male	High School	Latin American	Toronto	Depression/Addictions	Divertible	2016	Both Group & one-on-one	No
Teddy	40s	Male	High school	Caucasian	Toronto	ADHD/PTSD/Addictions	Divertible	2018	One-on-one	No

Kabir	30s	Male	College	Middle Eastern	Toronto	Schizophrenia	Divertible	2017	Group	No
Matt	30s	Male	University	Bi-racial	Toronto	Schizophrenia	Divertible	2017	One-on-one	No
Frank	30s	Male	University	Caucasian	Toronto	Psychosis	Divertible	2020	Group	No

The next table (Figure 2) also presents the background of the 5 CDP clients who received treatment as usual (medication). To maintain the confidentiality of the participants, their specific ages and charges are vaguely reported, and pseudonyms are used for their names as well.

Figure 2: Demographics of CDP pharmacotherapy clients

Participants	**Age**	**Gender**	**Education**	**Ethnicity**	**Diagnosis**	**Offense**	**Graduation year**	**Recidivism**
Albert	30s	Male	Grade 8	Caucasian	Schizophrenia/Addictions	Divertible	2017	Yes
Douglas	20s	Male	High Sch	Black African	Schizophrenia/Addictions	Divertible	2018	No
Rod	60s	Male	High Sch	Caucasian	Bipolar/Anxiety	Divertible	2018	No
Eric	20s	Male	College	Black American	Schizophrenia	Divertible	2020	No
Pearson	60s	Male	College	Caucasian	Depression	Divertible	2018	No

Description of Themes and Sub-themes

Though Goodrick (2014) admits that there are no set rules or specific guidelines as to how one should present their qualitative case study results, he recommends the use of tables, diagrams, etc. to illustrate the findings as it is sometimes difficult to make sense of long narratives that attempt an explanation of similarities and differences within and between cases. The below table (Figure 3) summarizes the various themes and sub-themes that emerged from the experiences of the five graduated CDP clients who received psychotherapy as part of their treatment plan when they enrolled in the Court Diversion Program (CDP).

Figure 3: Summary of Themes and Sub-themes—-CDP psychotherapy clients

	Themes	**Sub-themes**	**# of times Sub-theme occurred**
1.	Why CDP clients enroll in psychotherapy	a. Referral by a psychiatrist	1
		b. Self-referral (previously used psychotherapy as a coping strategy)	2
		c. Self-referral due to medication side effects	2
2.	Modality of psychotherapy	a. CBT	3
		b. Psychodynamic	1
		c. Combination of other models	2
3.	Participants' experiences in psychotherapy	a. Therapeutic alliance	5
		b. Engagement	5
4.	Key Outcomes of psychotherapy	a. feelings of fulfillment and satisfaction	5
		b. Insight	3
		c. Improvement in relationships	4
		d. Community participation	4
		e. Improved mental health	5
		f. Reduced offending behavior	5
		g. Housing stability	5
		h. Religious/spiritual lessons	3
5.	Reframing reintegration in the context of wellbeing	a. Being employed/volunteered	3

		b. Family reunion	3
		c. Being respected/appreciated	1
		d. Guaranteed income	3
		e. Affordable housing	5
		f. Enrolled in training/education	2
6.	Barriers to navigating psychotherapy services	a. Limited choice	4
		b. Insufficient funding	3
		c. Mental health status	3
		d. The influence of medication in CDP	5
7.	Hope after completing CDP	a. Return to School	1
		b. To volunteer or find a job	2
		c. Establish own business	1
		d. Settle and raise a family	1
		e. financial planning and/or acquiring property	2

Description of themes and subthemes of CDP psychotherapy clients

The above common recurring patterns and themes were highlighted from the responses of the 5 CDP clients who received psychotherapy as part of their treatment plan. Before data collection, the researcher was curious about three key items i.e., reasons why graduated CDP clients chose psychotherapy, how they experienced their participation in this form of treatment, and how they perceived psychotherapy to shape/did not shape their way of life and community reintegration after encountering the justice system. However, in listening attentively to their stories about how they came to encounter psychotherapy, and their participation and completion of the court diversion program, additional essential themes and sub-themes emerged, which the researcher found useful to this study. Therefore, additional emerging themes (Satisfaction & accomplishments through psychotherapy, what reintegration means to CDP psychotherapy clients, barriers to navigating psychotherapy services, and hope after completing CDP) have also been included in the table above (Figure 3).

Theme 1: Reason(s) for choosing psychotherapy as a treatment plan.

Three subthemes emerged from the interview that explains how/why CDP clients enroll in psychotherapy.

Subtheme a: Referral by a psychiatrist.

Among the five participants who received psychotherapy, one of them (Ray) reported that his psychiatrist referred him to a psychotherapist when the doctor learned what Ray was dealing with emotionally and psychologically. Ray shared that when he was brought to the court, he was filled with fear and confusion. Ray stated his psychiatrist saw some deficiencies that needed to be addressed before he could build self-confidence. Ray and his psychiatrist, therefore, worked together to restore these emotional and psychological deficiencies.

Subtheme b: Self-referral (previously used psychotherapy as a coping strategy)

Two participants, Matt, and Frank, both shared that they enrolled in psychotherapy because they previously used psychotherapy and found it helpful as a treatment for stressful life situations prior to their encounter with the justice system. Therefore, they perceived psychotherapy as a treatment model when they came to court. Matt briefly described how he came to the justice system and why he chose to do psychotherapy:

> I started psychotherapy when I was young. I left my parents' home and moved to Ontario from another province when I started College. That was when I started

> having issues (drinking, bad friends, homelessness, and street life) I ended up joining gangs and got arrested when we robbed a shop. I was diagnosed with ADHD. When I was brought to court, I decided to see a psychotherapist because I believed psychotherapy was what I needed to bring about the desired behavior change in my journey.

Matt shared that he learned different ways of perceiving things in life, and his experiences led him to conclude that relapse can happen to anyone who receives psychotherapy.

The lessons of Matt seem to rhyme with Frank's experience of psychotherapy. Being in his thirties, Frank said his first experience of psychotherapy was when he was 21 years old. He said he went to the Centre for Addiction and Mental (CAMH) looking for support for his mental health as he was going through life experiences that were affecting him heavily. According to Frank, he was later hospitalized for mental health crisis and when he was discharged, it was recommended for him to do group psychotherapy focusing on anger management. Frank shared that he learned to keep his temper and was able to relate well with his relatives because of the new skills he acquired in the anger management group.

Subtheme c: Self-referral due to medication side effects

One of the participants, Teddy, shared that he decided to concentrate mainly on doing psychotherapy because of the serious side effects of his prescribed medication. Teddy specifically mentioned that he had already started receiving psychotherapy when he came to court. Teddy said his court support worker encouraged him to continue with the psychotherapy as long as he sees his doctor. But upon seeing his doctor, Teddy said he did not have a good experience with the medication he received. Teddy shared: “I was already doing it. I got into trouble because the medication I was taking was causing me anxiety and a lot of aggression. The medication I had been taking made me aggressive.” Teddy said he continued to struggle with his doctor and his pharmacist until they removed him from that particular medication. Kabir also shared that he chose to do psychotherapy because of the previous negative experience he had with medication treatment. Kabir declared:

> I was allowed to go for psychotherapy when I told my court support worker that I do not want to take medication. First, the agency I was referred to for psychotherapy told me that I am not eligible if I still have charges pending in court. This was very frustrating for me, so I nearly walked out of the CDP. Then I saw a flyer outside the court about a free psychotherapy group for people hearing voices. I called the number and after a brief interview, they accepted me.

Kabir’s experience echoes the explanation given by some of the court support workers who informed the researcher that psychotherapy is probably not for CDP clients just because of the reluctance of some psychotherapists in accepting CDP clients who are involved in the criminal justice system. Kabir said he was able to find psychotherapy services by himself, through his participation in the psychotherapy group, he shared that he learned new ways of reasoning, which helped him avoid fighting and getting charged.

Overall, when inquired about how graduated CDP clients came to choose psychotherapy as their treatment plan, the responses elicited from the participants differed slightly one from the other. While someone was referred by his psychiatrist, others made self-referrals either because they did not want to receive medication (due to possible side effects) or because they had previously used psychotherapy in the past as a coping strategy and believed psychotherapy will likely help them deal with their mental health issues and offending behaviors. As noted by Matt, psychotherapy helped these clients in different ways, but relapse is always possible if one does not practice and commit to what they learn in therapy sessions.

Theme # 2: Modality of psychotherapy

It was not a primary objective of this study to investigate the modality of psychotherapy received by clients in the CDP. However, an in-depth interview with the participants also underscored a couple of subthemes of psychotherapy models. This includes Cognitive Behavioral Therapy (CBT), psychodynamic therapy, and a combination of other forms of psychotherapy.

Subtheme a: CBT

CBT aims to reduce negative behaviors and reinforce positive ones. It operates on an assumption that by learning new skills people can modify their behavior and change their feelings (Jones-Smith, 2016). Some of the participants shared their experiences in their participation in CBT. Teddy reported that he had one-on-one sessions with his therapist for about a year and a half focusing on learning new skills that helped him deal with his PTSD. As a teen, Teddy said he lost his dog in a house fire. This incident traumatized Teddy to the extent that even in his adulthood he could not leave his two dogs in the house when going to work. Teddy said the therapist supported him to implement a strategy that helped him not to think about his house and his dogs as much when he is away from home. This is how Teddy described his experience:

> What the therapist did was to help me not to think about my house and my dog as much when I am away from home. The therapist helped me put into practice a couple of ideas that can help me focus. For instance, now when I am out, I have a phone number to call and ask a lady who lives down the hall from me to see if everything is ok.

Teddy shared that he learned some behavior modification skills that helped improve his feelings about his house and dogs when he goes out.

Kabir also reported joining a CBT group for people who hear voices. During the training activities, Kabir said he was given homework to complete at the end of each session for about six weeks. Kabir shared that he found the sessions helpful because he was able to learn how to cope with hearing voices. Kabir pointed out: “one thing that continues to help me today is the tool kit, which I developed from the class. I still apply those techniques today when I am in crisis.” Another client, Frank, also disclosed that he struggles with delusional thinking and anger issues. And the charge that brought him to the court was Threat. Thus, Frank shared that attending a Day program and Anger Management group rubbed on him some skills that he is able to apply. In his own words, “These programs taught me life skills, stress management, techniques to deal with and control my anger, how to seek help when I am in crisis.”

Subtheme b: Psychodynamic therapy

Among the five participants, only the description of Matt’s experiences in therapy sessions fits the psychodynamic modality. Matt said his therapists asked him many questions that deeply explored his past experiences from his childhood. And because of the strong therapeutic relationship that was first established between Matt and his therapist, Matt said he was able to open up to his therapist and shared much about his life experiences from his infancy. Matt said he met once a week with the therapist for almost a year. According to Matt, the one-on-one meetings offered him an opportunity to learn about himself during therapy sessions, and the therapist helped him unlearn his negative past behaviors such as crying and self-blame.

Subtheme c: A combination of other forms of therapy

Among the five psychotherapy participants, only Ray reported that he received different psychotherapy models for the treatment of addictions, mental health, and anger management which he experienced at the time he came to court. Ray said he was supported by different professionals—both psychotherapists and psychiatrists. Though Ray did not use the term Assimilative psychotherapy for the treatment model he received, it is probable that the different psychotherapists and psychiatrists he encountered must have adopted different therapy models. According to Ray, he gained much from both the one-on-one and the group sessions as well. Ray said he comes from a dysfunctional family whose members are all given in to addictions, but he never saw anything wrong with addictions until he met a psychotherapist. Thus, Ray stated that he gained insight from seeing a psychotherapist because the therapist told him his secret and helped him to overcome his struggles with alcohol.

Theme # 3: Participants’ experiences in psychotherapy

Four subthemes became apparent from CDP clients’ participation in psychotherapy.

Subtheme a: Therapeutic alliance

A therapeutic alliance is a relationship established between a therapist and a client that cements the therapy process (Jones-Smith, 2016). When such kind of relationship develops, it enhances the therapy process for both the clinician and the client. All five participants who were interviewed described a considerable degree of a therapeutic relationship that evolved between them and their therapists during therapy sessions. In describing the relationship with his therapist, Teddy, for instance, said my therapist “was very friendly, very cool and very relaxing”. As a result, Teddy continued to work collaboratively with his therapist for a long time. This strong therapeutic alliance translated into great accomplishments for Teddy as he describes:

> The psychotherapy was quite helpful, the therapist taught me how to deal with my PTSD and coached me on how to ground myself in getting back to my address. They also gave me some ideas, grounding techniques etc. that I never knew before.

Matt’s description of his relationship with his therapist is another example: “Our meetings continued for about a year. My therapist and I trusted each other. I had nothing to hide. I told him everything I have been through since my youth”. Besides Teddy and Matt, Kabir also threw light on the therapeutic relationship he had with the facilitators of his group therapy:

> the facilitators were caring and supportive. I was therefore encouraged to attend the sessions and complete all my assigned readings and homework. And because of their support, I became open to them after building trust in them. Thus, I received a lot of support from the group sessions

This therapeutic alliance seems to explain why CDP clients who received psychotherapy experienced some positive outcomes, which they shared during the interview.

Subtheme b: Engagement

Therapeutic engagement creates a mutually beneficial relationship between the therapist and the client especially when therapy is non-directive. All five participants who were interviewed talked about an experience of a certain level of engagement with their clinicians during therapy sessions. For instance, through active engagement with his clinician, Matt and his therapist trusted each other, therefore, Matt was able to tell the therapist much about his youthful life experiences without reservation. The therapist's feedback in an engaging environment also helped Matt to conclude that "I learned different ways of understanding things and approaching life." Ray, who had the unique experience of both one-on-one therapy and group therapy said this: "my therapist helped me to know what is inside me and then talked about it. He helped me to be honest to myself." Kabir also, who attended group therapy said this about his therapists: "the facilitators were caring and supportive. They gave us the chance to share our life experiences, challenges, successes, etc.". This shows that the therapy session was not a monologue, but a time for both clients and therapists to sit and talk about issues that are important to clients.

In sum, the study reveals that after developing a therapeutic relationship with their clinicians, CDP clients who received psychotherapy actively participated in therapy sessions through engagement, asking questions and receiving answers, completing homework, designing a toolbox, and learning new skills that they apply on their own in the community. Participants shared that the skills they learned could help them handle the unwanted feelings, behaviors, and thoughts that disturb their mental health.

Theme #4: Key outcomes of psychotherapy

One of the major objectives that this research aimed to explore about graduated CDP clients who received psychotherapy was to investigate the role psychotherapy played or did not play in their community reintegration after encountering the criminal justice system. Eight main subthemes emerged from the interview with the participants as they expressed their satisfaction and accomplishments upon receiving psychotherapy. The following is the synopsis of the eight subthemes:

Subtheme a: Feelings of fulfillment

All five participants who received psychotherapy expressed feelings of fulfillment and satisfaction for being able to complete their court diversion program in Toronto successfully. This is not surprising because the methodology of this study purposefully targeted CDP clients who have completed their court diversion program in Toronto within the last five years. It is, however, important to mention that for these graduated clients, completing CDP means a lot because it is not everyone who enrolls in the CDP that is able to complete it. Perhaps it is for this reason that some of the participants concluded their interview with exceptional notes. For instance, after receiving psychotherapy treatment and his final graduation from CDP, Teddy shared that he has learned important lessons in life since completing his diversion in 2016. Teddy felt that he has some experience to share, so he advised: “I wanted to say anyone that wants to learn from my mistake, please listen and learn”. Teddy experienced self-consciousness and awareness and took responsibility for his action. He became satisfied with the therapy he received and was willing to share his experiences with others. After receiving the needed support in the group therapy while in the CDP program, Kabir perceived the completion of his CDP as a great relief when he said: "Upon completing the group therapy and CDP, my charges were dropped, and it felt like a load was lifted from my shoulders." Thus, in concluding his interview, Kabir remarked: “I just want to thank everyone who helped me to finish the program”. Matt was elaborate in his expression of appreciation to the agency where he received help to complete his CDP:

> Fred Victor came into my life at a time when I had no hope and did not even understand the things I was going through. But here I am now with a big change a few years later. I think anyone in a similar situation to mine should be hopeful.

Subtheme b: Insight:

Insight occurs when clients begin to gain self-awareness or when they become conscious of the factors that contribute to their emotional disturbance and irrational beliefs. Jones-Smith (2016) notes that insight is not complete until clients commit themselves to work with a therapist and make the effort to rid themselves of the very issues troubling them. Three out of the five participants who were interviewed said they gained insight from their psychotherapy sessions. Ray describes his family as “dysfunctional” because of their excessive alcohol consumption. Ray then shares his insight as he continued to work with his clinician:

> My sisters and brothers, as well as my father, were all alcoholics. But I saw nothing wrong with that. I did not know alcohol was my problem until I met with

> a psychotherapist. He helped me to learn that if I control the alcohol, I can address my charges in court.

From his group sessions, Kabir also shared that "I began to learn new ways of reasoning that helped me to control my impulse, which in the past had led me into fighting and getting charged." When caught up in self-blame, Matt also stated that his therapist helped him realize the root cause of his suffering: "the therapist pointed out the self-toxic judgment with me and he helped me understand how society's and my family's expectations pushed me out of the family home."

Subtheme c: Improvement in relationships

Accused people who suffer from mental health challenges tend to have relationship issues, which stem from anger and frustration, especially, given their experience of discrimination and stigma. Four out of the five psychotherapy clients who participated in the research reported a certain degree of improved relationships either with their friends, family, neighbors, or professionals in their circle of care after receiving psychotherapy. Besides having a good relationship with his first therapist, Teddy reported an improved relationship with his mother, whom he had previously cut off from his life. Before therapy, this is what Teddy said concerning his family: "to me, they are more poison to me than any kind of help. And I was not talking to any of my bloodlines." But after therapy, Teddy said, "Therapy helped me to correct my past, so I called my mom for the first time after many years".

Matt left the family home from a particular province in Canada and made his way to Toronto when he started College. This move-out affected the relationship between Matt and his parents. But during the interview, Matt discussed some positive changes that had taken place in his life after receiving therapy. With regard to his family, Matt pointed out: “My parents are still worried about me, so we have started talking. They send someone to visit me once in a while to talk to me on faith.” Frank also admitted to having anger issues prior to therapy, and he said one day, he "snapped" at his case worker on a minor issue in court. However, after receiving psychotherapy treatment, Frank said: “The skills I learned in the groups have helped me interact with people more effectively. For instance, I now rent with my mom, my sister, and her boyfriend, and my relationship with each of them is great.”

Subtheme d: Community participation

Four out of the five CDP clients who participated in the study reported that they feel part of the community because of some activities they are involved in or have been doing in the community. Ray said he volunteers his time at the Good Shepherd shelter supporting homeless men who are looking for a place to sleep. Teddy also shared that he secured a job in the community after treatment and completion of his CDP: "After that, I got a job at a restaurant and worked for about a year. I was working forty-five to fifty hours a week." Matt also discussed at length how he actively participated in the community through working and studying:" I took a part-time diploma program at the University of Toronto and completed it in 2018. I was also working at the same time when I was studying. I changed my job about two years ago". Frank, on the other hand, did not feel he is fully participating in the community, however, he shared that he has done some updated university courses, and he is currently doing employment training in his area of interest. All these activities make graduated CDP clients feel part of the community.

Subtheme e: Improved mental health

All five graduated CDPs who received psychotherapy experienced improved mental health. This is not surprising because improved mental health is one of the criteria that CDP clients must meet before they graduate from the program. As we read about Frank earlier, he stated his delusional thought and anger issues were addressed after receiving psychotherapy: "I deal with delusional thinking and anger issues at times. The nature of my charge was like a Threat, so attending the anger management group and learning some skills in the group did help for sure". Matt disclosed in the interview that he used to blame himself a lot, and this affected his mood and thinking pattern. But after receiving psychotherapy, Matt stated: "I learned in the therapy sessions that self-blame will offset me from reaching my goals. I stopped blaming myself and my parents". Kabir preferred to do psychotherapy when he declined medication at the court. Upon completion of his group sessions, he had this to say: "The group therapy helped improve my cognitive functioning as I began to learn new ways of reasoning that helped me to control my impulse, which in the past had led me into fighting and getting charged." Teddy also reported having control over his PTSD, which ultimately helped him to focus and leave his dogs home when he is at work. And for Ray, his mental health improved after gaining insight into the devastating effects of his excessive alcohol consumption.

Subtheme f: Reduced offending behavior

All five graduated CDP clients who received psychotherapy reported that they have not reoffended after completing the court diversion program. This may partly be a result of CDP clients gaining insight or improved mental health through psychotherapy. For instance, Ray remarked: "before, I thought I was not good enough". The feeling of inadequacy could make one vulnerable when it comes to making the right decision especially if one does not receive the needed help. But after attending group psychotherapy sessions, Ray said he was able to overcome his addictions issues and never committed any offense again. In answering questions about his experiences on his charges, and whether or not he has reoffended after completing his CDP, Teddy also said: “I try to steer away from the cops. I have not been involved in the justice system since I completed my diversion in 2016…. I know what happened and why it happened". Teddy's last statement echoes self-awareness and insight. Teddy is now trying to avoid the cops after receiving psychotherapy treatment and after completing his CDP program. Frank also shared earlier that anger and delusional thoughts predisposed him to get involved in the justice system, but after receiving treatment, he was able to avoid legal problems.

Subtheme g: Housing stability

Homelessness and housing became a recurring theme throughout the interview with the graduated CDP clients. Mental health improvement is not the only required condition for one to graduate from CDP. Finding housing sometimes also boosts CDP clients’ chances of completing their diversion program on time. All five CDP clients who received psychotherapy as part of their treatment shared that they experienced homelessness at one point or another in their life prior to completing their diversion program. Ray, for instance, highlights how the skills he learned in psychotherapy sessions went a long way to help him find housing: “The sessions helped me to suppress my ego. It helped me to learn how to talk to people, socialize, and acquired housing, which eventually helped me to settle in the community.” Teddy, who is currently stable in his apartment with his two dogs after learning some new skills in psychotherapy sessions reminisces:

> Now I can go out and I do not have to worry about my dogs or my apartment as much. And that is where the grounding technique comes. Just to let you know, my dogs and I were homeless for a long time moving from one shelter into a basement apartment and then taking over the whole house with my roommate only to get forced back into the same shelter I came from. I then found the apartment I live in now and got my therapy a few years after I moved here. So, I did gain a lot of knowledge about my PTSD from the therapy, and it helped me get reintegrated into the community.

Kabir succinctly expressed his housing experience in this way: “Life in a shelter came to an end as I found a beautiful apartment with government subsidy.” Additionally, the following is Matt’s own experience of homelessness and housing: “I showed up to court and attended my probation signing more promptly than before. I have an address because I got my own apartment, therefore, I was not thrown into jail again. Matt did not only tell his excitement about being housed, but he also tied how housing helped him stabilize in the community. Frank, on the other hand, shared that he was happy he could rent a home with his mom, sister, and his brother-in-law.

Subtheme e: Religious/spiritual lessons

Religion and/or spirituality meant different things to different participants of this study. Having received psychotherapy as part of their treatment plan, and having successfully completed their diversion program, two of the five participants who were interviewed (Teddy and Frank) said they were neither religious nor spiritual. The three other participants (Ray, Matt, and Kabir), on the other hand, discussed how their involvement in the justice system and the treatment they received taught them some religious /spiritual lessons. When asked to tell whether or not spirituality/religion played any role in understanding his mental health, his charges, and his successful completion of the diversion program, Matt disclosed that:

> I was brought up in a home where religion played an especially important role. Therefore, I believe in God. All that happened to me can be likened to the prodigal son. Things would have been different if I had not left the family. But my spiritual restoration is in process.

In answering a similar question above, Kabir also declared:

> I believe in God, and I do pray. Things happen in life sometimes that one is not prepared for. My health issues, the charges, and my experience in the court system taught me different lessons. But I am thankful that God listened to my prayers, and everything is over now.

Unlike Matt and Kabir, Ray rather perceived religion as a hindrance to his recovery until he rid himself of it and embraced spirituality. For Ray, it was a spirituality that he found helpful in his recovery journey as it is apparent from the following quote:

> One of the most effective treatments for people suffering from addiction is changing their environment. CDP program did not save my life; it changed the way I was living my life. I was a Roman Catholic by choice but when I discovered Spirituality (deal with intangible - the no material part of the human being - emotions - feelings) everything changed.

Ray continued his story with his perception of the nature of the problem confronting CDP clients: “I used to be a Catholic, but I do not practice religion again. Religion is outside (illusion) while Spirituality is inside (reality - here and now - without involving the Intellect - Ego). CDP clients’ problem is inside.”

In sum, graduated CDP clients who received psychotherapy as part of their treatment plan expressed feelings of fulfillment and satisfaction as they shared their experiences by highlighting key areas where they have made some life accomplishments. Some of these accomplishments include, but are not limited to successful completion of CDP, insight, improved relationships with family members and/or professionals, community participation, improved mental health, reduced offending behavior, housing stability, and religious/spiritual lessons.

