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Perceived Social Ties and Mental Health Among Formerly Incarcerated Men in New York City

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Abstract
The incarcerated population has been substantially burdened by syndemic productions involving mental health illness and substance abuse problems. The present analysis describes the mental health symptoms of a nonprobability sample of 225 formerly incarcerated men and establishes the types of perceived support they received during incarceration as predictors of their psychological well-being upon release. The men were between 35 and 67 years of age; the mean age was 47.27 ($SD = 6.64$), and Blacks and Latinos were about equally represented. Most respondents did not finish high school, were unemployed, convicted of a nonviolent crime, and were housed in a New York state prisons. The majority were also single (never married) and had children. The findings indicate that greater social, community, and spiritual support were correlated with lower mental health scores. The strongest predictor was perceived social support. Access and use of social resources, including social support, are important factors in influencing the psychological functioning among formerly incarcerated men.

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Introduction

Incarceration in the U.S.

The United States (U.S.) has the highest numbers of incarcerated individuals in the world. During the 1990s, the growth rate of the prison population was seven times that of the general population (Diamond, Wang, Holzer, Thomas, & Cruser, 2001). Currently, more than 1.5 million people are incarcerated in U.S. federal or state prisons (Bureau of Justice Statistics, 2016b). In 2015, the average daily jail inmate population was about 721,300, with admission population of 10.9 million (Bureau of Justice Statistics, 2016a).

In the single year of 2015, a total of 641,027 prisoners were released. Incarceration in the past decades has dramatically increased the percentage of the population who possess criminal records from federal or state prisons (Bureau of Justice Statistics, 2016b), and at year-end 2014, more than 100 million Americans from the 49 states, the District of Columbia, Guam, and Puerto Rico were expected to have a criminal record (Bureau of Justice Statistics, 2015). As a result, approximately one-third of Americans have a criminal record.

Men in the Criminal Justice System

Some populations are disproportionally affected by incarceration. Males make up most of the incarcerated population and represent 92.7% of inmates and at least 85% of the annual jail population (Bureau of Justice Statistics, 2016a, 2016b). It is estimated that for every 100 adult men in the U.S., at least one will be sentenced to prison for more than 1 year (Bureau of Justice Statistics, 2016b).

Racial and ethnic minorities are also disproportionately affected by the criminal justice system, further burdening an already vulnerable population. The rate of imprisonment for Black and Latino adults is more than five, and two times the rate of non-Hispanic Whites (Bureau of Justice Statistics, 2016b). It is estimated that one in every 15 Black men and one in every 36 Latino men are incarcerated, in comparison with one in every 106 non-Hispanic White men (American Civil Liberties Union, 2011).

Predictors of Mental Health Among Incarcerated Individuals

The incarcerated population is substantially burdened by syndemic productions involving mental illness and substance abuse (Wilper et al., 2009). In the U.S. criminal justice system, it was reported that 37% of prisoners and 44% of jail inmates had a history of mental illness, and 14% of the prisoners and 26% of the jail inmates met the threshold for severe psychological distress (Baillargeon, Penn, et al., 2009; Bronson & Berzofsky, 2017; World Health Organization, 2007). A systematic review study of inmates from 12 Western countries concluded that, among male prisoners, the prevalence of major depression was 10%, antisocial personality disorder was 47%, and psychotic illness was 3.7%. Compared with the general population, inmates were 10 times more likely to suffer from antisocial personality disorder and two to four times

more likely to suffer from psychotic illnesses and major depression (Fazel & Danesh, 2002). These numbers are in contrast with the estimated 17.9% of adults in the U.S. who are affected by mental health problems each year (National Institute of Mental Health, 2017).

One reason that the criminal justice system may see more individuals who suffer from mental illnesses is that individuals who should be sent to mental health hospitals upon conviction because of the hospitals' ability to better treat acute psychological distress are, instead, incarcerated. The U.S. has a long history of detaining individuals with mental illness in prisons (Arboleda-Florez, 1999). An early observation of the relationship between mental illness and crime suggests that the increased number of beds in mental health hospitals was associated with a decreased prison population (Penrose, 1939). Furthermore, people with a severe mental illness who commit minor offenses are often arrested and unfortunately processed in the criminal justice system instead of admitting them to mental health hospitals (Lamb & Weinberger, 1998). Another reason the criminal justice system has more inmates with mental health problems is because they are more likely to recidivate than inmates without mental illness (Skeem, Manchak, & Peterson, 2011). Baillargeon, Binswanger, Penn, Williams, and Murray (2009), for example, found that the rates of multiple incarcerations over a 6-year period were significantly higher for inmates with major psychiatric disorders.

The proclivity for criminal activity among those with mental illness is exacerbated by the well-documented relationship between mental illness, substance abuse, and incarceration (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012). In 2010, an estimated 84.8% of the incarcerated population had a substance use disorder, and 64.5% met medical criteria for any alcohol or drug use disorder (Bureau of Justice Statistics, 2006; National Center on Addiction and Substance Abuse at Columbia University, 2010). After following up with 1,440 individuals with comorbidity of substance use disorder and severe mental illness for a period of 4 years, Kubiak, Essenmacher, Hanna, and Zeoli (2011) found that 63% of them entered jail.

The stress of the incarceration experience has a substantial adverse impact on the mental health and well-being of all inmates involved (Greenberg & Rosenheck, 2008a, 2008b). Some of those demands of incarceration that negatively impact mental health include but are not limited to over-crowding, deprivation of freedom, separation from family and friends, limited social networks, and lack of rehabilitation services (Huey & McNulty, 2005).

Support Types

Access and use of social resources are important factors in influencing one's physical and psychological functioning among formerly incarcerated men (Muñoz-Laboy, Severson, Perry, & Guilamo-Ramos, 2014). *Social networks* are defined as structures composed of relational patterns of interactions among a set of actors, including individuals, families, groups, or organizations