Theme #5: Reframing reintegration in the context of wellbeing

It was part of the researcher’s curiosity to understand what belonging to the community means to the graduated CDP clients and whether or not psychotherapy supported their community reintegration. Six sub-themes emerged from the interview as to how the psychotherapy participants perceive community reintegration.

Subtheme a: Being employed or volunteering

Some of the participants shared that working or volunteering after completing their diversion program makes them feel integrated into the community. Ray, for instance, was excited about his volunteer role at the homeless shelter and he was looking forward to continuing his position after Covid 19 restrictions are relaxed. Teddy felt integrated after completing his diversion because he “got a job at a restaurant and worked for about a year”. Teddy also expressed that the community members’ appreciation of who he is, also makes him feel belonging. Kabir said: “I was able to find a part-time job in the beginning, and later established my own security company.” Thus, being able to establish his own security company after working part-time made a huge difference in Kabir’s community reintegration.

Subtheme b: Family reunion

Some of the CDP clients reported that they had relationship issues with their family members prior to receiving psychotherapy treatment. For those clients, being able to reconnect with their family means a lot in their community reintegration. Matt, for instance, said: “My parents are still worried about me, so we have started talking.” After completing his treatment, Matt attended school and secured a job, and yet his reconnection with his family is still playing a crucial role in his community reintegration. It was, however, striking to learn from Frank that though he was reconnected with his mom, sister, and brother-in-law that did not mean reintegration for him. Frank said: “I do not feel integrated as I am supposed to. Specific example is my social isolation that is a kind of an ongoing battle that I have to deal with.”

Subtheme c: Being respected/appreciated

Among the five CDP psychotherapy clients, Teddy was the only one who expressed this subtheme. In his description of how he feels integrated, Teddy said “People in my community know that I am a good guy. People tell me “You got a good heart” So I feel belonging to my community.”

Subtheme d: Guaranteed income

Most of the participants highlighted the importance of income to their community reintegration. Both Matt and Teddy worked very hard to raise income after receiving treatment. Kabir emphasized the importance of securing funding when he was first housed, and he also stated: "I stopped receiving Social Assistance (Ontario Works) because I became financially independent. I work Monday to Friday now, and I am able to save some money." Frank also mentioned earlier that he could say he was fully integrated as long he does not have money to pay his bills: "To be honest, I do struggle to pay my bills". Thus, in the absence of guaranteed income, life will be difficult for graduated CDP clients.

Subtheme e: Affordable Housing

With their experience of homelessness prior to being housed, all five participants who were interviewed endorsed affordable housing as crucial to their community reintegration. Matt, for instance, shared that finding housing with secure funding ensured his housing stability and community reintegration. Frank could not have afforded housing if he did not rent with his relatives. The following quote explains Frank's situation well:

> I have learned different skills like budgeting and how to save money, but it is challenging to save when you are on such a low income as I am right now. To be honest, I do struggle to pay my bills, and I am fortunate that I have a living situation that I have. I rent an apartment with my mom, and this is how we get by...eh!

Subtheme f: Enrollment in a training program/education

As we read earlier, some of the graduated CDP clients consider education and employment training as part of their accomplishments and community reintegration. Matt, for instance, mentioned this during the interview: "I took a part-time diploma program at the University of Toronto and completed it in 2018. I was also working at the same time when I was studying."

From the following quote, Frank also describes his expectation of community reintegration:

> I feel very isolated, and I blame myself for that. I don't get out of the house early as I am supposed to. That's a kind of where I am at in my life at the moment. I am trying to get employment or go back to school.

Frank feels that going back to school or finding a job is a way forward to overcoming the isolation and getting integrated into the community.

In sum, graduated CDP clients who received psychotherapy as part of their treatment plan are currently living in the community, but whether or not they feel integrated depends on the individuals' circumstances, dreams, and aspirations. What makes one feels integrated in the community may differ from another. Nonetheless, there were some common recurring subthemes among the participants as to what community reintegration means to them. This includes employment or volunteer activities, family reunions, earning respect or being appreciated by one's community members, guaranteed income, stable or affordable housing, possession of a property, and enrollment in training or education programs.

Theme #6: Barriers to navigating psychotherapy services

As graduated CDP clients (who received psychotherapy as part of their treatment regime) shared their experiences about their involvement in the justice system, their appearance before the court, their enrollment in the court diversion program, and their successful completion of CDP, four main barriers became apparent.

Subtheme a: Limited choice

When it comes to options available for CDP clients regarding treatment, four out of the five participants who were interviewed shared that they had limited options in the area of treatment decisions. It appeared CDP clients were persuaded to receive pharmacotherapy treatment prior to receiving psychotherapy. Teddy, for instance, said that he was already doing psychotherapy when he came to the court. However, he was still asked to see his physician. When asked about the options offered him when he enrolled in the CDP program, Kabir stated: “I cannot say I had enough options to choose from as far as treatment is concerned.” On the same subject matter, Ray, who was referred to psychotherapy service by his psychiatrist, looked back and said: “Given my condition at the time, there were no other options for me when I came to the court.” In the same vein, Frank also disclosed that: “I was recommended to take the anger management course and continue to talk to my doctor.” Thus, seeing a medical doctor seems to be a key component of the CDP program.

Subtheme b: Insufficient funding

Some of the CDP clients expressed that they could not have afforded the cost of their psychotherapy service if it was not funded by an agency or a community organization. Frank, who earlier said he struggles to pay his bills, informed the researcher that all the psychotherapy sessions and the programs he attended “were funded by the hospital and not-for-profit organizations.” Matt, on the other hand, stated his therapist was sensitive to his financial status at the time, therefore, he used a sliding scale to charge a small amount of money based on Matt’s income at the time. In describing his experience of psychotherapy sessions, Teddy said “It was one on one for about 1.5 years.

It was funded through the CMHA, otherwise, I could not have afforded it. They said psychotherapy can be expensive." Teddy's quote clearly spells out how funding could be a barrier for CDP clients who want to navigate psychotherapy services.

Subtheme c: Mental health status

The study revealed that when CDP clients appear at court, their mental health status and/or how they present emotionally and cognitively more or less determines their treatment modality. As some court support workers indicated earlier during the data collection, it appears that pharmacotherapy (rather than psychotherapy) is recommended for clients showing severe symptoms of mental illness. For instance, because of the nature of his mental health crisis, Frank said he was hospitalized first before he attended the group therapy sessions, which were run at the hospital. Also, because of his "confused" state of mind, Ray said he saw a psychiatrist first, who later referred him to a psychotherapist. On the contrary, Kabir, who was relatively mentally stable at the time of his CDP enrollment was able to insist on doing psychotherapy after successfully refusing pharmacotherapy.

Subtheme d: The influence of medication

As previous studies (Leroux, 2008) have shown, pharmacotherapy is the main treatment model for CDP. All five participants who were interviewed expressed their experience in one way or another about this subtheme. When Frank was hospitalized, he received pharmacotherapy treatment before he was referred to a psychotherapist. In dealing with his struggle with substance use, Ray also said he was first connected with a psychiatrist, who then later referred him to a psychotherapy group. Matt had a previous experience with psychotherapy and wanted to repeat it when he came to court. However, Matt said: “My court support worker was ok with my choice as long as I continue to see my family doctor and my bail supervisor.” When Kabir enrolled in CDP, he said his CSW wanted him to go and see a psychiatrist, but he declined and opted for psychotherapy treatment instead.

In sum, even though psychotherapy looks promising for CDP clients with mental health issues and offending behaviors, there are some barriers that confront them as they try to navigate psychotherapy services when they enroll in the court diversion problem. These barriers include but are not limited to limited choice/options in choosing psychotherapy as their treatment plan; insufficient income to fund the cost of psychotherapy; clients’ mental health status when they come to the court; and the influence of pharmacotherapy in the court diversion program.

Theme #7: Hope after completing the CDP

To better understand graduated CDP clients’ reintegration experience, the participants were asked to discuss their hopes following their participation in the court diversion program. Five main subthemes became apparent in the study.

Subtheme a: Return to School

One out of the five participants (Frank) expressed the desire to return to school. Frank stated he wants “to return to school to complete my university degree.”

Subtheme b: To volunteer or find a job

Two out of the five clients who were interviewed said that they either want to volunteer or find a job. In his response to the question about his hope after completing diversion, Ray stated: “I am waiting for the lockdown to reopen then I can continue my volunteer work and improve my life condition." Frank also verbalized that he needs to return to school or find a job before feeling integrated into the community.

Subtheme c: Establish own business

One out of the five participants (Teddy) said "Right now, I am networking to establish my own business." After working for some time, Teddy is also planning to become a sole dealer of a device that will make use of solar energy to recharge batteries for bicycles and automotive.

Subtheme d: Settle and raise a family

Matt was the only participant who shared this theme i.e. In answering the question about his hope after graduating from CDP, and doing some financial planning, Matt said also wants to "get married and raise a family"

Subtheme e: Financial planning and/or acquiring property

Two out of the five participants expressed this subtheme. Matt specified what financial planning entails for him: "To build my credit and get a mortgage" On the same subtheme, Kabir also said "To continue working, save some money and become financially independent. I don't want to receive social assistance anymore."

In sum, the question of hope after completing the diversion elicited different responses from the five participants who received psychotherapy as part of their treatment plan. However, all the responses seem to suggest that graduated CDP clients have some unmet needs that they still want to work on in their community reintegration process. Among others, these unmet needs include returning to school, volunteering or finding a job, establishing their own business, settling, and raising a family, financial independence, and property acquisition.

Description of Themes and Subthemes of CDP pharmacotherapy clients

The following table presents the summary of themes and subthemes of the five participants who received treatment as usual (medication) when they enrolled in the court diversion program.

Figure 4: Summary of Themes and Sub-themes--CDP pharmacotherapy clients

	Themes	**Sub-themes**	**# of times sub-theme occurred**
1	Why CDP clients enroll in pharmacotherapy	a. Persuasion from CDP workers	5
		b. Compliance with CDP	1
		c. Prior pharmacotherapy experience/treatment	3
		d. Severity of mental illness	4
		e. Severity of charges	3
2.	Participants' experiences in pharmacotherapy	a. Regular appointments	5
		b. Negotiating medication change	3
		c. Firing health professionals	2
3.	Satisfaction for & accomplishments through pharmacotherapy	a. Successful completion of CDP	5
		b. Insight	2
		c. Improvement in relationships	3
		d. Sense of belonging to the community	3
		e. Improved mental health	5
		f. Reduced offending	4

		behavior	
		g. Housing stability	5
		h. Religious/spiritual lessons	3
		I. Liberation/freedom from CDP expectations	3
4	Pharmacotherapy clients' feelings about reintegration	a. Not integrated	1
		b. Partially integrated	2
		c. Fully integrated	1
		d. Not applicable	1
5.	Challenges expressed by CDP pharmacotherapy clients	a. Medication side effects	3
		b. Strained relationships with health professionals	3
6.	Hope after completing CDP	a. Find a job	3
		b. Freedom/autonomy	2
		c. Never to return to CDP	1

Theme # 1: Why/how CDP clients enroll in pharmacotherapy

While pharmacotherapy seems to be the main treatment method for clients who enroll in CDP, the experiences shared by the participants of this research presented five main subthemes as to why or how they came to receive medication for their treatment.

Subtheme a: Persuasion from CDP workers

All five participants who were interviewed responded that when they enrolled in the court diversion program, they were asked to continue seeing their psychiatrist or their family doctor. Consequently, they were prescribed with medication, and that was how they received their treatment. Albert, for instance, stated he started taking mental health medication as a student when the teachers saw that “something was wrong with him”. Therefore, it was not new to him when he was asked to receive medication treatment at the time he came to court. Rod also shared: “I was told to go and see my doctor and continue with my medication. They told me that I have to bring a letter from my doctor to confirm that I have actually met with him.” Rod gave a specific example of the types of medication his doctor prescribed for him. The same applies to Douglass in his experience of medication treatment when his drug use impacted his psychotic condition. Douglass said: “They told me to see a psychiatrist, who diagnosed me with Schizophrenia and started giving me medication (Olanzapine, Clonazepam etc.)”

Subtheme b: Compliance with CDP

One out of the five participants (Eric) shared that he just surrendered to the court to take the medication to conform to the court’s expectations. Eric stated categorically that:

> In all cases with the CDP, I chose pharmacology because it was the easiest and most viable option in terms of treatment, and it also brought about my loyalty to the program. When I came to the court, I learned that the emphasis was on treatment through medication, so I just had to comply.

Though Eric accepted pharmacotherapy treatment, it was not only because he wanted to be loyal to CDP, but he also thought it was the most convenient and easiest way of treatment.

Subtheme c: Prior pharmacotherapy treatment

As it was found among CDP psychotherapy clients, three out of the five participants who were interviewed said they received pharmacotherapy treatment in CDP because they had previously been treated with medication in the past. For instance, Albert stated he started taking mental health medication early as a student when the teachers figured out that "something was wrong with him." Albert explained:

> Therefore, when I came to the court, medication was a default treatment option for me. I was very sick, I personally did not object to the meds because I thought it will help me better than therapy. In fact, I haven't done much psychotherapy.

Rod also expressed that he had experienced manic for years, and his treatment has always been pharmacotherapy. Rod said his reluctance to treatment made the court request doctor's note to prove that he visited the clinic. Douglass also started receiving medication in jail before he got released. So, he said when he came to the court, he was asked to continue with his medication.

Subtheme d: Severity of mental illness

Just as it was found among psychotherapy clients, a client's mental health status at the time they appear in court greatly determines the type of treatment required. It was discovered that some of the graduated CDP clients received pharmacotherapy treatment mainly because of their severe mental health conditions. In the quote below, Douglas describes his mental state when he came to the court:

> I felt like I was getting mad. I got charged with Weapons, so they brought me to court after spending two weeks in jail. They told me to not smoke weed or drink beer. They saw me yelling and doing all sorts of bad things. They told me to see a

> psychiatrist, who told me that I have a Schizophrenia, so they started giving me medication.

Albert also described his mental condition, his offense, and how he got arrested. He said he took a swing at someone and barricaded himself in a room. Albert stated he had also been drinking at the time and damaged property in the house (boarding home). And when the police came, he also gave them a hard time before he was finally arrested. Thus, with regards to his treatment with medication, Albert admits that: "I was very sick, I personally did not object to the meds because I thought it will help me better than therapy."

Subtheme e: Severity of charges

As we read from the above quotes of both Douglas and Albert, it is clear that not only does a person's mental status determine their treatment option, but the nature of their behavior and/or their charges as well. The severity of clients' charges oftentimes links them to prolonged hospitalization and treatment. Albert was drinking and fighting; he destroyed property, barricaded himself in a room, and resisted police arrest. Hence, Albert was placed on medication for treatment. Rod also shared: "I used to hit people and kick furniture here and there. My partner thought I was too crazy, so she left our apartment to go and live in a shelter for a while." Given his behavior, Rod said he not only received medication for treatment, but his medication dosage was also increased.

In sum, the study shows that CDP clients get hooked up with pharmacotherapy for diverse reasons including but not limited to, persuasion from the court diversion program staff, clients' conformity to the expectation of the CDP program, clients' previous experience and familiarity with pharmacotherapy, clients' mental health status, and the severity of charges that brought CDP clients to the court.

Theme # 2: How CDP clients participate in pharmacotherapy

As graduated CDP pharmacotherapy clients shared their experiences during the interview, three main subthemes became apparent with regards to how they participate in the treatment through pharmacotherapy

Subtheme a: Regular appointments

A regular appointment with their doctors was a common thread among the responses of the participants. Sometimes, CSWs may assist clients in booking these routine appointments for the clients. Community case workers also escort clients for such medical appointments, especially if clients are not motivated or are not so well.

Subtheme b: Negotiating medication change

Even though a few pharmacotherapy clients expressed feelings of persuasion/ compulsion to see a psychiatrist, some participants actively participated in the program by negotiating their medication change. For instance, Rod discussed how his medication got changed by his psychiatrist: "one day, I asked her to prescribe me a particular medication to which she refused. I became rude to her and left the clinic." Rod persisted until he finally got his medication reviewed. Albert, on the other hand, had a related experience but in a different way. Contrary to Rod, Albert wanted to stay on a particular psychotic medication though his doctor wanted to wean him off. Albert said he persisted until he disengaged with his psychiatrist.

Subtheme c: Clients firing health professionals

The firing of health professionals including psychiatrists is another subtheme that came up during the interview with graduated CDP pharmacotherapy clients. Albert, for instance, not only disengaged with his psychiatrist, but he also shared that:

> My relationship with the psychiatrist was good. But something happened to me that made me lose my temper and fired my psychiatrist. I kind of wanted to continue with the meds but the doctor wanted to take me off the anti-psychotic medication, so I became mad and fired him. I haven't had a psychiatrist since then, but I think I need one.

At the time of the interview, Albert said he still had not been able to find another psychiatrist. Albert said he is now being followed up by another doctor at a Methadone clinic.

Part of Rod's story is that he is not conscious of his obsession with high sedative medications. Rod has had a couple of psychiatrists within the last few years during which he enrolled in the court diversion program. And Rod said he always gets rid of the doctors who would not prescribe him with the medications he is used to.

In sum, based on the findings from the participants of this study, graduated CDP pharmacotherapy clients who participate in CDP are not passive, they take active part in their treatment protocol either by attending routine appointments, negotiating medication change, and/or disengaging or firing their psychiatrists when necessary.

Theme # 3: Satisfaction for & accomplishments through pharmacotherapy

When asked to tell their feelings and experiences of how pharmacotherapy supported their enrollment in CDP and their reintegration into the community, several subthemes came up from the responses of graduated CDP pharmacotherapy clients. Here are the experiences and thoughts of the five participants who were interviewed:

Subtheme a: Successful completion of CDP

Just as it was noted about psychotherapy clients, successful completion of CDP was one of the requirements for clients to participate in this study. In the same context, all five graduated CDP pharmacotherapy clients who partook in the study said that pharmacotherapy did help one way or another in their successful completion of the diversion program. The following quote presents Douglas' description of how he benefited from his medication treatment: "The change in medication helped calmed me down. All the confusion and paranoia feelings minimized, so I was able to stop drinking and smoking. And once I stopped that, I did not get into trouble again." Rod stated that "In some way, the medication did help me in addressing my charges.". Eric also shared that he felt the urge to take his medication at the court, so he noted: "with that push, I felt obliged to take the meds and it ultimately helped me address the issues that brought me to the court."

The experience of Albert captured on this subtheme needs to be flagged: "I do not think that my medication helped to address these issues that brought me to the court. This is because I see these behaviors as different problems." Even though Albert was able to complete his CDP, he does not believe that medication was of any help to him in addressing the issues that brought him to court. This is an indication that successful completion of CDP does not necessarily imply a total recovery for CDP clients.

Subtheme b: Insight

Two participants shared that they became insightful about their situation upon completing the CDP program and pharmacotherapy treatment. Don, for instance, said about his medication that “It helped me in some ways. I can understand things now and relate better with people.” After navigating the social services and the health care system in support of his enrollment in CDP, Eric also became insightful and made an important comment with regard to his choice of treatment: “I chose pharmacotherapy because it was the easiest and most viable option in terms of treatment.” Eric did not seem to have a good experience during his time with the CDP program, however, he still believes that medication was the right choice of treatment for him.

Subtheme c: Improvement in relationships

While some CDP pharmacotherapy clients reported a positive relationship with people around them, some rather discussed their experience of problematic relationships. Rod could not maintain a good relationship with the professionals in his circle of care, however, with respect to his partner, Rod said: “I do have a good relationship with my common-law partner.” Albert struggles with his relationships, but in the following quote, he attributes that to the effects of his medication:

> medication could not help me establish relationships. It is hard for me to make friends because I can’t love, I can’t smile, it is hard to be happy because the anti-depressant medication makes one numb, so it can’t help you relate with other people.

Albert, however, noted how medication can be beneficial for him when it comes to relationships: “The only benefit I got from the medication was that it helped me to forgive others of what they have done against me.”

Unlike Rod and Albert, Douglas and Pearson did report positive relationships after their pharmacotherapy treatment. Douglass declared: “My relationship with my doctor and other people has been good especially after the medication was changed.” In the same token, Pearson also said: “My relationship with my mother got better. I was visiting and talking to her more often. Also, I still keep in touch with my court and community workers who helped me.”

Subtheme d: Sense of belonging to the community

Except for Albert, who “feels left out” and Rod, whose partner is the only person in his life, the rest of the graduated CDP pharmacotherapy clients pointed out specific examples to show how/why they feel belonging to the community. From the quotation below, Douglas articulates his experience very well:

> The people I live with make me feel part of the community. Most people do not speak French, it feels lonely sometimes. Otherwise, I can go wherever I want to go without any issues. I use the same TTC bus, library, grocery shops and others as everyone else. This makes me feel part of the community.

Douglas’ first language is French, which sometimes limits his socialization with the dominant English-speaking people in Toronto. Apart from that, Douglass has a sense of belonging to the community in different ways as he has outlined. For Eric, it is taking part in the “essential needs of the community and being respected” that makes him “feel somewhat integrated into the community.”

Subtheme e: Improved mental health

All the participants who were interviewed said their mental health improved upon receiving medication for treatment. Pearson noted that “of course, medication helped my depression which resulted from life in the shelter”. Not only did medication help improve the relationship between Eric and his family, but he also shared that medication helped with the treatment of his Schizophrenia. The following quote illustrates the transformation of Rod’s life after receiving medication for his Bipolar:

> I used to hit people and kick furniture here and there. My partner thought I was too crazy, so she left our apartment to go and live in a shelter for a while. They told me my medication dosage was too low, but when it was increased, things got better and my manic was brought under control.

As pointed out in the findings from the CDP psychotherapy clients, improved mental health is a significant factor in graduation from the CDP program. Therefore, all the participants of this study must have attained some degree of mental wellness as CDP graduates.

Subtheme f: Reduced offending behavior

Four out of the five participants shared that their treatment with medication resulted in a reduction in their offending behavior. After sharing his pain resulting from his enrollment in CDP, Eric, for instance, admitted that medication “ultimately helped me address the issues that brought me to the court.” After being placed on medication treatment, Douglass did not initially see any changes until his medication was changed for him. Thus, Douglas narrates: “The change in medication helped calmed me down. All the confusion and paranoia feelings minimized, so I was able to stop drinking and smoking. And once I stopped that, I did not get into trouble again.” Rod also shared earlier that his manic was brought under control after receiving medication treatment.

Subtheme g: Housing stability

All the participants who were interviewed attested to the fact that they attained housing stability upon receiving treatment through pharmacotherapy. Albert said “meds help keeps me stable” when it comes to housing. After he was released from jail and enrolled in CDP, Douglas said “I spent six months in the shelter. My compliance with treatment and cooperation with other workers helped me to find housing.” Douglass confirmed that he had not moved out or been evicted since he moved into his current apartment. And Rod has successfully returned to his partner’s apartment after a long-standing legal condition was removed.

Subtheme h: Religious/spiritual lessons

While Eric and Rod noted no religious or spiritual connotations associated with their mental health condition, their charges, treatment, and their community reintegration experience, three other participants had something to share. Pearson said he is a Christian, and this is how he interprets his experiences he went through especially when he reflects on how his girlfriend called the police for his arrest: “I felt that I was being tempted. I prayed a lot and read my Bible and other Christian literature. And I believe God answered my prayer by saving my life and giving me another chance to live.” Douglas also disclosed his religious/faith identity as a Christian and below are the spiritual/religious lessons he learned:

> I am a Christian and I go to Church. Considering what happened to me….my addictions behavior, my charges, treatment, and community settlement, all I could say is that all things work together for good for them that love God. Because if I did not come into contact with the law, I would not have received treatment, housing, and all the support I have today.

For Albert, his faith helped him to complete the CDP program. In his own words, Albert said "I believe in God, and my faith keeps me strong in going through hard times. That was why I was able to complete the CDP when I was brought to the court.".

Subtheme i: Liberation/freedom from CDP

From the researcher's perspective, completion of CDP was considered a success since not all clients who enroll in the program are able to complete it. The data collected from the participants with regards to this subtheme appears paradoxical, for, in one way, CDP pharmacotherapy clients expressed joy for receiving treatment, which helped them accomplish many things in their recovery journey. And yet, some of them also expressed some feelings of freedom for doing away with CDP. Eric, for instance, expressed this thought by saying:

> My main hope is that I never have to go through the CDP again. It was not an easy experience for me. I just want to enjoy my freedom and live a peaceful life without having no one to report to etc.

Rod had mentioned earlier how happy he was when his manic was brought under control and was able to join his partner after receiving treatment. However, when he was asked to tell his feelings about completing his CDP and moving into the community, Rod expressed this paradoxical feeling: "On the one hand, I felt relieved for that liberation. On the other hand, I was a bit nervous because of all the suspicion. The good thing is that my community members know that I have a mental illness." In the same vein, Douglas also said: "For me, transitioning from the legal institution into the community feels like a bird out of the cage. I feel a kind of freedom that words cannot describe." That is how the

CDP pharmacotherapy clients expressed their freedom and liberation from the legal system.

Theme # 4: CDP pharmacotherapy clients' feelings about reintegration

As part of the objectives of this study, the researcher was curios to uncover graduated CDP clients' feelings about how pharmacotherapy supported their reintegration into the community, and if it did not, what must have got in the way. And from the responses of the participants, four subthemes were gleaned.

Subtheme a. Not integrated

Among the five pharmacotherapy clients who were interviewed, Albert was the only one who stated that he does not feel integrated at all. Albert explained why he does not feel being part of the community:

> I feel like I am left out when it comes to community reintegration, because I do not have a job, I do not contribute to society and do not have friends. I need friends, a house, a job, and a car like anybody else in order for me to feel part of the community.

Albert seems honest here because his unmet needs (i.e., job, friends, housing etc.) are very similar to the accomplishments, which other participants cited to support their feelings of community integration and belongingness.

Subtheme b. Partially integrated

Two participants expressed this subtheme. Though Douglass lives in the community after his successful completion of CDP, his ultimate goal suggests that he is still transitioning: "My hope is to settle well in the community and get to know more people who will be able to help me find a job and become more stable.". Eric also discussed some issues that must have gotten in the way of his reintegration. And since he is slowly overcoming now, his response was that: "I feel somewhat integrated in the community."

Subtheme c. Fully integrated

Among the five graduated CDP pharmacotherapy clients who were interviewed, Pearson was the only one who was able to declare with confidence that he is well-integrated. Pearson proved this by saying: "I have a job, I have a stable income, and I can access community resources and all facilities just like anyone else. Therefore, I feel integrated in the community."

Subtheme d. Not applicable

A close examination of my interactions with Rod revealed that he is still trying to "fit into the community". He was not able to clearly articulate why he feels integrated though he appreciates the fact that his partner and his medication did help in his completion of CDP and his return to the community.

In sum, graduated CDP clients who received medication for their treatment responded differently to the theme of reintegration. Some felt not integrated at all, others felt partially integrated, and some felt fully integrated while others are still trying to fit into the community.

Theme # 5: Challenges expressed by CDP pharmacotherapy clients

An interview with graduated CDP clients who received pharmacotherapy treatment also revealed some challenges they faced, especially in the area of treatment, reintegration into the community and their relationship with some professionals. Two main subthemes came up under this theme.

Subtheme a: Medication side effects

Three of the five participants shared their experience of medication side effects. When Albert was asked whether or not pharmacotherapy played any role in his consideration of education, apprenticeship, employment, or volunteerism, Albert narrated his experience of medication:

> Oh God! I wouldn't have ever taken medication if I were to go back to the CDP. The reason being that I have low energy because of medication. I can't do jobs or anything because I have no energy. Like, like, because of the medication, I can't get motivation to do anything because I am so tired all the time because of medication. I don't even have the energy to shower. I stopped taking it and got rid of them without telling the pharmacist because I don't want them to give me a "shi…t".

In spite of the above, Albert is still considering reconnecting with his doctor and his pharmacist because he realizes that medication helps him in some way. When Eric was asked the same question, this was his response: "I think some of the side effects such as weight gain and pain from taking needles may have got in the way at the start." Thus, Eric also felt that his community reintegration and his attempt to consider education, apprenticeship, employment, or volunteerism was impacted by medication side effects. Also, when Douglas was sharing his experience with pharmacotherapy treatment, he said: "I started with injections, but I was seeing things, hearing voices, and feeling bad.

Therefore, the doctor changed it and put me on pills". Douglas is stable now after being switched from injections to pills.

Subtheme b: Strained relationships with health professionals

Some of the participants who received medication for treatment reported having relationship issues, especially with their professionals. For instance, even though Rod had no issues living with his partner, he reported having relationship problems with his doctors. Within a short span of time, Rod changed a couple of doctors because of relationship issues. Albert also had a similar experience of relating with his psychiatrist as well. Hence, he said he became mad and fired his psychiatrist when the psychiatrist tried to take him off his antipsychotic medication. Albert also said his medication did not help him in terms of friendship or relationship building: "medication could not help me establish relationships. It is hard for me to make friends because I can't love, I can't smile."

Though graduated CDP clients who received medication as their treatment model experienced great benefits in different ways, these few reports speak volumes about how some of them were impacted by side effects.

Theme # 6: Hope after completing the CDP

Just as this theme was explored among CDP psychotherapy clients, the researcher asked CDP pharmacotherapy clients also to discuss their hopes following their participation in the court diversion program. Three subthemes became apparent from the responses of the participants.

Subtheme a: Return to school

One out of the five participants who were interviewed stated their hope is to return to school.

Subtheme b: Find a job

Three clients expressed this subtheme in different ways. Albert said he was hoping to find a part-time job when certain conditions are met: “I am thinking of getting some part-time job, but I can’t get out of the house, and I also do not have a resume.”. Pearson was already working, but his hope was to change jobs and pursue other goals: “To look for a better job, get my driver’s license back, and move out of the province.”. In answering the same question, Douglas also said: “My hope is to settle well in the community and get to know more people who will be able to help me find a job and become more stable.” Douglas believes that he will be able to find a job if he connects with more people in the community.

Subtheme b: Freedom/autonomy

Eric and Rod expressed their need for freedom and/or personal autonomy after treatment and completion of the CDP program. Rod said, “My hope is to be able to return to the places where I was restricted from going in the past.”. When Eric shared his hopes, he ended his narrative by saying: “I just want to enjoy my freedom and live a peaceful life without having anyone to report to” etc. Here, Eric is referring to the regular court appointments that CDP clients must commit to at the court on a regular basis until they complete the diversion program.

Subtheme d: Never to return to CDP

Among the five participants, Eric was the only one who expressed this hope. When asked to discuss his hopes following his participation in the court diversion program, Eric shared: “My main hope is that I never have to go through the CDP again. It was not an easy experience for me.” Eric said he was not pleased with the court attendance and all the CDP expectations he had to commit himself to.

Summary

All in all, this chapter has presented the summary of themes and subthemes of an interview with graduated CDP clients who enrolled in and completed their court diversion program in the City of Toronto within the last five years and are currently living in the community. Part one of this chapter presented the lived experience of five graduated CDP clients who received psychotherapy as part of their treatment. Part two of this chapter also presents the summary of themes and subthemes of the other five graduated CDP clients who received treatment as usual (medication) when they enrolled in the court diversion program. A close look at the themes and subthemes reveals some common similarities and slight differences, which will be discussed in Chapter five of this study.

Chapter 5: Discussion of the findings

Introduction

Knowledge of, experience with, and concern about clients living with mental health issues and offending behaviors aroused my interest in this field of research. This began after several years of my work with Court Diversion Program (CDP) clients and close observation of how these clients enroll and participate in CDP, and how they settle, adjust, and integrate into the community.

I read that psychotherapy is effective for the treatment of mental illnesses and offending behaviors (Feingold & Fox, 2018; Feucht & Holt, 2016). However, with my twelve years of work experience as a community case manager serving people living with mental illness and offending behaviors, I did not see many CDP clients receiving psychotherapy treatment. My observation raised several perturbing questions that I did not have answers to. First, I noticed that CDP clients hardly access psychotherapy services when they come to court despite the effectiveness of psychotherapy in the treatment of mental illness and offending behaviors. Second, I noticed and the reviewed literature (e.g., Leroux, 2008) also confirmed that CDP clients receive medication as the main treatment plan when they encounter the law. Third, earlier studies in the mental health and justice field did not show any evidence of how CDP clients experience psychotherapy even though psychotherapy is effective in the treatment of mental illness and offending behaviors. And learning how researchers such as Burns et al., (2013); Gottfried, et al., (2014); Redlich et al., (2010); and Ryan et al., (2010)) attribute the success of CDP to several factors other than psychotherapy, I became curious and wondered about this missing gap in the justice system as far as this population is concerned.

Purpose of the study

My curiosity was taken to the next level when I set up the goal to find out if there be any CDP clients who have accessed psychotherapy and to explore how those clients find psychotherapeutic approaches to treatment when they enroll in the CDP program. My main purpose in this study was to discover how graduated CDP clients in the City of Toronto experience psychotherapy as they integrate into the community. Specifically, this study sought to explore why clients choose psychotherapy, how they experience their participation in this form of treatment, and the impact (if any) of psychotherapy on their community reintegration after encountering the criminal justice system. The main research question was: what are the lived experiences of graduated CDP clients who receive psychotherapy as part of their treatment plan for their community reintegration compared to those clients who do not receive psychotherapy but treatment as usual (medication)?

Thus, using the qualitative comparative framework of Goodrick (2014), Merriam (2009), and Remenyi, (2013), this chapter will review, analyze, and compare the data for patterns that reveal group differences in the experience and outcomes of psychotherapy and pharmacotherapy modes of treatments for graduated CDP clients in Toronto as they integrate into the community. Such an exploratory comparative study is intended to serve as a guide toward the incorporation of psychotherapy in the court diversion program in the near future.

Enrollment in CDP and the choice of treatment

The reviewed literature provides brief information on how clients with mental health issues come into contact with the law and enroll in CDP. Experience has shown that not all CDP clients get diagnosed through the healthcare system. Some clients get diagnosed only after they have come into contact with the criminal justice system. Sometimes people living with severe mental illness come into the psychiatric system through an encounter with the police before they are assessed, hospitalized, and/or treated. Police officers may get calls from friends, professionals, neighbors, and family members of clients, to assist in addressing seeming problematic behaviors of this population. Such behaviors may be misconduct, inappropriate gestures, violations of civil rights, and so forth. Munetz and Griffin (2006) note that police officers have the option of sending clients who are in a crisis situation to jail or connecting them to community resources. Mental health clients with minor offenses who are not linked to community resources may get charged and end up in court and eventually enroll in CDP.

The pertinent question is: do clients with mental health issues and offending behaviors have the right to choose their own treatment options when they enroll in CDP? The noun “choice” as applied in the above subheading was used prior to the data collection. This was because after speaking with CDP key planners at the court, the researcher presumed that every client may have the liberty to make their own choice of treatment when they enroll in CDP. In consultation with the key planners of CDP, the researcher learned that mental health improvement is one of the key objectives of CDP. Therefore, improved mental health condition is an expectation from clients who enroll in CDP. The Crowns explained that treatment is more important to them than how clients are treated. The Crowns also emphasized that CDP clients may choose their treatment plan in consultation with their court support workers.

However, an interview with the graduated CDP clients themselves who participated in this study threw more light on the Crowns' explanation. In what follows, I discuss the experiences of those who received treatment through psychotherapy as well as those who received pharmacotherapy treatment.

The experience of psychotherapy clients on choice of treatment

The findings from the study revealed that psychotherapy clients enroll in CDP through different routes and for different reasons, and the treatment they receive also depends on factors such as the nature or severity of the charges as well as the severity of one's mental health issues. Below are how the participants of this study got connected to psychotherapy services when they enrolled in the court diversion program:

- Referral by a psychiatrist
- Self-referral (previously used psychotherapy as a coping strategy)
- Self-referral due to medication side effects
- Personal choice after refusing medication treatment

Among the participants who received psychotherapy, Ray shared that he enrolled in psychotherapy through a referral by his psychiatrist. This implies that Ray was not aware that he could benefit from psychotherapy, nor did he know psychotherapy may be one of the intervention programs that clients in CDP may consider as a treatment modality. Teddy and Kabir also enrolled in psychotherapy through self-referral. However, whereas Teddy did psychotherapy due to his experience of medication side effects, Kabir said he enrolled in psychotherapy after refusing pharmacotherapy treatment. Kabir's enrolment in psychotherapy came from his own initiative and persistence. Kabir must have gone through a lot by standing on his grounds at the court. In the psychiatric and the healthcare system in general, one could make themself vulnerable if they refuse a prescribed or recommended treatment. Terms like “noncompliance” “difficult to serve” etc. are commonly used to describe people like Kabir. Kabir, however, appears to be one of the few fortunate clients who enrolled in the court diversion program and have the opportunity to encounter compassionate, caring, and dynamic court support workers who have strong training in client-centered and recovery principles. Therefore, Kabir was allowed to look for his own preferred treatment (psychotherapy).

Other psychotherapy clients, Matt and Frank also shared a common experience. Both said they had previously used psychotherapy and found it helpful as a treatment for stressful life situations prior to their encounter with the justice system. Therefore, they requested to do psychotherapy as part of their treatment plan when they came to court. One may argue that if Matt and Frank previously received psychotherapy and still got charged, then psychotherapy treatment is ineffective. First, Matt and Frank received psychotherapy when they were younger. Second, receiving psychotherapy does not pre-empt relapse if one does not continue to practice what they learn in therapy. The most important lesson we can deduce from these two clients’ experiences is that they enrolled in psychotherapy because they had experienced it before. Therefore, as more CDP clients experience psychotherapy the greater the chances of considering it in the future as a treatment option. Psychotherapy might not be helpful or needed for every client in the court diversion program, but if CDP clients are aware of its existence in the community, they may be able to apply and receive this service. CDP clients need help to be informed about and linked to affordable psychotherapy services in the community.

That Kabir, Matt, and Frank enrolled in psychotherapy as a treatment option at the court seems to suggest that they were presented with different types of treatment modalities, from which they made their own choice. In theory, that appears to be the case, but in practice, CDP clients do not seem to have that option. Though Kabir was allowed to go for psychotherapy after refusing medication, he said his worker at the court still asked him to see his doctor first. Kabir also reported that the agency he was referred to for psychotherapy told him he was not eligible if he still has charges pending in court. Kabir's experience is consistent with what some court support workers at another site of the Mental Health Court in Toronto shared with the researcher during the recruitment process. After being rejected for his first attempt to enroll in psychotherapy, Kabir said he became very frustrated and nearly walked out of the diversion program. But fortunately for him, Kabir later found a flyer outside the court dubbed *psychotherapy group for people hearing voices*. Kabir said he called the number himself, attended an initial interview and assessment, and got accepted into this psychotherapy group. Therefore, when asked about the options of treatment presented to him when he came to the court, Kabir said: "I cannot say I had enough options to choose from as far as treatment is concerned.".

Another psychotherapy client, Matt, said he did psychotherapy when he was younger, so he wanted to do psychotherapy again when he became involved with the justice system because he believed psychotherapy could "bring the desired behavior change" he was looking for in his life. During the interview, Matt remarked: "My court support worker was okay with my choice as long as I continue to see my family doctor and my bail supervisor". Ray also shared that he had serious addictions and substance use issues that he was battling when he came to court. Ray said he was first referred to a psychiatrist when he came to the court. Then later, his psychiatrist referred him to a psychotherapist after a thorough assessment. On the issue of options, Ray stated: "Given my condition at the time, there were no other options for me when I came to the court". Ray said because of fear of going to jail, he was willing to see a psychiatrist who later referred him to a psychotherapist.

Not all CDP psychotherapy clients felt they had limited options with regard to treatment. Frank, for instance, had a couple of hospital admissions and he had to attend different treatments here and there including inpatient and outpatient programs. Therefore, Frank thinks he had a distinctive experience from the rest of the other psychotherapy CDP clients when he declared: "I was recommended to take the anger management course and continue to talk to my doctor. I also did a day program at the North York General hospital, so I guess I had a couple of options". A critical look at Frank's experience, however, appears that he had limited options as well, though he did not feel that way. In an interview with Frank, it was apparent that he perceived "options" to be the number and variety of services he was referred to when he enrolled in the diversion program. It is, therefore, not surprising that he used the term "I guess" to answer the question on his options of treatment in CDP. Frank's experience may have been different if he had decided to make his own selection of treatment from the list of services that were recommended for him at the court.

In the context of this study, it can thus, be surmised that only a few CDP clients are aware of the availability of psychotherapy services in the community. And among those who are aware of the existence of psychotherapy support, they seem to have limited options with regard to treatment decisions. The seeming lack of awareness about the existence of psychotherapy treatment for CDP clients is explained by the prominence of pharmacotherapy in the court diversion program. As we read from the participants, court support workers consistently ask them to see their doctors even when they are doing psychotherapy. On the other hand, it was only Ray, whose psychiatrist saw the need to refer him to a psychotherapist. Given that most CDP clients are referred to pharmacotherapy treatment, one may assert that this practice perpetuates the dominance of pharmacotherapy over psychotherapy. However, the fact that some clients are seeing their physicians and are also doing psychotherapy is also an indication that the two forms of treatment may co-exist, for they are not mutually exclusive. For this to continue happening, there is the need to support eligible CDP clients to access psychotherapy when they come to court. Matt and Frank requested to do psychotherapy because they were already aware of the effectiveness of psychotherapy as they had previously received psychotherapy treatment in the past. Ray would not have become aware that attending group sessions will help him deal with his addiction issues if he was not referred by his psychiatrist. This implies that as more professionals in the CDP become aware of the effectiveness of psychotherapy, and if other accessibility barriers are removed, CDP clients will be able to receive psychotherapy services with less difficulty.

The experience of pharmacotherapy clients on choice of treatment

We have examined the experience of psychotherapy clients in their enrolment in CDP as well as their options when it comes to treatment. This section discusses the experience of pharmacotherapy clients with regards to the factors determining their enrolment in CDP and the options of treatment they were presented with if any.

Just as we read about psychotherapy clients, different factors also accounted for pharmacotherapy clients' enrollment in CDP, and some of these clients felt equally restricted in terms of options they had for their treatment in the court diversion program. The factors that accounted for CDP clients' enrollment in pharmacotherapy include the following:

- encouragement from the court diversion program staff
- clients' compliance with the CDP program expectations
- clients' previous experience and familiarity with pharmacotherapy
- the severity of clients' mental health issues
- the severity of charges that brought the clients to court.

All the five participants who were interviewed indicated that they were persuaded by their court support workers to consult with a physician (family doctor or a psychiatrist) when they enrolled in CDP. Persuading CDP clients to receive medication treatment is perhaps a smart thing for Court Support Workers (CSWs) to do given what these workers need to accomplish within a short period of time in terms of program expectations. CSWs do their due diligence to complete multiple tasks within a specified time frame when working with CDP clients. CSWs play several important roles in the CDP program. Though only the Crown Attorney determines the types of charges that can be diverted, court support workers also help screen clients' eligibility for the diversion program (Human Services & Justice Committee, 2017). Among other functions, CSWs conduct release plans, complete assessments, referrals, and they also have to submit periodic reports to the Crown and their program managers for evaluation. And given that psychotherapy is not easily accessible, especially, for clients with pending charges, and the fact that not all psychotherapy services are covered under the Ontario Health Care Plan, it makes perfect sense for CSWs to persuade their clients to receive pharmacotherapy so that they can accomplish their goals within a specific time frame.

Compliance with court diversion program expectations was also a subtheme that emerged as one of the factors that explain why CDP clients enroll in pharmacotherapy. During an interview with the participants who received pharmacotherapy treatment, Eric highlighted this subtheme by saying: “When I came to the court, I learned that the emphasis was on treatment through medication, so I just had to comply”. Eric’s observation confirms the predominance of pharmacotherapy in the court diversion program (Leroux, 2008). Another factor that influences CDP clients’ enrollment in pharmacotherapy is the severity of charges and/or severity of mental health issues. Severe and persistent mental illness may sometime lead to prolonged hospitalization and medication treatment. Albert, for instance, suffers from Schizophrenia and severe addiction issues, so he has been on medication and methadone for a very long time. And as he shared during the interview, Albert is currently experiencing several challenges in trying to reintegrate into the community. Rod also lives with Bipolar and Severe Anxiety Disorder. Rod’s behavior, his charges, and the severity of his mental health challenges speak volumes about why he continues to rely on a high dosage of medication even after completing his diversion.

As mentioned earlier, when police officers encounter clients in crisis associated with problematic behaviors, they may choose to send these clients to jail or connect them with community resources (Munetz & Griffin, 2006). It follows that clients whose offenses are severe are more likely to receive pharmacotherapy treatment. Treatment for

Albert and Rod are typical examples. Albert, for instance, was drinking and fighting; he destroyed property, barricaded himself in a room, and resisted police arrest. Hence, Albert was placed on medication for treatment. Rod also shared: “I used to hit people and kick furniture here and there. My partner thought I was too crazy, so she left our apartment to go and live in a shelter for a while”. Given the nature of his charges, Rod said he did not only receive medication treatment but his medication dosage was also increased. Thus, the severity of one’s charges, their mental health status at the time they appear in court, and many other factors, may limit CDP clients’ ability to choose their desired treatment option.

Benefits of treatment through CDP

Despite the barriers confronting CDP clients as they participate in therapy and treatment, most of them also shared various accomplishments and breakthroughs in their lives after receiving treatment and returning to the community. The striking feature of these accomplishments is that it does not matter whether one received pharmacotherapy or psychotherapy treatment, all the participants were very appreciative of the successes they achieved at the end of their graduation. Some of the common benefits and accomplishments that the participants shared include the following:

Successful completion of CDP

All ten participants (five psychotherapy clients and five pharmacotherapy clients) who partook in the interview reported that they successfully completed their court diversion program in Toronto. This is not surprising because one of the inclusion criteria of this study was the completion of a court diversion program in Toronto within the last five years. It is, however, important to mention that for these graduated clients, completion of CDP means a lot because it is not everyone who enrolls in the CDP is able to complete it successfully. For this reason, some of the psychotherapy participants concluded their interview with exceptional remarks. For instance, Teddy shared that he has learned important lessons in life after completing his diversion in 2016. Kabir remarked: “I just want to thank everyone who helped me to finish the program”. Matt was elaborate in his expression of appreciation to the agency where he received help to complete his CDP:

> Fred Victor came into my life at a time when I had no hope and did not even understand the things I was going through. But here I am now with a big change a few years later. I think anyone in a similar situation as mine should be hopeful.

Pharmacotherapy clients also shared that medication did help one way or another in their successful completion of the diversion program. The following is Douglas’ description of how he benefited from his pharmacotherapy treatment: “The change in medication helped calm me down. All the confusion and paranoia feelings were minimized, so I was able to stop drinking and smoking. And once I stopped that, I did not get into trouble again”. Rod stated that “In some way, the medication did help me in addressing my charges”. Though Eric said he felt the urge to take his medication at the court, he noted that: “with that push, I felt obliged to take the meds and it ultimately helped me address the issues that brought me to the court”.

Insight

Both psychotherapy and pharmacotherapy clients who partook in the study reported insight as one of the benefits they gained from receiving treatment in the CDP. As perceived by Jones-Smith (2016), insight occurs when clients begin to gain self-awareness or when they become conscious of the factors that contribute to their emotional disturbance and irrational beliefs. Jones-Smith (2016) further notes that insight is not complete until clients commit themselves to work with a therapist and take the necessary steps to rid themselves of the very issues troubling them. Three psychotherapy clients shared that they gained insight into their condition during therapy sessions. Ray described his family as "dysfunctional" because of their excessive alcohol consumption. Ray then shared his insight as he continued to work with his psychotherapist:

> My sisters and brothers, as well as my father, were all alcoholics. But I saw nothing wrong with that. I did not know alcohol was my problem until I met with a psychotherapist. He helped me to learn that if I control the alcohol, I can address my charges in court.

Kabir, who attended a group psychotherapy session also shared that "I began to learn new ways of reasoning that helped me to control my impulse, which in the past had led me into fighting and getting charged."

Among the pharmacotherapy clients, Douglas also shared his insight resulting from taking his medication: "It helped me in some ways. I can understand things now and relate better with people". Eric also became insightful and made an important comment with regards to his choice of treatment after combing various services in the healthcare system: "I chose pharmacotherapy because it was the easiest and most viable option in terms of treatment". Eric did not seem to have had a pleasant experience during his time with the CDP program, however, he still believes that medication was the right choice of treatment for him. Thus, both psychotherapy and pharmacotherapy clients completed their treatment with profound insight into their situations in life.

Improved relationships

Among the five psychotherapy clients who were interviewed, four of them discussed an experience of improved relationships either with their friends, family members, neighbors, or professionals in their circle of care after receiving psychotherapy. Teddy, for instance, reported an improved relationship with his mother, whom he had previously cut off from his life. Before therapy, Teddy said his family was more like a "poison" to him. But after receiving psychotherapy treatment, Teddy shared that psychotherapy helped him to correct his past, so he is now in constant touch with his mom. Matt also shared that his move out from the family home affected his relationship with his parents. But after receiving psychotherapy treatment through the CDP, Matt observed some positive changes and said: "My parents are still worried about me, so we have started talking. They send someone to visit me once in a while to talk to me on faith". Frank, who used to "snap" at his case worker on minor issues in court also noticed a change after receiving psychotherapy and noted: "The skills I learned in the groups have helped me interact with people more effectively. For instance, I now rent with my mom, my sister, and her boyfriend, and my relationship with each of them is great".

Similarly, improved relationships also occurred among some of the CDP pharmacotherapy clients. Douglas and Pearson, for instance, reported positive relationships after their pharmacotherapy treatment. Douglass declared: "My relationship with my doctor and other people has been good especially after the medication was changed". Pearson also acknowledged: "My relationship with my mother got better. I was visiting and talking to her more often. Also, I still keep in touch with my court and community workers who helped me".

Despite these reported positive relationships, some pharmacotherapy clients had mixed experiences of both positive and problematic relationships. Though Rod had a great relationship with his partner, he said he could not maintain a good relationship with the professionals in his circle of care. Albert continues to struggle in maintaining good relationships with his neighbors and the professionals providing him with care and support. As he demonstrates in the following quote, Albert, however, attributes the poor relationships he has to the side effects of his medication:

> medication could not help me establish relationships. It is hard for me to make friends because I can't love, I can't smile, and it is hard to be happy because the anti-depressant medication makes one numb, so it can't help me relate with other people.

Albert further disclosed that he "shrinks people" from himself, so he fired his psychiatrist. Just like Rod, Albert also shared that he did not hesitate to let go of his psychiatrist because this doctor tried to wean him off a particular medication he got so used to.

Therapeutic alliance transcends therapist-client relationship

One of the key lessons the data analysis revealed is how psychotherapy clients experienced relatively stable relationships with their clinicians more than pharmacotherapy clients. The reason for this may be explained by the therapist-client relationship that is developed prior to therapy sessions as well as clients' engagement and their active participation in psychotherapy. The participants who received psychotherapy treatment shared that before the therapy session begins, the psychotherapists established a therapeutic alliance with them. The clients in turn also played an active role in therapy sessions through engagement and interactions. By this, the clients felt respected and validated. These psychotherapy clients said they asked questions and received answers to their questions, they completed homework, designed a toolbox, and learned new skills that they applied on their own in the community even after completing their diversion program. The participants of psychotherapy shared that the skills they learned could help them handle the unwanted feelings, behaviors, and thoughts that disturb their mental health. Those who attended group psychotherapy sessions also learned to tolerate and respect the opinion of others in the group. Thus, the preparation before therapy, therapeutic alliance with their clinicians, and active engagement in individual and group sessions helped CDP psychotherapy clients apply those skills to real-life situations when they re-entered the community.

Not all the participants of this study discussed the specific psychotherapy models applied by their clinicians. However, some of the CDP psychotherapy clients' expression and feelings of validation, respect, and empowerment mirrors the values of postmodern psychotherapy (e.g. Narrative therapy). Narrative therapy usually sees the client as an expert and the author of his/her own life. Postmodernism therapists assert that a change is possible through an exploration of alternatives. Postmodern therapist collaborates with clients to deconstruct discourses that block change in the therapeutic process (Karen, 2005). In postmodern therapy, attention is on the client's strengths rather than deficits. The postmodern therapist views individuals' lives as stories in the sense that they are narratives (Jones-Smith, 2016; Karen 2005). The therapist-client relationship which produced validation, respect, and empowerment for CDP psychotherapy clients also helped to improve how CDP clients relate not only with their therapist but with their neighbors, families, and community members at large.

Community participation vs. sense of belonging to the community

Community participation and a sense of belonging to the community are two separate subthemes that showed how CDP clients expressed their involvement in the community upon graduation from the diversion program. One of the key lessons the researcher noted from these subthemes is that while psychotherapy clients discussed experiences pertaining to their community participation, pharmacotherapy clients pointed out specific encounters that underline their sense of belonging to the community.

Most of the CDP psychotherapy clients who were interviewed reported that they felt being part of the community because of the specific activities in the community in which they were involved. Ray, for instance, said he volunteers his time at the Good Shepherd shelter where he supports homeless men who are looking for a place to sleep. Teddy was also employed in the community after treatment and his completion of his CDP. Teddy said: " I got a job at a restaurant and worked for about a year. I was working forty-five to fifty hours a week". Matt was multitasking in his community participation and shared: "I took a part-time diploma program at the University of Toronto and completed it in 2018. I was also working at the same time when I was studying. I changed my job about two years ago". Frank, however, did not feel he fully participated in the community though he shared that he had done some upgraded university courses and was still doing some employment training in his area of interest. All these activities made graduated CDP psychotherapy clients feel part of the community.

On the other hand, CDP pharmacotherapy clients also shared their unique experiences of how they felt part of the community. Apart from Albert, who said he "feels left out" and Rod, whose partner is the only close companion in his life, the rest of the graduated CDP pharmacotherapy clients pointed out specific examples to show how/why they have a sense of belonging to the community. The following is how Douglas' articulates his experience of a sense of belonging:

> The people I live with make me feel part of the community. Most people do not speak French, it feels lonely sometimes. Otherwise, I can go wherever I want to go without any issues. I use the same TTC bus, library, grocery shops, and others as everyone else. This makes me feel part of the community.

Douglas is not very fluent in English because his first language is French. This is restricting his attempt to socialize with the dominant English-speaking population in Toronto. Apart from that, Douglass has a sense of belonging to the community in different ways as he has outlined. When talking to Eric during the interview, it was his ability to take part in the "essential needs of the community and [him] being respected" that make him "feel somewhat integrated with the community".

Improved mental health

There was a significant improvement in mental health among all the graduated CDP psychotherapy clients as well as all the graduated pharmacotherapy clients who participated in this study. This is not surprising given that improved mental health is one of the key indicators of clients' progress that lead to their discharge or graduation from the CDP. And since the researcher interviewed only graduated CDP clients, it was not out of the ordinary to hear these clients talk about their improved mental health experiences.

One psychotherapy client, Frank stated that his delusional thought and anger issues were addressed after receiving psychotherapy. Matt also disclosed that he used to blame himself a lot, and this affected his mood and thinking pattern. But after receiving psychotherapy, Matt stated: "I learned in the therapy sessions that self-blame will offset me from reaching my goals. I stopped blaming myself and my parents". Kabir preferred to do psychotherapy when he declined medication at the court. Upon completion of his group sessions, he had this to say: "The group therapy helped improve my cognitive functioning as I began to learn new ways of reasoning that helped me to control my impulse, which in the past had led me into fighting and getting charged". Teddy also reported having control over his PTSD, which ultimately helped him to leave his dogs in the house and stay focused when he is at work.

Among the pharmacotherapy clients, Pearson expressed how his medication helped in the treatment of his depression when he became homeless: “of course, medication helped my depression which resulted from life in the shelter”. Eric noticed that besides the significant improvement in his relationship with his family upon receiving pharmacotherapy treatment, his medication also helped with the treatment of his Schizophrenia. Rod also shared the following quote to illustrate the transformation of his life after receiving pharmacotherapy treatment for his diagnosis of bipolar disorder:

> I used to hit people and kick furniture here and there. My partner thought I was too crazy, so she left our apartment to go and live in a shelter for a while. They told me my medication dosage was too low, but when it was increased, things got better and my manic was brought under control.

It is clear from the above CDP clients' experiences that both psychotherapy and pharmacotherapy are supporting clients in different shades and forms when they enroll in the court diversion program, and the support they receive also plays a major role in their efforts to re-enter the community. However, the fact still remains that the number of clients in the court diversion program receiving psychotherapy services is significantly low due to certain factors, which we will review later in this discussion.

Reduced offending behavior

The data shows that CDP clients who participated in this study had a low recidivism rate. Whereas all five graduated CDP clients who received psychotherapy reported no reoffending behavior after graduation, four of the pharmacotherapy clients also shared that they had not come into contact with the legal system after completing their diversion program (i.e., within the last five years). This success story may be said to have occurred as a result of CDP clients gaining insight and experiencing improved mental health through psychotherapy and pharmacotherapy services they received. For instance, Ray remarked that "before, I thought I was not good enough". The feeling of hopelessness and inadequacy has the potential of making a person vulnerable in making the right decision if help is delayed. But after attending group psychotherapy sessions, Ray said he was able to overcome his addictions issues and has not committed any offense since graduating from the CDP. After receiving psychotherapy support and his graduation from CDP, Teddy also said: "I try to steer away from the cops. I have not been involved in the justice system since I completed my diversion in 2016…. I know what happened and why it happened". Teddy's last statement echoes self-awareness and insight, which is helping him to avoid repeating the past.

Eric and Douglas who received pharmacotherapy treatment also discussed how their treatment led to a reduction in their offending behavior. After sharing his pain resulting from his enrollment in CDP, Eric, for instance, admitted that medication "ultimately helped me address the issues that brought me to the court". Douglass said he did not initially see any behavior changes until his medication was changed for him. Thus, Douglas recounts: "The change in medication helped calmed me down. All the confusion and paranoia feelings were minimized, so I was able to stop drinking and smoking. And once I stopped that, I did not get into trouble again". Albert presents as a unique case in this study because he is the only graduated CDP pharmacotherapy client who reoffended about two years after completing his diversion in 2017. Albert is diagnosed with Schizophrenia, and he also struggles with addiction issues. I was initially tempted to conclude that his recidivism was due to the nature of his diagnosis. However, the demographic features of the research participants clearly show that Albert is not the only client diagnosed with schizophrenia and addictions. Albert seems to be isolated at this moment in his life. He has no case manager nor support workers following him up in the community. He disclosed that he has fired all his physicians, and the only professional he sees is his methadone clinic doctor. Albert has no friends, and he is distant from his family who might be able to provide some support. Whilst some CDP clients are able to find a job, volunteer, or go to school, Albert says: "My mental health has affected my finances severely. I haven't been able to work". During the interview, Albert cried out for help as he made an honest request of wanting to see a psychiatrist again. It is therefore fair to attribute his recidivism to this precarious condition.

According to Hirschi (1969), an individual's strong bonds to social institutions such as family, education, employment, school, and friendship, do "control" or restrain them from deviant or delinquent behavior. Were Albert able to connect with resources just like other participants of this study, his experience might have been different.

In the context of the other nine graduated clients who were interviewed for this study, it can be asserted that CDP clients who receive the needed treatment at the right time are more likely to have a low recidivism rate.

Housing stability

One of the common problems confronting clients with mental illness and offending behavior when re-entering the community is homelessness (Baillargeon, Hoge & Penn 2010). It was observed that almost all the ten participants in this study had experienced homelessness and/or a shelter stay at one point in their lives prior to completing their diversion program. Just as mental health improvement and reduction in offending behavior make a huge difference in the clients' graduation, one's ability to find housing also facilitates their successful completion of CDP. Among the psychotherapy clients, Teddy was suffering from PTSD, and he used to get obsessed with the safety of his dogs when he is away from home. During the interview, Teddy reminisced the new skills he learned in psychotherapy sessions that helped him maintain his housing and his two dogs:

> Now I can go out and I do not have to worry about my dogs or my apartment as much. And that is where the grounding technique comes in. Just to let you know, my dogs and I were homeless for a long time moving from one shelter to the

> other. So, I did gain a lot from the therapy, and it helped me get reintegrated into the community.

Also, Kabir succinctly expressed his housing experience in this way: “Life in a shelter came to an end as I found a beautiful apartment with government subsidy.” Frank, on the other hand, stated he was happy that he could finally rent a home with his mom, sister, and his brother-in-law.

Pharmacotherapy clients also attested to the fact that they attained housing stability upon receiving medication treatment. Albert, for instance, said: “meds help keeps me stable” when it comes to housing. After his release from jail and his enrollment in CDP, Douglas said “I spent six months in the shelter. My compliance with treatment and cooperation with other workers helped me to find housing.”. Also, Rod successfully returned to his partner’s apartment after completing his probation and bail conditions.

The role of housing in CDP clients’ return to the community is one of the key discoveries in this study. CDP clients’ accessibility to housing speaks volumes about how clients are benefiting from the City of Toronto’s housing first plan for the homeless population. In the last ten years, the City of Toronto has consistently developed its housing strategies to respond to the housing needs of vulnerable groups including seniors, youths, people living with addictions and mental health issues, as well as ex-offenders. Between 2013-2014, the City of Toronto partnered with community mental health agencies like Fred Victor, the Canadian Mental Health Association, John Howard Society, and COTA, to provide housing and financial support (subsidy) to justice-involved clients living with mental health and addiction issues. While most of the participants of this study benefited from this program, the fact still remains that some of these clients lack the support services they need in order for them to thrive in the community. Post-incarcerated clients living in the community have access to pharmacotherapy services, but many are unable to access psychotherapy due to a lack of funding and other systemic barriers.

Religious/spiritual lessons

CDP program is not set up to teach clients religion or spirituality. And court support workers do not directly or indirectly encourage nor dissuade clients from their involvement in religious and spiritual activities. However, when the participants were asked to tell whether religion and/or spirituality played any role in their participation in the CDP program and their community reintegration, it was apparent that religion and/or spirituality meant different things to different participants of this study. Two of the five CDP psychotherapy clients who were interviewed (Teddy and Fred) said they were neither religious nor spiritual. The three other psychotherapy clients (Ray, Matt, and Kabir), on the other hand, discussed how their involvement in the justice system and the treatment they received taught them some religious /spiritual lessons. While Matt and Kabir found religion useful and beneficial, Ray denounced religion and embraced spirituality before achieving a full recovery.

Religious and spiritual lessons among CDP pharmacotherapy clients also differed just as they manifested themselves among CDP psychotherapy clients. While Eric and Rod noted no religious or spiritual connotations associated with their treatment and their community reintegration experience, three other participants Pearson, Douglas, and Albert had some positive experiences to share about the role of religion and/or spirituality in their participation in CDP and community reintegration. Details of these clients' religious and spiritual experiences will be fully captured in another chapter (Theological reflection).

Liberation/freedom from CDP expectations

An expression of freedom from CDP expectations is a subtheme that came up from the experiences of only some of the pharmacotherapy clients. The researcher firmly believes that completion of CDP is a success since not all clients who enroll in the program are able to complete it. The data collected from the participants with regards to this subtheme, however, appeared paradoxical, for, in one way, CDP pharmacotherapy clients expressed joy for receiving treatment, which helped them accomplish many things in their recovery journey. And yet, some of them also expressed some feelings of freedom for doing away with CDP. Eric, for instance, expressed this feeling when he talked about his hope for the future:

> My main hope is that I never have to go through the CDP again. It was not an easy experience for me. I just want to enjoy my freedom and live a peaceful life without having no one to report to etc.

Rod rejoiced over receiving treatment for his manic episodes and in particular, the support he received in CDP to reconnect with his partner. However, when he was asked to tell his feelings about completing his CDP and moving into the community, Rod also expressed this paradoxical feeling: “On the one hand, I felt relieved for that liberation. On the other hand, I was a bit nervous because of all the suspicion. The good thing is that my community members know that I have a mental illness.” Rod referred to the completion of his diversion program as "liberation". In the same vein, Douglas also said: “For me, transitioning from the legal institution into the community feels like a bird out of the cage. I feel a kind of freedom that words cannot describe." That is how the CDP pharmacotherapy clients expressed their freedom and liberation from the legal system. In this context, graduated CDP clients find the diversion program as a route to total freedom from the criminal justice system and its high expectations from the offenders of the law.

In sum, the participants of this research who received either of the two treatment modalities had their individual challenges, but they also expressed deep appreciation given the specific areas of accomplishments they gained through the CDP program as they tried to reintegrate into the community. The accomplishments of these graduated CDP clients are a very promising outcome, and it signals the dawn of a new beginning as previous studies (such as Burns et al., 2013; Gottfried et al., 2014; Redlich et al., 2010; Ryan et al., 2010,) have attributed the success of CDP to several factors other than psychotherapy. The list of factors that these early researchers have attributed to the success of CDP includes one or more of the following: effective case management, medication compliance, probation and parole, participants' regular appearance at court, and the Judge's praise and encouragement to the clients during court attendance. However, the analyzed comparative data of this study clearly shows how psychotherapy may be an important ingredient for the success and total recovery of clients registered in the court diversion program.

Reintegration of graduated CDP clients

One of the objectives of the researcher in this study was to understand the reintegration experience of graduated CDP clients, in particular, what belonging to the community means to them, and whether or not their treatment modality (psychotherapy/pharmacotherapy) supported their community reintegration. A better understanding of reintegration required an operationalization of the term *reintegration* as we read earlier in the introductory part of this study.

Description and measurement of reintegration

The term “community reintegration” is used when people return to the community after an extended period of hospitalization or incarceration. Completing court diversion and staying in the house all the time is not a recovery. Therefore, as is conceptualized in this study, the reintegration of CDP clients must entail their involvement and active participation in the community after their release from institutions. The measurement of community reintegration can be complex since CDP clients have different skills, training, and different functional levels. However, the work of Baillargeon et al. (2010) and Elnitsky et al. (2017) provide a tool that can be used to measure CDP clients’ community reintegration. According to these authors, there are common barriers that returning inmates with serious mental illnesses face when re-entering the community. This includes homelessness, lack of adequate mental health services, unemployment, treatment relapse, criminal recidivism, and much more. In this context, when CDP clients make significant changes to overcome one or more of these barriers, they may be considered to have attained some level of successful community reintegration. This is a framework that the researcher applied to assess the community reintegration experience of the participants in this study.

Prior to the data collection, it was proposed that clients who show signs of one or more of the following will be deemed to have achieved reintegration: 1) evidence of clinically meaningful reductions in symptoms; 2) reduced reoffending behavior; 3) actively engaged in healthcare or compliance with treatment; 4) engaged in employment; 5) volunteering; 6) enrolled in an education or an apprenticeship program; 8) improved relationship with family members, friends or loved ones; 9) financial/guaranteed source of income, 10) housing stability, and 11) spirituality i.e. religious or a sense of meaning and purpose (Elnitsky et al., 2017).

The data shows that both psychotherapy and pharmacotherapy clients seem to have experienced most of the above constructs.

***CDP clients' perception of reintegration*:**

While the above constructs of reintegration seem to fit the circumstances of most of the research participants in general, a close look at the data analysis reveals that not all pharmacotherapy clients feel they are reintegrated, for they have their own perception of what reintegration means to them. Among the five pharmacotherapy clients who were interviewed, only one person could say with confidence that he was fully integrated. Two were partially integrated, one was not integrated at all, and the other participant was not sure of his situation as he was in a kind of transitional period. A pharmacotherapy client, Albert shared in an interview that he does not feel integrated at all. Albert explained why he does not feel being part of the community:

> I feel like I am left out when it comes to community reintegration because I do not have a job, I do not contribute to society, and I do not have friends. I need friends, a house, a job, and a car like anybody else in order for me to feel part of the community.

Albert is being honest because his unmet needs (i.e., job, friends, housing, etc.) are similar to the accomplishments, which other participants cited to support their feelings of community integration and belongingness. Douglas, who also received pharmacotherapy treatment appears partially integrated from his remarks: “My hope is to settle well in the community and get to know more people who will be able to help me find a job and become more stable.”. Eric also discussed some issues that must have gotten in the way of his reintegration. And since he is slowly overcoming now, his response was that: “I feel somewhat integrated into the community.”

In sum, graduated CDP clients who received medication for their treatment responded differently to the theme of reintegration. Some felt not integrated at all, others felt partially integrated, and one participant felt fully integrated while others are still trying to fit into the community. On the other hand, four out of the five psychotherapy clients did not only confirm their reintegration but also illustrated their role and involvement in the community in different respects. As the data clearly indicates, CDP psychotherapy clients talked about their employment and volunteer experience, they shared the evolving strong ties with their family members and good relationship with the professionals in their circle of care. All the psychotherapy clients have secured affordable housing, and most of them have relatively stable incomes though they still fall under the bracket of low-income earners. Last, but not least, the data shows some of the psychotherapy clients enrolling in the educational program while others are changing jobs here and there. For instance, Kabir talked about his employment to show his participation in the community: “I was able to find a part-time job in the beginning, and later established my own security company.” Thus, being able to establish his own security company after working part-time made a huge difference in Kabir's community reintegration. Matt also considers his education and employment training as part of his community reintegration. Matt mentioned during the interview: "I took a part-time diploma program at the University of Toronto and completed it in 2018. I was also working at the same time when I was studying."

Even though the operationalization of community reintegration in this study seems to apply to both psychotherapy and pharmacotherapy clients, the participants themselves have their own perception of what reintegration means to them. Graduated CDP pharmacotherapy clients have a sense of belonging to the community, but they seem to struggle in the area of active participation in the community. On the other hand, graduated CDP psychotherapy clients appear to be making headway, and they are actively participating in the community and integrating well. What makes one feel integrated into the community may differ from another. Nonetheless, there are some common themes among the participants as to what community reintegration means to them. This includes employment or volunteer activities, family reunions, earning respect or being appreciated by one's community members, guaranteed income, stable or affordable housing, possession of a property, and enrollment in training or education programs. And these were more prevalent among graduated CDP psychotherapy clients than graduated CDP pharmacotherapy clients.

Barriers and challenges confronting CDP clients

As the participants of this study shared the experiences of their enrolment and participation in the CDP program, their encounter with community and healthcare professionals during their treatment, and their transition from the justice system to the community, some barriers and challenges emerged. I divide the problems confronting CDP clients into two:

1) challenges faced by CDP pharmacotherapy clients, and

2) barriers confronting CDP psychotherapy clients.

The division is warranted because while the problems of CDP pharmacotherapy clients tend to be personal struggles, the issues faced by CDP psychotherapy clients appear to be systemic in nature. Here is a brief overview of the clients' challenges as they participated in the court diversion program.

Challenges of CDP pharmacotherapy clients

CDP pharmacotherapy clients expressed two major concerns during the interview. The first is a medication side effect, and the second is relationship issues.

a) Medication side-effects

When Albert was asked whether pharmacotherapy played any role in his consideration of education, apprenticeship, employment, or volunteerism, Albert narrated his experience of medication:

> Oh, God! I wouldn't have ever taken medication if I were to go back to the CDP. The reason being that I have low energy because of medication. I can't do jobs or anything because I have no energy. Like..., like, because of the medication, I can't get the motivation to do anything because I am so tired all the time because of medication. I don't even have the energy to shower. I stopped taking it and got rid of them without telling the pharmacist because I don't want them to give me a shi…t.

Despite his experience, Albert is ambivalent as he is contemplating reconnection with his doctor because there is a part of him that believes that medication could help him in some way. Eric is another pharmacotherapy client who shared how medication side effects did not help his community reintegration: “I think some of the side effects such as weight gain and pain from taking needles may have got in the way at the start.”. Eric felt that his community reintegration and his attempt to consider education, apprenticeship, employment, or volunteerism were impacted by medication side effects.

b) Relationship issues with mental health professionals

Another challenge expressed by CDP pharmacotherapy clients during the interview was their struggle to maintain a good relationship with the professionals in their circle of care. It was acknowledged earlier in this discussion that improved relationships occurred among some of the CDP pharmacotherapy clients. Douglas and Pearson, for instance, reported some positive relationships after their medication dosage was changed. Yet, the relationship issues reported by other pharmacotherapy clients, especially, in relating with community and healthcare professionals, cannot be grossed over. For instance, even though Rod had no issues living with his partner, he reported having relationship problems with his doctors. Within a short period of time, Rod changed a couple of doctors because of relationship issues. Albert also had similar relationship issues with his psychiatrist. Hence, he said he became mad and fired his psychiatrist when the psychiatrist tried to wean him off his antipsychotic medication. Albert added that his medication did not help him to maintain friendships: “medication could not help me establish relationships. It is hard for me to make friends because I can’t love, I can’t smile”. As discussed earlier, it is plausible that the key ingredients such as therapeutic alliance and active engagement which glued psychotherapy clients and their therapists together were missing among the CDP pharmacotherapy clients and their clinicians. This partly explains why pharmacotherapy clients did not experience strong relationship ties with their care providers compared to psychotherapy clients.

Barriers confronting CDP psychotherapy clients

Even though psychotherapy seems to be working effectively for CDP clients' reintegration, there are some barriers that confront them as they try to navigate psychotherapy services upon their enrollment in the court diversion program. These barriers, as outlined in the data analysis, include a limited option in choosing psychotherapy as their treatment plan; insufficient income to fund the cost of psychotherapy; and clients' severe mental health status when they come to the court. While one cannot do much with regard to CDP clients who first appear at the court with a severe unstable mental health condition, the first three problems are systemic in nature and must be addressed at the systemic level.

Limited choice

It has been discussed extensively in the early part of this chapter that in theory, CDP clients appear to have the option of choosing any type of treatment they prefer when they enroll in the diversion program, but in practice, they have limited options about treatment decisions. For instance, out of the five participants who were interviewed, four of them expressed that they had limited options in the area of treatment decisions. Some of the clients reported that they were persuaded to receive pharmacotherapy treatment prior to receiving psychotherapy. Teddy, for instance, said that he was already doing psychotherapy when he came to the court. However, he was still asked to see his physician. Kabir also said: "I cannot say I had enough options to choose from as far as treatment is concerned." On the same subject matter, Ray, who was referred to psychotherapy service by his psychiatrist, said: "Given my condition at the time, there were no other options for me when I came to the court." In the same vein, Frank also disclosed that: "I was recommended to take the anger management course and continue to talk to my doctor." Thus, seeing a medical doctor or taking medication remains a key component of the CDP program.

Insufficient funding

While the cost of medication is fully covered for pharmacotherapy clients, some of the CDP psychotherapy clients expressed that they could not have afforded the cost of their psychotherapy service if it were not funded by an agency or a community organization. Frank, who earlier said he struggles to pay his bills, informed the researcher that all the psychotherapy sessions and the programs he attended "were funded by the hospital and not-for-profit organizations." Matt, on the other hand, stated his therapist was sensitive to his financial needs at the time, therefore, he used a sliding scale to charge a small amount of money. In describing his experience of psychotherapy sessions, Teddy said "It was one-on-one for about 1.5 years. It was funded through the CMHA, otherwise, I could not have afforded it. They said psychotherapy can be expensive." This highlights the need for funding for psychotherapy programs in the community.

The influence of pharmacotherapy

The place of medication in the treatment of clients who enrolled in the CDP program does not seem to encourage court support workers and their clients to explore other effective service interventions for clients' mental health improvement. It appears pharmacotherapy is still the main treatment model in CDP (Leroux, 2008). All five participants who were interviewed expressed their experience in one way or another of this. When Frank was hospitalized, he received pharmacotherapy treatment before he was referred to a psychotherapist. In dealing with his struggle with substance use, Ray also said he was first connected with a psychiatrist, who later referred him to a psychotherapy group. Matt had a previous experience with psychotherapy and wanted to repeat it when he came to court. However, Matt said: "My court support worker was ok with my choice as long as I continue to see my family doctor and my bail supervisor." When Kabir enrolled in CDP, he said his court support worker had wanted him to see a psychiatrist, but he declined and opted for psychotherapy treatment instead.

The severity of mental health issues

The study reveals that when CDP clients appear at court, their mental health status and/or how they present emotionally and cognitively can influence their treatment modality. As some court support workers indicated earlier during the data collection, it appears that pharmacotherapy (rather than psychotherapy) is the default treatment option for clients showing severe symptoms of mental illness. For instance, because of the nature of his mental health crisis, Frank said he was hospitalized first before he attended the group therapy sessions, which were run at the hospital. Also, because of his "confused" state of mind, Ray said he saw a psychiatrist first, who later referred him to a psychotherapist. On the contrary, Kabir, who was relatively stable at the time of his CDP enrollment was able to insist on doing psychotherapy after he refused pharmacotherapy. All these cases show that the severity of a person's mental health challenge will determine the nature of their treatment modality when they appear at a mental health court.

Summary of key findings

This study reveals that clients who enroll in CDP and comply with their treatment plan (be it psychotherapy or pharmacotherapy) receive the needed support to graduate successfully from the program. But graduation from CDP is one thing and reintegration into the community is another thing. Even though both pharmacotherapy and psychotherapy clients benefited greatly from their treatments and subsequently, graduated from CDP, a close examination of the data analysis reveals that because of the skills that psychotherapy clients acquired during therapy sessions, they were more successful in their community reintegration endeavors compared to the pharmacotherapy clients. The psychotherapy clients learned new skills through a therapeutic relationship with their clinicians, through active engagement in therapy, by asking questions and receiving answers, completing homework, designing toolbox, and so forth. The psychotherapy clients shared that these skills helped them handle the unwanted feelings, behaviors, and thoughts that used to disturb their mental health.

Another remarkable discovery from the study is CDP clients' unique perception of community reintegration. The researcher applied eleven constructs to operationalize the measurement of community reintegration of CDP clients (Baillargeon et al., 2010; Elnitsky, Fisher et al., 2017). The participants of this study, however, discussed their own understanding of community reintegration. Some of the CDP clients who received medication treatment felt not integrated at all; others felt partially integrated; one of these participants felt fully integrated while others were still trying to fit into the community.

On the other hand, four out of the five psychotherapy clients felt well integrated and cited their active involvement in the community to prove this. As the data highlights, CDP psychotherapy clients talked about their employment, volunteer experience, social ties, and good relationship with the professionals in their circle of care to prove their community reintegration.

The study also shows that CDP clients have limited options in selecting their treatment of choice. This does not seem to be the CDP program's goal, but because some of the clients show up at the court with severe symptoms of mental illness and/or severe charges, pharmacotherapy remains a default treatment option for such clients. While this unfortunate situation predisposes CDP clients to medication treatment, it does not prevent them from exploring psychotherapy especially after the clients become relatively stable mentally. For instance, as cited in the discussion, Pearson shared that he received medication treatment, but it was therapy and counselling that saved him from killing himself.

In sum, the study reveals that though CDP clients benefit from psychotherapy, only a few of them actually receive psychotherapy services when they enroll in the CDP program. The study underlined three main reasons for this:

a) CDP clients are usually denied psychotherapy service when they still have charges pending in court.
b) lack of funding for psychotherapy

c) CDP clients usually have severe and persistent mental illnesses that require immediate psychotropic medication; therefore, psychotherapy is not usually considered by CDP program planners.

Moreover, both psychotherapy and pharmacotherapy clients seem to have very similar treatment benefits (improved mental health, insight, successful completion of CDP, housing stability, community reintegration, etc.). However, their challenges differ in a unique sense. Problems confronting CDP clients, in general, can be grouped into two:

1) challenges faced by CDP pharmacotherapy clients, and

2) barriers confronting CDP psychotherapy clients.

The division is necessary because while the problems of CDP pharmacotherapy clients tend to be personal struggles (e.g., medication side effects and relationship issues), the problems confronting CDP psychotherapy clients appear to be systemic in nature.

- While psychotherapy clients faced funding and accessibility to psychotherapy services problems, pharmacotherapy clients had easy access to medication treatment. However, both psychotherapy and pharmacotherapy clients have one problem in common—limited options in choosing their treatment preference.
- The few CDP clients who accessed psychotherapy reported that funding would have been an issue if the service were not provided by their agency for free or the use of a sliding scale (for those who paid from their pocket).
- In the area of relationships, both psychotherapy and pharmacotherapy clients reported some improved relationships with family members and friends; however, while psychotherapy clients were also able to maintain a professional relationship

with their workers, some pharmacotherapy clients had challenges keeping the relationship with their physicians and other professionals in their circle of care. Broken relationships occurred more frequently among pharmacotherapy clients than among those who received psychotherapy.

- Some of the CDP clients reported more often that they followed the instructions that their court support workers (CSWs) gave them in their participation in the diversion program. This implies that the knowledge of CDP professionals could impact the recovery goals and the overall service plan of CDP clients on a daily basis. This has a significant implication for the training and professional development of the CSWs and other staff members in the CDP program.
- It was also noted that while there was significant stability in therapy sessions of psychotherapy clients, it called for frequent medication reviews involving changes in kinds and dosage of medication for some pharmacotherapy clients before they were able to attain some improvements in their mental health.
- Hope for the future: in spite of the barriers confronting CDP clients, most of them were resilient and hopeful. In most parts, the participants of this study were hoping to either find a job, return to school, reconnect with their loved ones, save money, buy a car, etc.

Surprisingly, except for only one pharmacotherapy client, none of the rest of the research participants mentioned anything about wanting to stay out of trouble, and neither did any say they were consciously doing something that will prevent them from reoffending. It is, therefore, not surprising that recidivism tends to be common among some CDP clients. But the absence of a conscious effort to avoid recidivism in the future may also be interpreted differently. It may also be that CDP clients come into contact with the law because they are not actively engaged in the community. And this is what most of the participants mentioned over and over again throughout the interview (housing, jobs, financial stability, education, respect, property acquisition, etc.). Albert, for instance, cried out loud that he is “left out” because he does not have any of the above. The craving for active involvement in the community echoes the belief that an individual’s strong bonds to social institutions such as family, school, education, and employment do “control” or restrain them from deviant or delinquent behavior (Hirschi, 1969).

Summary of the chapter

I have discussed how observation, knowledge, and experience of working with CDP clients led me into the field of this research. This study was approached with one main objective—to discover how graduated CDP clients in the City of Toronto experience psychotherapy as they integrate into the community. In particular, I sought to explore why CDP clients choose psychotherapy, how they experience their participation in this form of treatment, and the impact of psychotherapy on their community reintegration after encountering the criminal justice system. Given the dominance of pharmacotherapy in the court diversion program, the research objective was explored in comparison with the experiences of other CDP clients who received regular pharmacotherapy treatment in the court diversion program. The data collection, analysis, and report are authentic, accurate, and unbiased as this study was conducted according to the prescribed directives of the APA Publication Manual on qualitative research.

The report discussed in this current chapter is what the participants of the study shared with the researcher. Both CDP psychotherapy and CDP pharmacotherapy clients were given the chance to discuss how they enrolled and participated in the treatment of their choice. The participants were asked about the options they had about treatment as well as the benefits, accomplishments, and barriers they encountered in their attempt to reintegrate into the community. The responses of the participants have been presented in the way they were provided to the researcher. Whereas the organization, comparative analysis, and professional systematic writing were done under the guidance of my supervisor, the discussion, inferences, reflection, and interpretation of the data are the original work of the researcher based on his observation, experience, and knowledge in the field of mental health and justice services in the community.

Much has been discussed in this chapter about the interpretation of the data. Chapter seven of this work summarizes and concludes the key findings of this research. The summary discussion will include some recommendations to help improve the recovery of mental health clients who are involved in the criminal justice system as they integrate into the community.

Chapter 6: Theological Reflection

Introduction

In responding to the needs of people suffering from mental health issues, the Christian church is called into a ministry of radical befriending with the people who need our care and support (Swinton, 2000). Important as this may sound since caregivers have their own theological viewpoints, such a daring call would not necessarily be beneficial for care seekers unless care providers like myself, open themselves for inner soul searching and do self-reflection. As counsellors and pastoral ministers, though we all may have good intention to care for the needs of people living with mental health issues, we should also be aware of our own "embedded theologies" that has the potential of harming care seekers who approach us for service (Doehring, 2015). For this reason, Stone and Duke, (2013) perceive the art of theological reflection as a "critical inquiry" that requires the Christian theologian to take a probing stance and remain alert when providing spiritual care (p.114). That is why theological reflection remains an important piece in this study.

There are different models and methods of doing theological reflection, but because the spiritual well being of CDP clients is the utmost priority of the researcher, this chapter will adopt Doehring's (2015) "trifocal lenses," approach to discuss and analyze the research participants' experience of religion/spirituality. This approach allows caregivers to draw from "precritical," "modern," and "postmodern" perspectives of knowledge to examine and explain spirituality. Doehring's method cautions caregivers from being punitive to the weaknesses of care seekers as it draws on inclusion, diversity, and person-centred principles of care.

The first part of this chapter discusses the theological training of the researcher and how he eventually came to gather the confidence to perform the task of theological reflection despite his previous extensive experience in Christian ministry. The second section presents the participants' own report of their religious/spiritual experiences. To place the participants' spiritual experiences under the context of Doehring's (2015) "precritical," and "modern," sources of knowledge, the researcher first examines the responses of the participants, and grounds these experiences in Scripture and apply client centred and strength-based approach to analyze such Scriptural references. The application of Doehring's (2015) postmodern phase of the "trifocal lenses" focuses on a couple of theological themes selected from the cases to explain why CDP clients need compassionate spiritual care intervention.

Theological reflection: my learning journey

I have had the opportunity to minister to both large and small congregations for several years now. As part of my role in the community, I also provide religious education and sometimes, I assess the emotional and psychological needs of individuals and families and respond with practical intervention strategies including spiritual coping methods. Occasionally, I do supervise volunteers in various sections of ministries such as children, youths, campus students, etc. through coaching and mentorship. Despite these experiences, I was still nervous about doing theological reflection on a study that examines clients' treatment experiences in the court diversion program and their community reintegration.

Theological reflection can be easy and straightforward if one has shared values, faith, and common belief system with their audience. On the contrary, sharing theological reflection can either be uncomfortable and/or intimidating if one is not sure of the theological background of their audience. The question that came to mind when I first learned about the necessity of theological reflection for this research was: "Whose theology do I use, and how can my audience understand me if they do not share my foundational theology"? Little did I know that by asking this question, I had already begun the task of theological reflection, for my question implies that there are different ways of thinking theologically, and people who do not share my theological underpinnings may probably be evaluating this reflection from their own theological viewpoint. My confidence to think theologically heightened after reading portions of the book *How to Think Theologically* by Stone & Duke (2013). Throughout this book, Stone & Duke (2013) repeatedly remind their readers that because every Christian already has a theological perspective, all Christians are theologians. This was soothing and comforting for me, and it prepared me to become attentive and respectful to the utterances and experiences of the participants of this research as they expressed their struggles with addictions, homelessness, mental health challenges, and offensive behaviors.

Growing up in a traditional Christian home characterized by strict moral teaching, patriarchal domineering ethos, hyper-sensitivity to diversity, rigidity, overly assertiveness, and an effort to maintain an identity rooted in past glory, it took several years of both spiritual and academic training before I began to acknowledge and accept the inclusivist philosophy and multicultural identity. Thus, to provide a credible theological reflection on the sensitive experiences of the participants of this study, I realized the need to continue to unlearn some of my own prejudice and biases as a traditional Christian counsellor in congregational settings. With my training in intercultural and client-centered theories in social work, philosophy, and psychotherapy, although I have attained some level of growth in acceptance, recognition, and appreciation for the *other*, there is still room for improvement. I have found the influential works of Doehring (2015), Emmanuel Lartey (2003), Kathleen McAlpin (2009), and Stone & Duke (2013) very useful not only on my learning journey, but also in the description of themes, methods, and approach of my theological reflection in this research.

Description of and approaches to theological reflection

Given that all Christians are theologians (though everyone might have their own unique theological insights), it can equally be assumed that theological reflection may take any shape or form in the context of one's tradition, culture, or faith. However, because theological reflection of caregivers can make or mar the spiritual well-being of care seekers, it is important for theologians to be mindful of how their theological reflection impacts others. In other words, theological reflection in a counselling setting should enhance human dignity and life flourishing but not limit or suppress it. So, what then is theological reflection, what does it take to theologize effectively, and how can it be beneficial to our clients? In the following citation, Stone & Duke (2013) provide a working definition to conceptualize the art of theological reflexivity:

> At its best, theological reflection is attentive to the testimony of the Scriptures and receptive to the promptings of the Spirit. At its best, it is also critical inquiry. That is not to say it is negative or faultfinding, but it questions. It takes an honest, observant, probing stance toward everything that falls under the watchful eye of the Christian as theologian. The theologian sees things in a different light by

> asking and answering question after question. New insights into the ongoing work of God are gained. (p.114).

In her work, McAlpin (2009) also offers a practical working definition of theological reflection and what it entails:

> Theological reflection is a way of doing theology that starts from the experiences of life and leads to searching in faith, for deeper meaning, and for the living God. However, it is deciding how to live out of this reflective search that is the critical intention of the process of theological reflection.
>
> Theological reflection places the reflector in conversation with other sources of the revelation of God, primarily the faith tradition of the person or community. The world context of the experience is also particularly revelatory of meaning and the living God. The faith tradition and spirituality of the reflector are additional significant sources revealing the experience of God. Critical conversation among the sources is a process by which clarification, differences, or insights mutually challenge and expand each other. From this deepened awareness of God's presence in the experience, decisions are made for more relevant and prophetic choices in ministry. Through this critical conversation, the reflector is often challenged to a response of conversion of heart, mind, and action. (p.7).

The art of theological reflection, is, therefore, a high calling that places great responsibility on all pastoral ministers and Christian thinkers to walk worthy of their role as servants and lovers of peace in order to restore justice in today’s divided world. For theological reflection to be credible, it must be transformational (McAlpin, 2009). This will require the training, adjustment, receptivity, and open-mindedness of the reflector as they encounter tough religious questions, diverse belief systems, and different shades of opinions in our pluralistic society. The therapists' acquisition of these skills is meant to promote the holistic well-being of care seekers to pre-empt their stigmatization and discrimination by the larger society.

Doehring (2015) also highlights the importance of counsellors' lived experience and intercultural care training in pastoral counselling. Given that caregivers have their own embedded beliefs and values formed in childhood and through social systems, Doehring (2015) strives to protect care seekers from being harmed by the caregiver's foundational theologies. To avoid imposing the counsellor's unexamined beliefs and values on vulnerable clients, Doehring (2015) encourages pastoral counsellors to become theologically reflexive and adopt inclusivist and intercultural care approaches and practices that foster compassionate care. By this, Doehring (2015) offers an innovative approach to spiritual care that recognizes the unique ways people cope with life challenges such as fear, guilt, shame, stress, loss, and violence.

Introduction of the participants of this research

Ten participants were interviewed for this study. Five of them received treatment through psychotherapy, and the other five also received treatment through pharmacotherapy. Even though a few of the participants said they do not have any association with religion or spirituality, there were a number of participants who shared some common religious and spiritual insights in relation to their arrest, participation in the diversion program, and their community reintegration. Among the five participants who received psychotherapy, two of them (Teddy and Frank) said they were neither religious nor spiritual. The three other participants (Ray, Matt, and Kabir), on the other hand, discussed how their involvement in the justice system and the treatment they received taught them some religious /spiritual lessons.

On the other hand, among the five participants who received pharmacotherapy treatment, only Eric and Rod did not associate religious or spiritual meaning with their lived experiences. The other three participants (Albert, Douglas, and Pearson) shared their religious and spiritual interpretations of their experiences in their enrollment in the court diversion program (CDP), their treatment, and their community reintegration. Since chapter four of this study outlines the demographics of the participants, the focus in this chapter will be on the participants' own reports of their religious/spiritual experiences and the researcher's theological reflection on those experiences. The two key concepts – religion/spirituality that will feature throughout this chapter should first be reviewed.

Religion and spirituality

The participants who were interviewed for this study were asked to tell whether or not spirituality/religion played any role in understanding their mental health, charges, and their successful completion of the diversion program. Therefore, before describing the participants' religious/spiritual experience in this study, it is important to attempt a brief discussion of what religion and/or spirituality mean(s). The two terms are used interchangeably but there seem to be some significant differences between them, and the definitions of the two terms are not easy either.

In the traditional sense of the term, Pargament (2007) notes that "religion was a broad construct, one that included both personal and social expressions, subjective and objective elements, and the potential for both good and bad." (p.30). Commenting on the accelerated rate of the changes in the meaning and content of religion and spirituality in academia over the years, Pargament (2007) further notes that being religious includes what many people today would define as spirituality. This observation suggests a close connection between the two terms. However, religion sometimes attempts to explain the mysteries of the world and it professes to offer answers to many ethical and moral questions thereby claiming to possess the *truth*, but spirituality does not go that far.

The growing interest in religious phenomena resulted in defining religion scientifically. This systematic method conceptualizes religion as a phenomenon that can be described methodologically through an observable comparison of what religious practitioners believe in and how they practice their faith (Idinopulos,1998). By comparing major world regions such as Judaism, Christianity, Islam, Buddhism, Hinduism, African Religions, etc., it can be said that the term religion may be understood as a belief in and the practice of what one has faith in. This may include people's conviction in mystic ideas and identified beliefs systems, arts and symbols, rituals, and values, and sometimes, a high reverence for the leaders, ancestors, or founders of a particular tradition, whose teachings attempt to connect the supplicants of that tradition with the divine.

But religion appears deeper than just looking at its observable resemblances despite the basic assumption that this is the scientific way of describing religion. Such a reductionist description of religion is contested. As noted by Idinopulos (1998), "religion is not exhausted by the observable. There is another dimension called the nonobservable, which is religion's purpose and meaning." (p. 366). Religion has been defined in many ways by different scholars. For this reason, in *The Varieties of Religious Experience,* William James (1961) made several comments about the disagreements in human understanding of religion. James (1961) taught that such variations indicate the futility of defining religion under a single principle, and he cautioned as well that religion should not be defined in terms of its essence (p.39). It is, however, interesting to note that in trying to distinguish *personal religion* from *institutional religion*, James (1961) himself could not resist defining religion in terms of its essence when he wrote: “[w]orship and sacrifice, procedures for working on the dispositions of deity, theology and ceremony and ecclesiastical organization are the essentials of religion in the institutional branch.” (p.41). If religion cannot be defined by its essence (James, 1961); and if the observable activities of religious groups alone is not enough to describe religion (Idinopulos, 1998), then religion is what it is than how scholars attempt to define it.

Spirituality on the other hand, has also been defined in various ways. According to McAlpin (2009), “Spirituality is a way of living life from what is believed in faith.” (p.8). McAlpin’s definition is not far from what some people may consider to be a religion, especially, because of how faith is linked up with life in the definition. For the purposes of this study, I adopt the definition by Lartey (2003), whose intercultural framework of pastoral ministry and counselling described spirituality as:

> the human capacity for relationship with self, others, world, God and that which transcends sensory experience, which is often expressed in the particularities of given historical, spatial and social contexts, and which often leads to specific forms of action in the world. In essence, our spirituality has to do with our characteristic style of relating and has at least five dimensions: 1. relationship with transcendence 2. intra-personal (relationship with self) 3. interpersonal

> (relationship with another) 4. corporate (relationships among people) 5. spatial (relationship with both place and things). (pp140-141).

The phrase “transcends sensory experience” in Lartey’s concept of spirituality is striking, for it takes the definition of spirituality beyond the so-called scientific description of religion, which focuses only on the observable. What we say about the spirituality of a people is deeper than what can be discerned from our sensory experience. Also, because of the integrative power of humans’ spiritual life, Lartey (2003) notes that the above five dimensions of spirituality are inseparable, for they are to be understood as working together in an integrated whole. Most importantly, Lartey (2003) emphasizes the relational nature of spirituality and wants counsellors to understand it “not in ultra individualistic and esoteric terms” (p.142). As social beings, humans want to feel at peace and feel better; we are curious about how things and events can correlate to promote our wellness, so being in harmony in terms of spirit, soul, and body tends to be our passion.

As Pargament (2007) noted about the “good” and “bad” aspects of religion, Lartey (2003) also mentioned that spirituality has both strength and direction, and it can shape our purposes, mission, journey, quest, and goals in life. In this context, Lartey (2003) underlines that spirituality could either lead one to serve God in a quiet ascetic fashion or take up arms and die in defense of one’s nation. And I think it is this propelling power of spirituality on humankind that makes the nurturing role of the pastoral minister so crucial. As O’Connor and Meakes (2014) emphasized the caring role of the pastor in their work *A Christian understanding of curing and caring for the soul*, Lartey (2003) also notes that “practices such as worship, prayers for the lonely, the weak, the sick;

preaching and visiting; are engaged in by the pastor in order to assist people in their spiritual journey." (p.144). The pastoral ministry by and large could be an instrument for the provision of hope and care for CDP clients as they deal with stress, loss, and emotional pain.

Theological themes from the participants' experiences

As mentioned earlier, all ten participants of this study were asked to tell whether or not spirituality/religion played any role in understanding their mental health, their charges, and their successful completion of the diversion program. Some participants were brief in their narrative whereas others discussed details about their experiences, which not only tell how they coped, but also how they interpreted the events they encountered in the justice system, their treatment, and their community reintegration. Responses from the participants were of two kinds— those who expressed and assigned religious/spiritual meaning to their experiences and those who said they were neither spiritual nor religious.

Among the five participants who received psychotherapy, two of them (Teddy and Frank) said they were neither religious nor spiritual. The three other participants (Ray, Matt, and Kabir) were comfortable discussing how their involvement in the justice system and the treatment they received taught them some religious /spiritual lessons. On the other hand, while two pharmacotherapy clients (Eric and Rod) did not associate religious or spiritual meaning with their lived experiences, the three other pharmacotherapy clients (Albert, Douglas, and Pearson) attempted spiritual/religious interpretation of their experiences with regard to their charges, enrollment in court diversion, treatment, and their community reintegration. The priority in this chapter is on the theological themes emerging from the participants' description of their experiences rather than the connection or differences between individuals' treatment modality and their theological understanding. Theological themes that emerged from the interactions with the participants during the interview include the following:

1. Addiction and spirituality

When asked to tell whether or not spirituality/religion played any role in understanding his mental health, his charges, and his successful completion of the diversion program, Matt said that he was brought up in a Christian home, so religion forms part of his life. During the interview, Matt looked back and reflected on who he was when life was "normal" in his parents' home before moving to Ontario. Due to peer influence, Matt said he became addicted to alcohol and got involved in street life when he became homeless. But after receiving treatment, Matt remarked: "All that happened to me can be likened to the prodigal son. Things would have been different if I had not left the family. But my spiritual restoration is in process.".

Matt's narrative sheds light on his foundational belief as a Christian. He is insightful about his circumstances and realizes the painful consequence of joining himself with peers who influenced his alcohol consumption. Matt seems to believe that living with one's family whilst continuing to adhere to the traditional moral and cultural values will automatically produce the "good life". Hence, he blames himself and attributes his addictions to his leaving the family home. In the religious traditional sense, the natural tendency will be to guide Matt and encourage him to confess his *wrongdoings* and repent in order to receive forgiveness from God. This form of counselling only draws on the "precritical" and "modern" lenses of Christian counselling stemming from one's embedded theology (Doehring, 2013). A full application of Doehring's (2013) pastoral counselling model of "trifocal lenses," however, encourages Christian counsellors to critically reflect and draw on "postmodern" perspective counselling to help Matt as a care seeker.

What would care for Matt look like within a postmodern counselling framework? Doehring (2013) reminds us that before care seekers come for counselling, they already have the embedded theologies that they grew up with, and she encourages both counsellors and clients to closely examine if the client's "lived theology is congruent with their espoused theology and whether their lived theology is helping or hindering them in the context of the crisis or transition that compels them to seek care." (p. 90). From all indications, Matt's embedded theology seems to limit his understanding of his current circumstances. Though Matt has managed to successfully complete his diversion and has reintegrated into the community, the feelings of shame and guilt could potentially damage his self-esteem and plunged him into depression, withdrawal from people, and other social problems. Matt would, therefore, benefit from postmodern counselling that can uplift his soul through compassion, love, and care to transform his present predicament and vulnerability.

In the postmodern context, counsellors assisting Matt are to be cognizant of the causal link between trauma, addiction, and spirituality. Addiction—be it alcohol, drugs, polysubstance use, or behavior in nature, are usually a way some people satisfy their spiritual quest and cope with stressful life situation (Pargament, 2007). Perceiving the close connection between trauma/mental illness and addictions as a "brother and sister malady", Oliver Morgan (2009) also suggests spirituality and growth complement addictions treatment plans. Thus, Morgan (2009) points out that faith, hope, and love are important virtues that clinicians must consider as “critical elements in a spiritually sensitive focus in clinical care” for addiction and trauma recovery (p. 12). Matt can be supported in his recovery as these concepts are integrated in his care plan.

Ray is another participant who faced addiction challenges as well. Ray, however, handled his struggles with addictions differently. Unlike Matt, Ray perceived religion as a hindrance to his recovery until he rid himself of religion and embraced spirituality. When it comes to his struggles in life, his addictions, and enrollment in CDP, Ray says, it is a spirituality that he found helpful in his recovery journey as he explains below:

> One of the most effective treatments for people suffering from addiction is changing their environment. CDP program did not save my life; it changed the way I was living my life. I was a Roman Catholic by choice but when I discovered Spirituality (deal with intangible - the no material part of the human being - emotions - feelings) everything changed.

Ray said he does not practice religion anymore. He perceives religion as something outside (illusion) while spirituality is inside (reality - here and now). It is, therefore, very clear from the experiences of these two participants that religion or spirituality may play a crucial role in how CDP clients recover from their dilemmas.

2. Spirituality of homecoming

A place to call home was a major theme for the clients of this research. Almost all the ten participants of the study experienced homelessness in their lives prior to completing their court diversion program. There was a considerable effort in place to support these CDP clients to find housing, however, the passion of some of the participants to return home and the way that passion was theologized is of great significance. For instance, as part of his encounter with the justice system and his treatment, Matt tied his experience with a biblical character called the *prodigal son*. This narrative echo one of the three parables Jesus spoke about in Luke chapter 15 of the Christian Bible, where the youngest of the two sons of a father requested for his portion of the father's possession and left the father's house for a far country and squandered everything he had. Matt relates his experience with this *prodigal son* and blames himself for his homelessness, charges, and his enrollment in the court diversion program. Matt seems to be longing for his family, and he continues to show signs of the desire to return to the father's home though he does not seem to know how. As he shared during the interview, Matt said he is being restored spiritually. According to Matt, his parents have some elders in the community who come to him every now and then to visit and encourage him in the faith. This intervention seeking to restore Matt to his faith is laudable, however, it should not be a precondition for the parents' acceptance of Matt, especially within the context of postmodern counselling models such as Doehring's (2013) pastoral care. Doehring's (2013) care approach would rather identify a common spiritual need that is lacking in the life of both Matt and his parents and seek to fill that gap. Doehring's (2013) care approach, for instance, may highlight how Matt is missing the family home vis-a-vis the parents' loss of Matt's presence in the family. The relationship can be worked out without stigmatizing Matt. This spiritual care approach could reconcile Matt and his parents while helping Matt to overcome the persistent self-blame that has the potential to impede his growth and his mental health recovery.

Rod is another graduated CDP client who shared how he successfully worked his way through to reunite with his family. In describing his religious/spiritual identity, Rod said "I am not a faith or religious person, but I do not bother those who practice their religion or beliefs." Rod had hit his girlfriend and got involved with the justice system. He was therefore restrained from returning to the family home. During this time, Rod missed the family home a lot. Thus, when sharing his next steps after completing his diversion program, Rob said "my hope is to be able to return to the places where I was restricted from going in the past. And I really fought hard to get all those restrictions lifted.". Rod had been struggling with relationship issues, however, he shared that he was able to work with his lawyer and got his court conditions revoked, so he eventually went back to live with his spouse as returning to the family was his ultimate dream.

Though Rod describes himself as a non-religious and faithless person, his strong passion for unity with his spouse and his desire to return to the family home underscore some of the key elements of spirituality. As Lartey (2003) noted, our spirituality is characterized by the way we relate, some of which include intra-personal (relationship with self), interpersonal (relationship with another), corporate (relationships among people), etc. (pp140-141). Rod's experience confirms that it is possible for a person to be spiritual without being religious. For this reason, postmodern spiritual care providers need to be equipped with spiritual assessment tools so as to be able to provide spiritual support to care seekers who might not explicitly disclose their spiritual needs.

3. Spirituality of resilience

All the participants of this research showed a level of resilience in their encounters with the justice system, their mental health diagnosis and treatment, and their community reintegration. But I will focus on two of the participants whose resilience is quite remarkable. Before examining the experience of these two participants, a brief overview of the construct of resilience would be helpful.

The ubiquitous of the term resilience in different academic and professional settings is established (Cook & White, 2019). The definition of resilience has also undergone rigorous academic scrutiny as there are different factors and contexts that determine, influence, and shape how persons, families, communities, and organizations experience resilience in the course of time (Southwick et al., 2014). Because of this variety of opinions about resilience, Southwick et al. (2014) carefully delineated the construct of resilience at a multidisciplinary meeting published in the *European Journal of Psychotraumatology*. In this work, Southwick et al. (2014) provide some insight into the concept of resilience, and although each of the panelists has a "slightly different definition of resilience, most of the proposed definitions included a concept of healthy, adaptive, or integrated positive functioning over the passage of time in the aftermath of adversity." (p. 1).

The causal link between extreme adversity in life and the negative outcome such as long-term health effects in human experience is unquestionable. But despite the devastating effects of hardships in life, some people are able to go through such stressful situations and overcome them, and some are even able to turn negative outcomes into positive ones. Thus, even though the term resilience is said to be both vague and pervasive, Cook and White (2019) observe that resilience purports to translate anxiety into something productive. After a substantive review of various definitions of resilience, Cook and White (2019) gleaned three main key components from resilience in human beings: 1. the experience of significant risk or adversity; 2. the utilization of resources to cope with adversity; and 3. A positive outcome.

This construct of resilience fits the experience of some of the participants of this study. For instance, Kabir expressed his religious/spiritual insight on his experience and said:

> I believe in God, and I do pray. Things happen in life sometimes that one is not prepared for. My health issues, the charges, and my experience in the court system taught me different lessons. But I am thankful that God listened to my prayers, and everything is over now.

Kabir showed resilience when he first came to the court. He refused pharmacotherapy treatment and started looking for psychotherapy. When he was rejected for having pending charges in court, he never gave up. Kabir said he persisted until he found a free psychotherapy group class to enroll in. Kabir also stated he believes in God, and he prays regularly. Kabir perceives challenges as part of human life, so his encounter with the justice system was considered as some of the things that could happen to anyone at any time. Kabir did not blame himself or anyone, but he seized the occasion to receive treatment and all the available resources at his disposal for life improvement. Having learned different lessons, Kabir said he is "thankful that God listened to [his] prayers, and everything is over now."

Albert is another participant who showed resilience in spite of his struggles in trying to reintegrate into the community. Albert said his faith helped him to complete the CDP program. In his own words, Albert stated "I believe in God, and my faith keeps me strong in going through hard times. That was why I was able to complete the CDP when I was brought to the court.". Undoubtedly, Albert's resilience speaks volumes about the faith he is talking about here. This is a young man who reports not being able to relate well, and not being able to smile at times because of the severe medication side effects.

And yet, Albert is holding the fort as he continues to stand firm in the faith. Albert's circumstances might differ in a very significant way in terms of his arrest and suffering, but his strong faith reminds one of Apostle Paul, who went through all kinds of hardship in his personal life and ministry—a thorn in his flesh (2 Cor 12:7), beatings and incarceration (Acts 16:22-23), hunger and thirst (2 Cor 11:16-27), shipwreck (Acts 27:13 ff), snake bites (Acts 28:3), etc. Yet, at the end of his ministry, Apostle Paul said: "I have fought the good fight, I have finished the race, I have kept the faith". (2 Tim 4:7, RSV). Albert's strong faith is worthy of note given his condition.

Douglas also disclosed his religious/faith identity as a Christian, and here is the lessons he learned from his experience:

> I am a Christian and I go to Church. Considering what happened to me….my addictions behavior, my charges, treatment, and community settlement, all I could say is that all things work together for good for them that love God. Because if I did not come into contact with the law, I would not have received treatment, housing, and all the support I have today.

Douglas' theological insight seems to align with Rom 8:28, a familiar verse of the Scriptures, which many people find empowering as it can be applied to help one understand and cope with the odds and difficult life situations. Christians who find themselves in similar situations may use their experiences as a springboard to another level in their lives if they do not give up. No matter how one interprets Rom 8:28, the fact still remains that the suffering of individuals trusting in God will eventually work out for good in the coming glory, where there will be no more pain or grief. It is for this reason that, the narrative in Romans chapter 8 ends with the assurance that nothing can separate the believer from the love of God.

One of the questions that is normally raised on resilience is, why are some people more resilient than others, and what are the factors that determine a person's resilience? Research experts such as Southwick et al. (2014) opine that a person can become more resilient than others depending on factors such as "better support systems, better opportunities, better DNA, and a host of other non-DNA factors either appearing alone or interacting with one another." (p. 5) Indeed, there seem to be different factors that could potentially make some people more resilient than others. The list of other factors that determine a person's resilience is inexhaustible. But to leave no stone unturned, Southwick et al. (2014) echo, Southwick and Charney (2012) and highlight additional factors such as support from religion and spirituality, attention to health and good cardiovascular fitness, the capacity to rapidly recover from stress, the ability to regulate emotions, cognitive flexibility, loving caretakers, role models, etc. In this context, Douglass' belief in God and his participation in spiritual activities such as prayer, did help him to cope with the challenges he experienced during his enrollment in the court diversion program.

Both Kabir and Albert also expressed faith and belief in God. Kabir made use of prayer as a religious practice. This mirrors the support from religion/spirituality which is underlined as one of the factors that help people to become resilient. Religion/spiritual beliefs and practices alone may not fully account for a person's resilience. Social support, genetic factors, developmental factors, psychological factors, self-confidence, positive thinking, humor, altruism, trust, realistic optimism, active high coping self-efficacy, etc. contribute to people's resilience as well (Wu et al., 2013).

4. Overcoming temptation

People living with mental illness are sometimes stereotyped as aggressive and deviants by the general public. Those who hold such stereotypical ideas tend to overlook the negative influence of the oppressive power structure of society on CDP clients. As the reviewed literature highlighted, Becker's (1963) and Goffman's (1963) Labelling and Stigma theories explain how such stereotypes may negatively impact the criminal behavior of CDP clients since people have to put up with what they have been negatively labeled in society. Thus, stigma has the power of damaging an individual's self-image. But this was not applicable to research participant, Pearson because he said he was able to resist the temptation to revenge when he was accused by his partner.

Pearson identified as a Christian, and this is how he interpreted his experience when his girlfriend called the police for his arrest: "I felt that I was being tempted. I prayed a lot and read my Bible…. And I believe God answered my prayer by saving my life and giving me another chance to live." Pearson was kicked out of his family home and was issued a restraining order, so he could not return to the house or talk to his partner. Consequently, he became homeless, depressed, and suicidal. By saying he felt tempted, one could infer from Pearson's theology that temptation is common to the Christian faith. First, placing his accusation and arrest in the context of "temptation" seems to have helped Pearson to control himself and submit to the police authority just as Jesus surrendered to the soldiers who came to arrest him prior to his crucifixion. Second, Christ was tempted three times by the devil, but he did not yield. Therefore, by seeing this event as a temptation, Pearson also had enough grace to restrain himself from harming his girlfriend as this could have escalated his charges. Pearson said he was thankful for the support he received through the court diversion program, and he believes this timely intervention saved his life. Pearson successfully completed his diversion, his mental health was improved, he secured another housing, and he was able to find a job and transitioned smoothly back into the community. It is, therefore, not surprising that he expresses his appreciation to God for giving him another chance to live. Without this intervention, Pearson could have killed himself. This is the fulfillment of the Scriptures that say, “Many are the afflictions of the righteous; but the Lord delivers him out of them all” (Psalm 34:19, RSV).

5. Hope for the future

There are two major kinds of hope in Christian thought. Eschatological hope and the hope people hold about their lives in this present world, i.e., hope about improved living conditions. Eschatological hope is the hope of future things to come such as the coming kingdom of Christ including the belief in the Rapture, the Second coming of Christ, Millennialism, etc. (see Hoekema, 1994). The second type of hope is optimism about life and the belief in better things to come our way now or in the near future. The participants of this study expressed this second type of hope. Reflection on the hope of CDP clients about better things to come in their lives may seem a topic of less interest since we live in a world full of fear, panic, and uncertainty about the future. The evidence of environmental pollution, economic disparities among nations, poverty, high inflation rate, Covid-19 pandemic and its attending effects on death, joblessness, travel restrictions, etc. are enough reasons for people to become hopeless. Theologians such as De La Torre (2017) reflect on such uncertainties, especially, the threats posed by environmental pollution, and affirm the justification for the Christian’s expression of hopelessness:

> And even if we escape the mathematical probabilities of such random astrological events, we still cannot escape the hopelessness of the human dilemma. Our sun, like all other stars in the universe, will one day expand to become a red giant, bringing an end to all that lives. “Vanity of vanities, absolute futility. Everything is meaningless.” (p.3)

Despite this seeming pessimistic view of the cosmos and the world in general, some of the participants of this study showed some optimism about the future. It is not out of the ordinary for people who have shown resilience to also express hope about the present life, because enduring difficult life situations naturally produces a sense of hope if one does not give up or succumb to hardships. Such was the experience of most of the CDP clients after they had encountered the criminal justice system, stigma from society, guilt and isolation from their family and loved ones, and other triggering traumatic experiences.

To better understand the research participants’ reintegration experience, they were asked to discuss their hopes following their participation in the court diversion program. Diverse but interconnected subthemes became apparent in the study among both the clients who received psychotherapy and those who received medication. Frank, for instance, expressed that he does not feel integrated into the community until he either returns to school to complete his university degree or finds a job. Some of the CDP clients who were interviewed also said that they either want to volunteer or find a job. In his response to the question about his hope after completing diversion, Ray stated: “I am waiting for the lockdown to reopen then I can continue my volunteer work and improve my life condition.” Another participant, Teddy, said, “Right now, I am networking to establish my own business.”. Matt shared that he wants to get married and raise a family as well as build his credit and get a mortgage. On the same financial planning, Kabir said he wants to “continue working, save some money and become financially independent. I don’t want to receive social assistance anymore.”.

Not all the hopes expressed by the participants were material in nature, some wanted to earn their freedom and respect. Eric and Rod for instance, expressed the need for freedom and/or personal autonomy after treatment and completion of the CDP program. Rod said, “My hope is to be able to return to the places where I was restricted from going in the past.”. When Eric shared his hopes, he ended his narrative by saying: “I just want to enjoy my freedom and live a peaceful life without having no one to report to, etc.”. What Eric implies here is that he no longer wants to attend regular court appointments that he used to do as a requirement of the court diversion program.

Evaluation of CDP clients’ hope for the future

Overall, the question of hope after completing the diversion program elicited responses that suggest that despite the enormous benefits that CDP clients receive when they enroll in the court diversion program, they still have some unmet needs that they want to work on in their community reintegration process. Among others, these unmet needs include returning to school, volunteering or finding a job, establishing their own business, settling down and raising a family, financial independence, earning respect, personal autonomy, and property acquisition. In the context of Lartey (2003), the identified needs of CDP clients are spiritual in nature if they could help connect them with transcendence, with the self or with one another or among other groups of people, or if the needs could heighten the relationship with both place and things (pp.140-141).

While it is not uncommon for justice-involved clients to get discouraged and depressed by the oppressive power of society, the above-expressed needs, on the one hand, seem to serve as the source of motivation for graduated CDP clients to move on in life despite the reality of adversities. On the other hand, the same list of needs or expectations is an indication that care providers have much more to do to help these clients achieve their dreams in life.

A critical examination of the future hope of these clients reveals that the participants of this study are not being over ambitious or unrealistic about what they are looking forward to actualizing in the future, for these needs are basic necessities, and they are essential to human life. To earn respect or to be able to exercise one's personal autonomy, settle down and raise a family, etc. are not an ostentatious mindset. Until society admits that it is not okay for mental health clients to continue living on the streets and in shelters, until caregivers realize that they have not yet given their best to change the circumstances of CDP clients, until families, social groups, churches, and religious groups acknowledge the gap between the abled and the disabled, until the state closes the gap between the rich and the poor, these basic necessities in life would remain a mirage for people living with mental health issues and criminal behavior.

Counsellors and caregivers who are driven by love and compassion can collaboratively support CDP clients to realize their dreams. We can help these clients connect with themselves and others and ensure their full participation in communal life (Lartey, 2003). As Christian caregivers, we are called to radically befriend clients struggling with mental health issues (Swinton 2000). Unless a change takes place, our embedded theologies will always blindfold us from perceiving the spiritual needs of our clients. Since we have received grace, life, and goodness from God, we need to share the same goodness with those who need our care and service the most. Doehring (2013) perfectly puts words together as she describes the powerful influence of shared compassion from service providers to service users:

> The compassion of caregivers reveals the goodness of creation, humanity, and God. When care seekers take in this goodness, the blinders of habitual life-limiting embedded values and beliefs begin to fall away when they experience the goodness, beauty, and mystery of life that connects all of creation. Theologies change as people assess which values and beliefs connect them with the goodness of life. (p. 85).

Conclusion

Like all persons, CDP clients have their own ways of coping with their fears, losses, guilt, and shame. They expressed their fears and challenges in different ways during the interview. Most of the CDP clients embraced religious and spiritual coping strategies in handling the challenges they faced in their encounters with the justice system, their enrolment in court diversion, their treatment, and their community reintegration. While some CDP clients adopted life-giving theologies, others relied on traditional life-limiting theologies which do not seem to promote a healthy recovery. I have analyzed how clients with such life-limiting theologies can be supported in their struggles with addictions and homelessness using postmodern care approaches such as Doehring's (2015) “trifocal" lenses of care.

Blending ideas from the works of James (1961), Idinopulos (1998), and Pargament (2007), the differences and similarities between religion and spirituality have been delineated, and Lartey' (2003) work has been applied to explain why the needs of CDP clients may be considered as spiritual in nature. Importantly, five remarkable spiritual themes have been discussed in this chapter. These are, first, addictions and spirituality and how the two are interrelated. The second is the spirituality of homecoming, which presents how some CDP clients and their loved ones are longing to reconnect. The third theme discussed the resilience of CDP clients and how some of them are bouncing back in the face of adversities. Related to resilience is the fourth spiritual theme, i.e., overcoming temptation, and the fifth, the hope for the future.

If the participants of this study were not asked to share their religious/spiritual experiences in going through the CDP program, these themes would not have come up. The implication here is that CDP clients would benefit from not just psychotherapy but spiritually integrated psychotherapy. But unfortunately, as studies have shown, not all care providers are comfortable exploring religious and spiritual copings with their clients who walk into their counseling room (Pargament, 2007). The onus is on counsellors, social workers, and court support workers to be sensitive to the spiritual needs of the clients we serve, for humans are spiritual beings with spirit, soul, and body. Therefore, as we care for the body, the quest for the spirit and the soul should not be ignored.

Chapter 7: Conclusions

Introduction

In this concluding chapter, I discuss the implications of the study based on the summary of the key findings discussed in chapter five with specific reference to the barriers confronting CDP clients, especially those that limit their access to psychotherapy in the community when they enroll in the mental health court diversion program. Following the practical implications of the present research for clinical practice, I evaluate the study and point out some limitations from which I make some suggestions for future research. This final chapter is concluded with some recommendations to help improve the recovery of CDP clients who have experienced severe mental health issues and offending behavior as they attempt to reintegrate into the community.

Implications of the study for practice and policy planning

This research examined why CDP clients choose psychotherapy or medication as their treatment modality, and how they experienced their participation in their respective treatment as they re-entered the community upon graduating from the diversion program. The participants shared varied experiences during the interview about their involvement with the justice system, their enrolment in the court diversion program, and the treatment they received. In the context of clinical practice, therapeutic alliance featured prominently that deserves the attention of psychotherapists, pastoral counsellors, and social work practitioners who are working with persons with mental illness and offending behaviors. All the five participants who received psychotherapy treatment shared a strong therapeutic relationship that was established between them and their therapists. This became possible after therapist-client trust had been established. Practitioners have the tendency to complete a lot of paperwork and ask service users to sign this and that during the initial meetings. This research confirms the importance of therapeutic alliance for therapy outcomes. As we read in chapter five of this research, the strong therapeutic relationship discussed paved the way for CDP psychotherapy clients to open up for their therapists to enter their *world.* From the interviews with the participants of this research, the unique therapeutic alliance described above was not very common among CDP pharmacotherapy clients and their service providers. Clinicians should, therefore, spend some time to consciously build this mutual trust with their clients as they strive to support them achieve their counselling goals.

Moreover, there were key outcomes of psychotherapy experienced by the participants of this study, which includes improved mental health, reduced offending behaviors, improved relationships, insight, community participation, and many others. This positive outcome of psychotherapy did not happen out of the blue. The participants of this research shared their active involvement in psychotherapy sessions during the interview. The CDP psychotherapy clients stated that they were engaged by their therapists to share their life stories and experiences when they went for therapy. Some shared that they learned life skills through individual sessions and group discussions. This highlights the importance of clients' engagement during therapy. When engaged in therapy sessions, service users are given the opportunity to discuss what is meaningful to them in their lives, and the clinician's facilitation skills can also have an enduring impact on the clients. The CDP psychotherapy clients who participated in this research discussed some key lessons and practical skills they acquired during therapy sessions, which they continue to use in their day-to-day lives. As CDP clients continue to navigate community resources to help them deal with their charges, psychotherapy programs tailored for this population should be designed to make them actively involved in their own treatment plan by asking them how the therapy is going for them, what their interests are, what should the therapy time be focused on etc. (Jones-Smith, 2016).

At the heart of clients' active participation and engagement in therapy in this study is the practice of homework. Some of the CDP psychotherapy clients shared that they were given assignments between therapy sessions. It was striking to note during the interview that those clients who completed their homework were still practicing the skills they learned in therapy even after completing their diversion program. This confirms a previous study by Morgan et al. (2012), whose meta-analytic research highlighted the practice of homework as the most effective tool (among all other strategies they reviewed) for addressing recidivism among persons with mental illness and offending behaviors. Thus, when working with persons with mental illness and offending behaviors, therapists should endeavor to empathize, validate, actively engage clients, and give them homework activities to complete and return. It might not be feasible to always assign homework to clients as it may depend on one's therapy approach. Thus, Jones-Smith (2016) suggests that homework is relevant especially when a client's mind is centered on one thing, but their heart is also saying something entirely different.

This study also shows that though medication treatment is prominent and seems to work faster for CDP clients, it does not always work in silos. My first surprise in this study was when a participant told me that his psychiatrist referred him to a psychotherapist. There were also a couple of psychotherapy clients who saw their doctors while doing psychotherapy. This is an indication that psychotherapy and pharmacotherapy could work concurrently to help improve the mental health of CDP clients, for the two approaches are not mutually exclusive. For instance, when Pearson completed his pharmacotherapy treatment, he shared in an interview that: “Medication improved my mood and the counselling also helped as it focused on the reasons to live after feeling down and suicidal. Life bounced back and I was able to complete the diversion after renting my own place.” Pearson’s experience is an indication that a robust response to the struggles of CDP clients calls for a comprehensive strategy of collaboration, which requires a combined effort of legal, healthcare, and allied professionals to work together in the achievement of the recovery goals of CDP clients. This vision is consistent with the principle that service integration promises a better solution to the problem of recidivism among individuals with mental illness and offending behaviors (Livingston et al., 2008). It follows that if governments fund and sponsor the training and research on pharmacotherapy services, then psychotherapy deserves government funding and sponsorship as well. This calls for a reform in terms of health care policies on services that deserve government funding.

What is also evident from the study is that the isolation of CDP clients could hamper their community reintegration and their total recovery. The experience of Albert in the discussion is a case in point. Albert could not make friends, because he says he cannot smile, and cannot relate well, and he is currently alone in his room. This provides great lessons for professionals who run community group programs for mentally challenged individuals and their families. Clinicians can draw on this in their implementation of programs, meetings, and group sessions to integrate the full participation of people experiencing mental health challenges. In one-on-one psychotherapy sessions, therapists may assess clients' social networks and offer the appropriate support. Group participation should also be encouraged among those who are comfortable sharing and speaking in groups.

It was also noted that CDP clients who established a good relationship with their court support workers (CSWs) ended up following the instructions and guidance of these workers. This implies that CDP clients will more than likely rely on the knowledge and the skill set of the CSWs who work in collaboration with them to achieve their goals in the program. Therefore, CSWs' familiarity with psychotherapy will be the initial source of psychotherapy exposure to CDP clients. Short-term introductory psychotherapy training courses for CSWs and other stakeholders of the CDP will go a long way to support potential CDP clients' accessibility to psychotherapy.

Moreover, when prompted during the interview, most of the participants of this study shared their religious and spiritual insights on their experiences with the justice system, their treatment, and their community reintegration. The implication here is that CDP clients may also benefit from spiritually integrated psychotherapy. But unfortunately, as studies have shown, not all clinicians are comfortable exploring religious and spiritual copings with their clients (Pargament, 2007). The care for CDP clients should not be lopsided, it should rather cover all areas— spirit, soul, and body.

As graduated CDP clients live in the community and receive the needed holistic support, they may receive spiritual/religious growth, attend schools, train, volunteer, work, socialize, and contribute to the economy. This active participation in the community may reduce recidivism, hospitalization, incarceration, and significantly reduce government expenditure on shelter, policing, and healthcare.

Limitations to the study

To establish a strong analytic framework for cross-case comparison, Goodrick (2014) as well as other key qualitative comparative experts such as Kaarbo and Beasley, (1999) Merriam, (2009), Terrell (2016) Yin (2013, 2014, 2018) recommend the mixed method or multiple sources of data collection. However, due to Covid-19 restrictions, this study was anchored on a single qualitative method and used only interviewing technique for primary data collection. This, therefore, limits the full benefits of comparative analysis and data triangulation. Even though the mixed method is highly recommended for comparative research, Bates et al. (2018) and Jones (2020) successfully completed their research using the single qualitative comparative case study approach.

As is common to all qualitative research, this study sampled only a few graduated CDP male clients who lived in the City of Toronto to draw its findings. It is worth mentioning that these small numbers of participant groups cannot represent the experiences of the general population of psychotherapy and pharmacotherapy recipients.

Recommendations

This study has shown that not many clients are aware of psychotherapy services in the community, especially in the CDP program. Thus, there is a need to create awareness and expose CDP clients to psychotherapy services. I suggest a couple of approaches in response to this longstanding barrier. Upon their enrollment in CDP, court support workers may provide CDP clients with an intake package, capturing a list of community intervention programs including psychotherapy services in the jurisdiction where clients are registered for the CDP. The three main not-for-profit organizations which provide court support services in Toronto (Fred Victor, COTA, Canadian Mental Health

Association) may also form a multidisciplinary team of professionals including at least one psychotherapist, to provide ongoing clinical support to clients who enroll in CDP. The programs, meeting times, and venue of such a multidisciplinary team should be advertised widely in the media, on websites, and in the brochures of the diversion programs in Toronto. Detailed activities of such an imaginary multidisciplinary team should be printed out and made available at each site of the court. Moreover, the three organizations, which provide court support services in Toronto may also add free and affordable psychotherapy links and service information to their website to help clients navigate psychotherapy resources.

To ameliorate the funding issue, all levels of government, researchers, stakeholders, agencies, as well as private psychotherapy practitioners in the community may also play their part in making psychotherapy accessible to CDP clients. Government budgets for healthcare at all levels (federal, provincial, and municipal) should include funding for psychotherapy services. Also, community organizations that provide court support services may apply directly from the government to sponsor individual and group psychotherapy services in the community. Small community agencies may partner with larger organizations such as the Centre for Addictions and Mental Health (CAMH), which already has psychotherapy services running, to accept CDP clients' referrals. Since there are CAMH forensic psychiatrists who are already involved in the assessment of CDP clients at the mental health courts in Toronto, partnering with CAMH psychotherapists for similar support for this population should not be a big deal. As more community psychotherapy services become available and restrictions are relaxed, justice-involved individuals with mental health issues could have alternative access to psychotherapy, and the long wait time problems may be curtailed.

Researchers may also commit to conducting more studies in this area to improve the effectiveness of psychotherapy and explore how funding can be raised to make psychotherapy affordable for low-income earners. Educationists can help to investigate the myths associated with the effectiveness of pharmacotherapy vs psychotherapy for the treatment of mental illnesses. They could evaluate those myths and debunk them with evidence-based studies.

Regulated professional bodies such as the Canadian Counselling and Psychotherapy Association (CCPA), the Ontario College of Social Workers and Social Service Workers (OCSWSSW), and the College of Registered Psychotherapists (CRPO), may also play an important role. Aside from their commitment to members' training and professional development, these bodies could also set up committees charged with the sole responsibility of making counselling and psychotherapy accessible and affordable to people experiencing issues of mental health and offending behaviors. Professionals who newly join these bodies may be asked to volunteer a certain number of hours during their first year of registration to serve clients who are unable to access psychotherapy because of financial limitations. To make this feasible, those volunteers could provide their service online, over the phone, or via video. As part of their advocacy work, these professional bodies could also continue to lobby for funding from the government in support of low-income earners who suffer from mental health issues. In response to the accessibility of psychotherapy problems in Canada (inadequate supply of efficient psychotherapists, long wait times, and the high cost of psychotherapy services), the

CCPA, for instance, recently launched a campaign and called on its registered members to action by asking them to send a petition to federal candidates of the 2021 elections. The purpose of this campaign was to create awareness around the main barriers to the provision of equitable and accessible mental health care to Canadians. In such creative ways, professional bodies can make a huge difference in addressing the psychotherapy accessibility problem.

Moreover, as we read in Chapter 6 of this study, the experiences of most of the participants of this research highlight CDP clients' spiritual/religious quest as they enroll and participate in the court diversion program and receive treatment. Spiritual/religious themes that emerged throughout the interviews with the participants of this study include addictions and spirituality, a spirituality of homecoming, a spirituality of resilience, and overcoming temptation. When prompted, some of the participants contextualized their life experiences using religious expressions and symbols, and others also found religious practices such as visitation or follow-up soothing for their recovery and restoration to their religious roots. This is a clear indication that CDP clients would benefit not just from psychotherapy but spiritually integrated psychotherapy. Trained professionals supporting this population should therefore incorporate spiritual care programs and practices to help the healing and restorative process of CDP clients who need compassionate care, hope, and love to thrive in the community after experiencing stress, loss, guilt, and shame. Sometimes, worship, prayers, visiting, singing, preaching, etc. can go a long way to help people cope with stressful situations in life (Lartey, 2003; O'Connor & Meakes, 2014).

Future research

This study adopted a qualitative method strategy to investigate its research question. I would love to see the outcome of a study that adopts quantitative research or a mixed method to examine the lived experiences of graduated CDP clients who receive psychotherapy as part of their treatment plan for their community reintegration in comparison with those clients who do not receive psychotherapy but treatment as usual (medication).

The analyzed data from an interview with psychotherapy clients presents three modes of therapy participation. This is either one-on-one, group, or a combination of the two. Most of the participants who were involved in this study received their psychotherapy treatment prior to Covid 19. Therefore, social and physical distance restrictions did not apply. Post pandemic experience has changed the way we live and do things. The technology of our age enhances different forms of therapy sessions including Zoom, Microsoft Teams, or WebEx, for the delivery of psychotherapy services to clients. And I would love to see the impact of these changes on how CDP clients participate, engage, and retain information during the pandemic period compared to the pre-pandemic period when direct communication and face-to-face therapy thrived.

Also, in this present study, the researcher did not pay much attention to the type of psychotherapy that yielded positive results for the participants though some clients mentioned that they received CBT (Cognitive Behavior Therapy) during the interview. It was, however, puzzling to observe constant expression of self-blame from a particular client who received CBT. As discussed in the reviewed literature, there is strong research evidence that CBT is effective for addressing mental illness and offending behavior. But if a client receives CBT and continues with self-blame talks, then there is still a lingering question as to what kind of psychotherapy model will be most effective to address the needs of CDP clients as they integrate into the community. So, it is not enough to just introduce or incorporate psychotherapy in CDP, future studies should critically investigate the type of psychotherapy model that can empower the marginalized and voiceless CDP clients without stigmatizing them for their struggles.

Conclusion

Mental Health Court Diversion Program (CDP) was established to help clients with mental illness and offending behavior (MIOB) to live in the community and receive treatment instead of being sentenced and institutionalized by the criminal justice system (Schneider, 2010). Clients who enroll in the CDP program oftentimes have severe mental health issues that require immediate pharmacotherapy treatment protocol. The continuous dispense of medication for the treatment of MIOB has made pharmacotherapy prominent in the CDP program for some pragmatic reasons—not only does it save time for consultation between patients and their physicians, but it also “fixes” clients’ mental health challenges quickly in line with the medical model approach, and it seems to be convenient for court support workers as it helps them achieve their goals within a specific time frame. As a result, CDP program planners and its professionals are becoming less conscious of the power of collaboration and the existence of other effective intervention strategies (such as psychotherapy) for the treatment of mental illness and offending behavior.

As the data analysis of this research has shown, psychotherapy looks promising for CDP clients living with MIOB, for there are some key achievements and breakthroughs that the participants of this research reported regardless of their treatment modality. Some of these common accomplishments include, but are not limited to, successful completion of CDP, insight, improved relationships with loved ones, community involvement, improved mental health, reduced offending behavior, housing stability, and religious/spiritual lessons. Beyond these common accomplishments, this study revealed that CDP psychotherapy clients were more successful in their community reintegration compared to the CDP pharmacotherapy clients. The success stories of these graduated psychotherapy clients signal the dawn of a new beginning as previous studies (e.g., Burns et al., (2013); Gottfried, et al., (2014); Redlich et al., (2010); Ryan et al., (2010)) have attributed the success of CDP to other factors other than psychotherapy.

Despite the breakthroughs, accomplishments, and prospects of psychotherapy in the CDP program, the study confirms that there are still systemic barriers confronting court diversion clients who want to explore psychotherapy for their mental health. The study highlighted some of these systemic barriers (e.g., insufficient funding for psychotherapy, long wait times, therapists' hesitance to serve criminally involved clients, the predominance of pharmacotherapy, etc.), and I have made some recommendations to help mitigate the problem. I have reviewed the data analysis and deduced some practical implications of the present research for clinical practice. Moreover, I have pointed out some limitations of the study from which I also made suggestions for future research. All these steps have been taken with the hope of paving the way for the incorporation of psychotherapy in the CDP program to help improve the recovery of CDP clients who are involved in the justice system as they integrate into the community.

Also, as the study has confirmed, not many CDP clients are able to access psychotherapy. This is not because there are no psychotherapy services out there in the community. The issue of accessibility is more of a structural and systemic problem. Therefore, a few steps have been suggested to help facilitate the incorporation of psychotherapy into CDP. These include but are not limited to, an orientation of both CDP clients and their workers to community psychotherapy programs; empowering CDP clients to choose their preference of treatment; partnering hospital psychotherapists with community agencies that are already running diversion programs; creation of a professional team including psychotherapists that will commit to addressing the needs of CDP clients; mobilization of financial resources to fund psychotherapy services in the community; lobbying for government funding and training of more psychotherapists; publishing and disseminating psychotherapy programs to CDP clients at the court, online, and in the media; reducing the cost of psychotherapy for CDP clients by offering a sliding scale fee, and recruiting more psychotherapy volunteers through professional bodies like CRPO, OCSWSSW, etc.

To empower CDP clients and ensure their total liberation from oppression, discrimination, and institutionalization, the recommended steps towards the incorporation of psychotherapy in CDP should be framed around the tenets of narrative therapy. As discussed earlier in chapter one, narrative therapy allows individuals and groups to share their life experiences in a story form and offers them the opportunity to make meaning of their lived experiences and reauthor the dominant part of their stories in a way that reduces the harmful effects of their lives. With this framework, CDP clients can be helped to develop an alternative story that contradicts the dominant story embedded in their life experiences. CDP clients are sometimes stigmatized and labeled as violent criminals. Labeling theory explains that through internalization, people end up doing what society has labeled them. Narrative therapy can help externalize this condemnation, shame, guilt, and the labeling internalized by CDP clients. Thus, with narrative therapy, CDP clients can have a better sense of themselves as the problems they bring to therapy will be externalized. CDP clients have suffered a great deal of rejection and humiliation for years. By incorporating psychotherapy into the court diversion program, the narrative framework will give CDP clients the opportunity to rewrite their stories that reflect their true authentic selves.

References

American Psychological Association. (2009). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author

Arkowitz, H. (1997). Integrative theories of therapy. In Wachtel, P.L. & Messer, S.B. (Eds.), *Theories of psychotherapy: Origins and evolution.* American Psychological Association.

Bachar, E. (1998). Psychotherapy: An Active Agent: Assessing the effectiveness of psychotherapy and its curative factors. *The Israel Journal of Psychiatry and Related Sciences* 35. (2), 128-35.

Baillargeon, J., Hoge, S.K. & Penn, J.V. (2010). Addressing the Challenge of Community Reentry Among Released Inmates with Serious Mental Illness. *Am J Community Psychol* 46, 361 375. https://doi.org/10.1007/s10464-010-9345-6.

Barnes, C.G., Hyatt, M.J. & Sherman, W.L. (2017). Even a little bit helps: An implementation and experimental evaluation of cognitive-behavioral therapy for high-risk probationers. *Criminal Justice and Behavior*. Vol. 44, No. 4, 611–630. DOI: 10.1177/0093854816673862

Bartlett, l. & Vavrus, F. (2017). Comparative case studies: An innovative approach. *Nordic Journal of Comparative and International Education* (NJCIE) Vol. 1(1), 5-17 DOI: 10.7577/njcie.1929

Bates, D., Adams, J., & Henderson, G. (2018). A Qualitative Comparative Case Study of the Experiences of Convicted African American Fathers. *Spectrum: A Journal on Black Men*, *7*(1), 37–45. https://doi.org/10.2979/spectrum.7.1.03

Becker, S.H. (1963). *Outsiders*: Studies in the Sociology of Deviance. New York: Free Press.

Bhatta, P.T. (2018). Case study research, philosophical position and theory building: A methodological discussion. *Dhaulagiri Journal of Sociology and Anthropology* Vol. 12, 2018, PP 72-79

Brandes, D. (2019, September 25). Personal Interview at the Old City Hall, Toronto, Canada.

Corey, G. (2005). Theory and practice of counseling and psychotherapy. (7th ed.). Belmont, CA: Wadsworth.

Bromberg, W. (1941). Psychotherapy in a court clinic. *American Journal of Orthopsychiatry* Vol. 11, Iss 4, 770-774. DOI: 10.1111/j.1939 0025.1941.tb05867.x

Brown, A.P. (2008). A review of the literature on case study research. *Canadian Journal for New Scholars in Education*, 1(1), 1-13.

Bull, R., Cooke, C., Hatcher, R., Woodhams, J., Bilby, C. & Grant, T. (2010). *Criminal Psychology: A beginner's guide*. England: Oneworld Publications

Burns, P., Hiday, V., & Ray, B. (2013). Effectiveness 2 years postexit of a recently established Mental Health Court. *The American Behavioral Scientist*, Vol.57 (2) 189-208.

Canadian Mental Health Association. (2013, January 25). Mental illness costs Canadian economy $50 billion per year. Retrieved from https://ontario.cmha.ca/news/mental-illness costs canadian-economy-50 billion per-year/

Canadian Mental Health Facts Sheet. Retrieved from https://ontario.cmha.ca/wp content/uploads/2016/10/CMHA-Mental-health-factsheet.pdf

Carter, K., & Olshan-Perlmutter, M. (2015). Impulsivity and Stillness: NADA, Pharmaceuticals, and Psychotherapy in Substance Use and Other DSM 5 Disorders. *Behavioral Sciences*, *5*(4), 537–546. http://doi.org/10.3390/bs5040537

Centre For Addictions and Mental Health. Mental illness and addictions: Facts and statistics (n.d.). Retrieved from https://www.camh.ca/en/Driving-Change/The-Crisis-is Real/Mental Health-Statistics College of Registered Psychotherapists of Ontario. (https://www.crpo.ca/what-ispsychotherapy/)

Creswell, W.J. & Poth, C.N. (2017). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). California: SAGE Publication.

Cross, B. (2011). Mental health courts effectiveness in reducing recidivism and improving clinical outcome: A meta-analysis

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, *11*, 100. https://doi.org/10.1186/1471-2288-11-100

Chen, G., & Einat, T. (2017). To punish or not to punish—that Is the question: Attitudes of criminology and criminal justice students in Israel toward punishment. *International Journal of Offender Therapy and Comparative Criminology*, *61*(3), 347367. https://doi.org/10.1177/0306624X15595061

De La Torre, A.M. (2017). Embracing Hopelessness. Minneapolis, MN: Fortress Press.

Doehring, C. (2015). The Practice of Pastoral Care, Revised and Expanded Edition. Presbyterian Publishing Corporation. Kindle Edition.

Draine, J., Salzer, S.M., Culhane, P.D., & Hadley, R.T. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, vol. 53, no. 5, pp. 565–573.

Draine, J., Wolff, N., Jacoby, J. E., Hartwell, S. & Duclos, C. (2005). Understanding community re-entry of former prisoners with mental illness: A conceptual model to guide new research. *Behavioral Sciences & the Law*, 23(5), 689–707. doi: 10.1002/bsl.642

Elnitsky, A. C., Fisher, P.M., & Blevins, L.C. (2017). Military service member and veteranreintegration: A conceptual analysis, unified definition, and key domains. *Frontiers in Psychology*. doi: 10.3389/fpsyg.2017.00369

Feingold, Z. R., Fox, A. B. & Galovski, T. E. (2018). Effectiveness of evidence-based psychotherapy for posttraumatic distress within a jail diversion program. *Psychological Service*. 15(4):409-418. doi:10.1037/ser0000194.

Feucht, T. & Holt T. (2016). Does cognitive behavior therapy work in criminal justice? A new analysis from crimesolution.gov. *National Institute of Justice Journal,* No 277. therapyhttps://www.ncjrs.gov/pdffiles1/nij/249825.pdf Retrieved on March 10, 2019.

Foucault, M. (1978). *Discipline and punish: The birth of the prison*. Translated by Alan Sheridan. New York: Pantheon Books.

Foucault, M. (1987). *Mental illness and psychology*. Translated by Alan Sheridan. Los Angeles: University of California Press.

Frailing, K. (2010). How mental health courts function: Outcomes and observations. *International Journal of Law and Psychiatry*. 33, 207-213.

Gannon, A. T. (2016). Forensic psychologists should use the behavioral experiment to facilitate cognitive change in clients who have offended. *Aggression and Violent Behavior* 27, 130–141

Gill, K. J., & Murphy, A. A. (2017). Jail Diversion for Persons with Serious Mental Illness Coordinated by a Prosecutor's Office. *BioMed research international*, *2017*, 7917616

Gold, J. and Stricker, G. (2006). Introduction: An overview of psychotherapy integration. In Gold, J. & Stricker, G. (Eds.), *A casebook of psychotherapy integration*. American Psychological Association.

Goodrick, D. (2014). Comparative Case Studies, Methodological Briefs: Impact Evaluation 9, UNICEF Office of Research, Florence. GoodTherapy Homepage. https://www.goodtherapy.org/learn-about-therapy/types/existential psychotherapy.

Greenberg, S.L. and Rice, N.L. (1997). Humanistic Approaches to psychotherapy. In Wachtel, P. L. & Messer, S. B. (Eds.), *Theories of psychotherapy: Origins and evolution.* American Psychological Association.

Government of Canada Justice Website. https://laws-lois.justice.gc.ca/eng/acts/C 46/section 16.html Retrieved on April 28, 2019.

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case Study Research: Foundations and Methodological Orientations. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *18*(1). https://doi.org/10.17169/fqs-18.1.2655

Healey, K. (2005). *Social work theories in context: creating frameworks for practice*. New York: Palgrave Macmillan.

Hirschi, T. (1969). *Causes of delinquency*. Berkeley: University of California Press.

Holmes, A. G. D. (2020). "Researcher positionality - A consideration of its influence and place in qualitative research - A New Researcher Guide." *Shanlax International Journal of Education*, vol. 8, no. 4, 2020, pp. 1-10. DOI: https://doi.org/10.34293/education.v8i4.3232

Huhn M, Tardy M, Spineli LM, Kissling W, Förstl H, Pitschel-Walz G, Leucht C, Samara M, Dold M, Davis JM, Leucht S. (2014). Efficacy of pharmacotherapy and psychotherapy for adult psychiatric disorders: a systematic overview of meta analyses. JAMA Psychiatry. 71(6):706-15. doi: 10.1001/jamapsychiatry.2014.112. PMID: 24789675.

Human Services & Justice Committee (2017). Mental Health Courts in Ontario: A review of the initiation and operation of mental health courts across the province. http://ontario.cmha.ca/wp-content/uploads/2017/11/Mental-Health-Courts-in Ontario 1.pdf Retrieved on April 26, 2019

Husserl, E. (2017). *Ideas: general introduction to pure phenomenology*. (Gibson, B. W.R., Trans.) Martino Fine Books. (Original work published 1913).

Idinopulos, T. A. (1998). What Is Religion? *CrossCurrents*, *48*(3), 366–380. http://www.jstor.org/stable/24460821

James, W. (1961). *The Varieties of Religious Experience: A Study in Human Nature*. New York: Macmillan.

Jones, J.E. (2020). *Shooting on three historically black colleges and universities: A qualitative comparative case study*. (Doctoral dissertation, Graduate School of

Creighton University). htpp://dspace.creighton.edu:8080/xmlui/handle/10504/128777

Kaarbo, J., & Beasley, R. K. (1999). A Practical Guide to the Comparative Case Study Method in Political Psychology. *Political Psychology*, *20*(2), 369–391. http://www.jstor.org/stable/3792081

Landenberger, A.N. & Lipsey, W.M. (2005). The positive effects of cognitive–behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology* 1: 451–476

Lartey, Y.E. (2003). *In living color: An intercultural approach to pastoral care and counseling* (2nd ed.). Jessica Kingsley Publishers. Law Facts: A legal information resource from Legal Aid Ontario. http://lawfacts.ca/node/307

Leonidaki, V. (2019, October 31). Moving Beyond a Single-Model Philosophy: Integrating Relational Therapies in Front-Line Psychological Therapy Services in England. *Journal of Psychotherapy Integration*. Advance online publication. http://dx.doi.org/10.1037/int0000192

Leroux, C. L. (2008). *A behind-the-scenes examination of the Kitchener mental health court: The diversion of persons with mental disorders* (Order No. MR43713). Available from ProQuest Dissertations & Theses A&I; ProQuest Dissertations & Theses Global. (304806364). Retrieved from https://libproxy.wlu.ca/login?url=https://search-proquest com.libproxy.wlu.ca/docview/304806364?accountid=15090

Livingston, D.J., Weaver, C., Hall, H.N., & Verden-Jones, S. (2008). Criminal Justice Diversion for Persons with Mental Disorders: A Review for Best Practices.

http://www.cmha.bc.ca/files/DiversionBestPractices.pdf Retrieved on June 7, 2016.

Lyon, R.D. & Welsh, A. (2017). *The psychology of criminal and violent behaviour*. Don Mills, ON, Canada: Oxford University Press.

McAlpin, K. (2009). *Ministry That Transforms: A Contemplative Process of Theological Reflection.* Collegeville, Minnesota: Liturgical Press. Google Books.

Melamed, Y. (2010). Mentally ill persons who commit crimes: Punishment or treatment? *Journal of the American Academy of Psychiatry and the Law.* Vol. 38 (1) 100 103. Retrieved from http://jaapl.org/content/38/1/100/tab-article-info.

Mental Health Commission of Canada (2014). Why investing in mental health will contribute to Canada's economic prosperity and to the sustainability of our health care system. Retrieved from http://www.mentalhealthcommission.ca/English/node/742.

Mental illness and addictions: Facts and statistics. Centre for Addictions and Mental Health (CAMH). https://www.camh.ca/en/driving-change/the-crisis-is real/mental-health statistics. Retrieved February 18, 2020.

Meyer, C.B. (2001). A case in case study methodology. *Field Methods*, Vol. 13, No. 4, 329–352. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.461.5170&rep=rep1&ype=pdf

Mitchell, P., Smedley, K., Kenning, C., McKee, A., Woods, D., Rennie, E. C., Bell, V., R., Aryamanesh, M., & Dolan, M. (2011). Cognitive behaviour therapy for adolescent offenders with mental health problems in custody. *Journal of Adolescence* 34: 433–443.

Morgan, R. D., Kroner, D. G., Mills, J. F., Bauer, R. L., & Serna, C. (2014). Treating justice involved persons with mental illness: Preliminary evaluation of comprehensive treatment program. *Criminal Justice and Behavior*, *41*(7), 902 916. https://doi.org/10.1177/0093854813508553

Munetz, R. M. & Griffin, A. P. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services* Vol. 57 No. 4

O'Neill, C. (2006). Liaison between criminal justice and psychiatric systems: Diversion services Central Mental Hospital, Dublin, Ireland. *Irish Journal of Psychological Medicine* Vol. 23, (3), 87-88.

Pargament, I.K. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York: The Guilford Press.

Peterson, J. K., Skeem J., Kennealy, P., Bray, B., Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? *Law and Human Behavior*.38 (5):439–449. doi: 10.1037/lhb0000075.

Pratt, C.T., Gau, M.J. & Franklin, W. T. (2011). Key Idea: Hirschi's social bond/social control theory. In Pratt, C.T., Gau, M.J. & Franklin, W. T. (Eds.), *Key ideas in Criminology and Criminal Justice.* (pp.55-69). Sage publications. DOI**:** http://dx.doi.org/10.4135/9781483388045

Prosser, A., Helfer, B., & Leucht, S. (2016). Biological v. Psychosocial Treatments: a myth about pharmacotherapy v. psychotherapy. *The British Journal of Psychiatry* 208, (4) 309- 311. doi:10.1192/bjp.115.178368.

Psychotherapy Act 2007. https://www.ontario.ca/laws/statute/07p10

Rector, N. (2010). Cognitive-behavioral therapy: An information guide. Canada: Centre for Addiction and Mental Health. https://www.camh.ca/-/media/files/guides and publications/cbt-guide-en.pdf

Redlich, D.A., Liu, S., Steadman, J. H., Callahan, L., Robbins, C. P., Vessilinov, R. & Ozdogru, A.A. (2010). The use of mental health court appearances in supervision. *International Journal of Law and Psychiatry*. (33), 272-277.

Redlich, D.A., Liu, S., Steadman, J. H., Callahan, L., & Robbins, C. P. (2012). Is diversion swift? Comparing mental health court and traditional criminal justice processing. *Criminal Justice and Behavior*. Vol 39. (4). 420-433.

Remenyi, D. (2013). *Case Study Research: The Quick Guide Series*. (2nd Ed.). [Kindle version]. Retrieved from an online bookstore

Reuland, M. Scharzfeld, M., & Draper, L. (2009). *Law enforcement responses to people with mental illnesses: A guide to research-informed policy and practice*. New York: Council of State Governments Justice Centre.

Ripstein, A. (2001). Equality, responsibility, and the law. Cambridge studies in philosophy and law. USA: Cambridge University Press.

Rotter, M & Carr, A. W. (2011). Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches. *Community Mental Health Journal.* 47:723–726 DOI 10.1007/s10597-011-9391-z

Ryan, S., Brown, C.K., & Watanabe-Galloway, S. (2010). Toward successful postbooking diversion: What are the next steps? *Psychiatry Serv.* May; 61(5):469-77. doi: 10.1176/appi.ps.61.5.469.

Sapp, M. (2009). *Psychodynamic, affective, and behavioral theories to psychotherapy*. Springfield, Illinois: Charles C. Thomas.

Schneider, D. R., Bloom, H., & Heerema, M. (2007). Mental health court: Decriminalizing the mentally ill. Toronto: Irwin Law Inc.

Schneider, D. R. (2010). Mental health courts and diversion program: A global survey *International Journal of Law and Psychiatry.* Vol 33, 201-206.

Schopp, R. F. (2012). Mental Illness, Police Power Interventions, and the Expressive Functions of Punishment Available at SSRN: https://ssrn.com/abstract=2164300 or http://dx.doi.org/10.2139/ssrn.216400

Seligman, M.E. (1996). The effectiveness of psychotherapy: The consumer reports study. *The American psychologist*. 50. 965-74. 10.1037/0003-066X.50.12.965.

Simpson, S. (n.d.) Mental Illness and the Prison System. Centre for Addictions and Mental Health. Retrieved from https://www.camh.ca/en/camh-news-and stories/mental-illness and the-prison-system

Sippel, L. M., Pietrzak, R. H., Charney, D. S., Mayes, L. C., & Southwick, S. M. (2015). How does social support enhance resilience in the trauma-exposed individual? *Ecology and Society*, *20*(4). http://www.jstor.org/stable/26270277

Sirotich, F. (2009). The criminal justice outcomes of jail diversion programs for persons with mental illness: a review of the evidence. *J Am Acad Psychiatry Law*. 37(4):461-72.

Smetanin et al. (2011). The life and economic impact of major mental illnesses in Canada: 2011 -2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.

Southwick, M.S., Bonanno, A.G., Masten, S.A., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives, *European Journal of Psychotraumatology*, 5:1, 25338, DOI: 10.3402/ejpt.v5.25338. https://doi.org/10.3402/ejpt.v5.25338.

Spivakovsky C (2014a) Making dangerousness intelligible in intellectual disability. Griffith Law Review: Law, Theory, Society 23(3): 389–404.

Spivakovsky C (2014b) From punishment to protection: Containing and controlling the lives ofpeople with disabilities in human rights. Punishment & Society 16(5): 560–577.

Stake, R. E. (1995). *The art of case study research.* Sage Publications, Inc.

Stake, R. E. (2006). *Multiple case study analysis.* Guilford Publications.

Statistics Canada. (2020, January). *Canadians with mental health-related disabilities*. Retrieved from https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627 m2020008-eng.htm

Statistics Canada. (2019, December). *Common offense Classification*. Retrieved from http://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=257740&CD=25 741&CLV=0&MLV=3&D=1.

Steele, L. (2017). Disabling forensic mental health detention: The carcerality of the disabled body. *Punishment & Society*, *19*(3), 327 347. https://doi.org/10.1177/1462474516680204

Stone, H. W. & Duke, J. O. (2013). How to Think Theologically. Fortress Press. Kindle Edition.

Stricker, A.G. & Gold, R.J. (1996). Psychotherapy Integration: An Assimilative, Psychodynamic Approach. American Psychological Association. D12 0969 5893/96/L5.00 http://gweeks.faculty.unlv.edu/Integration%20Stricker%20and%20Gold%20199 pdf. Retrieved on August 29, 2019.

Swinton, J. (2000). *Resurrecting the person: Friendship and people with mental health problems*. Nashville: Abingdon Press.

Terrell, S.R. (2016). *Writing a proposal for your dissertation: Guidelines and examples*. New York: The Guilford Press.

Theories and causes of crime. The Scottish Centre for Crime and Justice Research. http://www.sccjr.ac.uk/wp-content/uploads/2016/02/SCCJR-Causes-of-Crime.pdf Retrieved on March 15, 2019.

Trepper, S.T., McCollum, E.E., De Jong, P., Korman, H., Gingerich, W. Franklin, C. (2014). Solution focused therapy treatment manual for working with individuals research committee of the Solution Focused Brief Therapy Association. In Kim, S.J. (Ed).

Solution-Focused brief therapy: A multicultural approach. DOI: http://dx.doi.org/10.4135/9781483352930.n2

Van Manen, M. (2016). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge.

Ward, T. & Brown, M. (2004). The Good Lives Model and conceptual issues in offender rehabilitation. Psychology, Crime & Law, 10, 243-257. DOI: 10.1080/10683160410001662744

Warman, D. & Beck, A. (2003). Cognitive Behavioral Therapy for Schizophrenia: An Overview of Treatment. Cognitive and Behavioral Practice - *Cognitive Behavior Practice.*10. 248 254. 10.1016/S1077-7229(03)80037-8

Wexler, D. (2000). Therapeutic jurisprudence: An overview. TM cooley 1. Rev., 17, 125. Retrieved from htpps://heinonline.org/HOL/LandingPage?handle=hein.journal/tmcr17&div=12 d=&pge=

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton.

Wolberg, R. L. (2018). *The technique of psychotherapy*. (4th ed). International psychotherapy institute.

Wu, G., Feder, A., Cohen, H., Kim, J. J., Calderon, S., Charney, D. S., & Mathé, A. A. (2013). Understanding resilience. *Frontiers in behavioral neuroscience*, *7*, 10. https://doi.org/10.3389/fnbeh.2013.00010

Yegidis, L. B. & Weinbach, W.R. (2006). *Research methods for social workers.* (5th ed.). Pearson Education, Inc.

Yin, K.R. (2013). Validity and generalization in future case study evaluations. *Evaluation* 19(3), 321-332. Doi 10.1177/1356389013497081

Yin, R. K., (2014). *Case study research: Design and methods*. Los Angeles, CA: Sage.

Yin, R K., (2018). *Case study research and applications*. SAGE Publications. Kindle Edition.

Appendices

Appendix A: Wilfrid Laurier University, Research Ethics Board clearance

LAURIER
Inspiring Lives.

February 04,2021

Dear Daniel Sem

REB #6660
Project, "Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in their Community Reintegration"
REB Clearance Issued:February 04, 2021
REB Expiry / End Date: January 31, 2022

The Research Ethics Board of Wilfrid Laurier University has reviewed the above proposal and determined that the proposal is ethically sound. If the research plan and methods should change in a way that may bring into question the project's adherence to acceptable ethical norms, please submit a "Request for Ethics Clearance of a Revision or Modification" form for approval before the changes are put into place. This form can also be used to extend protocols past their expiry date, except in cases where the project is more than four years old. Those projects require a new REB application.

Note – Minor Revision with Approval: As a part of this approval, please update the recruitment materials to include a statement indicating that the research project was approved by the WLU REB (REB # optional) and update the approval number included in the consent document from "REB# 10010686" to "REB#6660"

Note – University Research Resumption Requirements: REB approvals do not supersede any current university guidelines or measures in place to contain the spread of the novel coronavirus (COVID-19) including restrictions on university laboratory, field, or in-person research activities. If laboratory, field, or in-person research activities are described in this application, you are not permitted to undertake these portions of the project unless you've received prior approval through the university research resumption process. In order to apply to resume in-person research activities with human participants, please submit the appropriate phase 3b (on-campus) or phase 3c (off-site) application form (https://lauriercloud.sharepoint.com/sites/office-of-research-services/Pages/default.aspx).

Please note that you are responsible for obtaining any further approvals that might be required to complete your project.

Laurier REB approval will automatically expire when one's employment ends at Laurier.

If any participants in your research project have a negative experience (either physical, psychological or emotional) you are required to submit an "Adverse Events Form" within 24 hours of the event.

You must complete the online "Annual/Final Progress Report on Human Research Projects" form annually and upon completion of the project. ROMEO will automatically keeps track of these annual reports for you. When you have a report due within 30 days (and/or an overdue report) it will be listed under the 'My Reminders' quick link on your ROMEO home screen; the number in brackets next to 'My Reminders' will tell you how many reports need to be submitted. Protocols with overdue annual reports will be marked as expired. Further the REB has been requested to notify Research Finance when an REB protocol, tied to a funding account has been marked as expired. In such cases Research Finance will immediately freeze funding tied to this account.

All the best for the successful completion of your project.

(Useful links: ROMEO Login Screen ; REB Students Webpage; REB Connect Webpage)

Yours sincerely,

Sybil Geldart, PhD
Vice-Chair, University Research Ethics Board
Wilfrid Laurier University

Please do not reply directly to this e-mail. Please direct all replies to reb@wlu.ca

Appendix B: Recruitment email sent to the court support workers

RECRUITMENT EMAIL
Daniel O. Sem
Doctoral Student (Human Relationships)
Martin Luther University College
Wilfrid Laurier University
75 University Ave W, Waterloo, ON N2L 3C5

E: semx1440@mylaurier.ca
T: 416-995-8413

Feb 5, 2021

Dear Court Support Worker/Case Manager,
My name is Daniel Sem. I am a doctoral student at Martin Luther University College, Wilfrid Laurier University. I am conducting research on how court diversion clients find the use of psychotherapy in their community reintegration. I will be comparing clients who accessed psychotherapy services with those who used medication during their enrollment in the court diversion program.

The research project was approved by Wilfrid Laurier University Research Ethics Board (REB#6660). Your assistance is needed in the recruitment process. Specifically, you will help me reach out to graduated male court diversion clients who are at least 18 years old; who completed their diversion within the last five years; who used psychotherapy or medication as their treatment plan; and who are currently living in the community. Attached please find a recruitment flyer and forward to eligible clients who might be interested in participating in this research. Please note that your involvement in the recruitment process and/or the potential clients' participation in the study is completely voluntary. You can decide to be involved or not to be involved in the recruitment process and your clients are not to feel any undue pressure to participate in this research if they choose not to. The researcher will not be advantaged or disadvantaged by you or your clients' decision to be involved or not to be involved in this study.
Clients' participation in this research includes taking part in a telephone interview for about an hour to an hour and a half. If they agree to be part of this study, please have them call or text me at 416-995-8413 or send me an email at semx1440@mylaurier.ca

Should you or your clients have any questions about this research, please feel free to contact me at 416-995-8413 or send me an email at semx1440@mylaurier.ca

Thanks in advance for your attention.

Sincerely yours,
Daniel O. Sem.

Appendix C: Participants' recruitment flyer

Volunteers Needed!

Are you interested in participating in a court diversion program and psychotherapy research?

Inclusion Criteria

Must be a male:

- **18 years or older**
- **Graduated from court diversion program in Toronto within the last five years.**
- **Used psychotherapy or medication as a treatment plan when in the diversion program**
- **and currently living in the community.**

Compensation: $25 Gift Card

Interested? Contact Daniel Sem (The Researcher):

Email: semx1440@mylaurier.ca

Phone: 416-995-8413

Appendix D: Informed Consent

WILFRID LAURIER UNIVERSITY INFORMED CONSENT STATEMENT

Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in their Community Reintegration

By
Daniel Oduro Sem, *Doctoral student, Wilfrid Laurier University*

Supervisor:
Gyeong Kim, PhD. (Supervisor) *(Assistant Professor, Spiritual Care and Psychotherapy Martin Luther University College. gykim@luther.wlu.ca Tel: (519-884-0710 X 4870*)

Feb 5, 2021

Dear prospective research participant,

You are invited to participate in a research study. The purpose of this study is to discover how graduated court diversion program (CDP) clients in Toronto experience psychotherapy as they integrate into the community. The researcher is a Laurier graduate student in the Theology department (Spiritual Care & Psychotherapy) working under the supervision of Dr. Gyeong Kim.

Information

The study will adopt a comparative case study design in which adult male graduated court diversion clients in Toronto (18 years or older) who completed their diversion program within the last 5 years and are currently living in the community. Participants will be asked to share how they experienced psychotherapy or medication as a form of treatment in the diversion program. Through an interview, participants will be asked to discuss why they chose psychotherapy/medication, how they experienced their participation in this form of treatment, and the impact (if any) of this treatment in their community reintegration after encountering the criminal justice system. The interview will take about 1.5 hours to complete. Data from approximately 10 research participants will be collected for this study.

- There is a potential conflict of interest for being recruited by your court support worker/case manager. Be aware that your relationship with your worker or the PI (if you already know the PI) may influence your decision as a participant. Do not feel pressured to participate in this research just to please either your court support worker or the researcher if you do not really want to be part of the study. Your participation in this study is totally voluntary. The researcher will not be advantaged or disadvantaged by your decision to consent or not consent for this study. And you are free to discontinue your participation even after signing the consent.

- As part of this study, you will be audio recorded for research purposes. You have the right to refuse being audio recorded. Only the researcher and possibly, the supervisor of this research, will have access to these recordings and information will be kept confidential. You will not be able to preview these voice recordings. The audio will be transcribed by April 30, 2020.
- The voice recordings will not be used for any additional purposes without your additional permission.
- To participate in this study, you will need an active telephone line as the interview will be conducted over the phone in line with the Covid-19 pandemic measures.
- If you do not have a phone, and you choose to meet face-to-face, please note that both you and the researcher will need to comply with public health's guidelines to prevent the spread of Covid-19 (i.e. wearing PPE, maintaining physical distancing, hand sanitization, etc.).

INCLUSION CRITERIA

To be eligible for this study, the following conditions must be met:
You must be a male
You are 18 years or older
You graduated from court diversion program in Toronto within the last five years
You used psychotherapy or medication for treatment when you enrolled in the court diversion program; and
You are currently living in the community.

Risks

There are no foreseeable physical risks for participating in this study. However, you may experience some emotional discomfort or unpleasant memories, especially, when sharing your experiences about the court process and your treatment. You can utilize the following safeguard measures to help you minimize any discomfort resulting from your participation in this research. During the interview, you will be allowed to do some breathing exercise, stretch yourself, pulse or take a short break from the interview if needed. You will also be provided with a list of free community mental health resources in the Greater Toronto Area (GTA), which you can contact for support to ensure your safety and well-being.
Note also that you are free to discontinue the study at any time and to choose not to respond to any question without loss of compensation.

Benefits

Participants may benefit from the participation in this research project by learning more about themselves after going through the interview questions. Participants may also contribute to knowledge through the outcome of the study. Participation in this research is also an opportunity for court diversion clients to play an active role in a study that may lead to an improvement of their care and well-being. Participants may as well discover different treatment options in the diversion program. The research will contribute to the body of literature/knowledge on psychotherapeutic intervention for offending behaviors and important resources that can support court diversion clients for their successful community reintegration after encountering the criminal justice system.

Confidentiality

The confidentiality/anonymity of your data will be ensured because the researcher will use pseudo names for direct quotations in the study. Apart from the researcher and his direct supervisor, no other person will have access to the audio recorded interview. The data will be stored on a password protected computer and, on a password-protected recording device, which will be kept in the researcher's private library.

All audio devices and papers of this research will be securely kept in the researcher's briefcase during the data collection process. And since voice can serve as a direct or indirect identifier, all audio recordings will be deleted once the interviews are transcribed.

- The researcher is bound by the policies and principles of the University Research Ethics Board, Wilfrid Laurier University. Therefore, he has a duty and is committed to protecting participants' information from unauthorized access, use, disclosure, modification, loss, or theft. Breach of confidentiality may, however, occur by professional codes of conduct or by factors that are beyond the researcher's control (e.g. when thieves break into the researcher's cabinet or when the researcher's password protected/encrypted device is hacked). In the event of confidentiality breach, the researcher will immediately contact the research advisor and/or the Chair of the Research Ethics Board for immediate action.
- Identifying information including consent forms will be placed in a binder and kept in researcher's cabinet. This will be stored separately from the data and will be kept for 10 years at the researcher's private library and will then be destroyed by the principal investigator.
- The de-identified/anonymized data will be stored indefinitely in a different secured locker at the researcher's private library and may be reanalyzed in the future as part of a separate project (i.e., secondary data analysis).
- To prevent future re-linkage of direct identifiers and a code, the assigned codes will be discarded soon after the analysis of the data and the write-ups of the dissertation.
- While in transmission on the internet, the confidentiality of data cannot be guaranteed.
- If you consent, quotations will be used in the write-ups/presentations and will not contain information that allows you to be identified. You will be able to vet your quotations by contacting the primary researcher or his advisor prior to the write ups/publication.

Compensation

For participating in this study, you will receive a $25 gift card. If you withdraw from the study prior to its completion, you will still receive this amount. The Gift card will be mailed to the physical address you provide to the researcher.

Contact

If you have questions at any time about the study or the procedures or if you experience adverse effects as a result of participating in this study, you may contact the researcher, Daniel Oduro Sem at semx1440@mylaurier.ca or 416-995-8413.

This project has been reviewed and approved by the University Research Ethics Board (REB# 6660), which receives funding from the Research Support Fund. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Jayne Kalmar, PhD, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 3131 or REBChair@wlu.ca.

Participation

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide not to participate, you may withdraw from the study at any time without penalty. You have the right to refuse to answer any question or participate in any activity you choose.

Due to the anonymity of the data, if you withdraw from the study it will be difficult, but not impossible to have your data removed/destroyed.

- The principal investigator may terminate the participant's participation without regard to the participant's consent to protect them from excessive risk and/or when the participant exhibits serious health challenges.
- Before termination of a participation, the researcher will explain to the participant why they cannot continue with their participation.

Feedback and Publication

The results of this research might be published/presented in a thesis, course project report, book, journal article, conference presentation, class presentation.

- As this project explores the use of psychotherapy by court diversion clients in Toronto, the participating agencies providing court diversion programs may receive a report upon completion of the project.
- You will be allowed to vet your own quotation(s) before they are released in any write-ups or publication.
- A check box is provided below for you to indicate if you want to vet your quotations before they are released to the public. If you choose to vet your quotations, the researcher will email you your quotations or send it to you via the phone (text of call) prior to the publication, so you can decide whether or not you want your quotations published. After making your decision, you have one week to think about it and contact the researcher in case you change your mind about your decision.
- On the other hand, if you indicate that you do not want to vet your quotation but you later decide to do so, you have up to 4 weeks after the day of the interview to contact the researcher or his supervisor via the phone or email.
- The results of this research may be made available through Open Access resources.

- An executive summary of the findings from this study will be available by October 20, 2021.
- You can request the executive summary by e-mailing semx1440@mylaurier.ca. Or if you choose to provide your e-mail address for this purpose at the end of the study, the executive summary will be e-mailed to you by December 15, 2021.

Consent

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature ______________________________ Date ______________

Investigator's signature ______________________________ Date ______________

AUDIO-RECORDING

☐ I consent to have my voice recorded for the interview

☐ I do not consent to have my voice recorded for the interview

QUOTATION

☐ I understand that the researcher will use anonymous names for my direct quotation.

☐ I do not want to be quoted at all in this study

VETTING OF QUOTATION

☐ I would want to vet my quotation(s) before they are released to the public

☐ I don’t need to vet my quotation(s) before they are released to the public

Appendix E: Interview questions for psychotherapy clients

Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in their Community Reintegration

By Daniel Sem

September 15, 2020

1. Please tell me a little about how you came to choose psychotherapy as your treatment option.

2. What was your experience of psychotherapy in addressing the issues that brought you to court?

3. Were there other options offered to you? If so, what contributed to the choice you made?

4. How do you feel that psychotherapy supported your reintegration into the community? If it did not, what do you think got in the way?

5. How would you say psychotherapy made or did not make a difference in the way you related with the support workers, family members, loved ones, and others? Can you describe any changes you have experienced?

6. What was it like for you to go back to your community with people who know your story?

7. How do you experience members of your community responding to you?

8. What would be belonging to a community mean to you? What might be some examples of that for you?

9. What are your hopes following your participation in the court diversion program?

10. Please tell me whether or not spirituality/religion played any role in understanding your mental health, your charges, and your successful completion of the diversion program.

11. Anything else you would like to tell me?

Appendix F: Interview questions for pharmacotherapy clients

Exploring Graduated Court Diversion Clients' Experience of Psychotherapy in their Community Reintegration

By Daniel Sem

September 15, 2020

1. Please tell me a little about how you came to choose pharmacotherapy as your treatment option at the CDP.

2. What was your experience of pharmacology in addressing the issues that brought you to court?

3. Were there other options offered to you? If so, what contributed to the choice you made?

4. How do you feel that pharmacotherapy supported your reintegration into the community? If it did not, what do you think got in the way?

5. How would you say pharmacotherapy impacted the way you related with the support workers, family members, loved ones, and others? Can you describe any changes you experienced in your relationship with these people?

6. Upon receiving treatment, what was it like for you to go back to your community with people who know your story?

7. How do you experience members of your community responding to you?

8. What would be belonging to a community mean to you? What might be some examples of that for you?

9. What are your hopes following your participation in the court diversion program?

10. Please tell me whether or not spirituality/religion played any role in understanding your mental health, your charges, and the successful completion of the diversion program.

11. Anything else you would like to tell me?

Appendix G: Community mental health resources provided for the participants

<u>COMMUNITY MENTAL HEALTH RESOURCES-GREATER TORONTO AREA (GTA)</u>

--Canadian Mental Health Association, Toronto Branch. 480-700 Lawrence Ave W

Toronto. Tel:416-789-7957.

--Gerstein Crisis Centre. (24-hour crisis line in Toronto). Tel 416-929-5200

--Centre for Addiction and Mental Health (CAMH), 250 College Street, Toronto. Tel 416-535-8501

--Relief Resources: 2788 Bathurst St, North York, ON M6B 3A3. Tel: 416-789-1600

--Toronto Distress Centres**.** Tel: 416-408-HELP (4357)

--Progress Place Warm Line**. Tel** 416-960-WARM (9276), every day from 8 pm to 12 midnight

--Adult Grief Support Program-East Toronto 416-926-0905 or 416-496-6431

--Adult Grief Support Program-West Toronto 416-515-0197

--Reconnect Mental Health Services 416-248-2050

--Woodgreen Walk-In Counseling 416-645-6000 x 2512

--Psychotherapy and Counselling Centre 416-516-6969

--Distress Line 416-408-4357

--Mental Health Crisis Management Service 416-891-8606

--TeleHealth. Tel: 1-866-797-0000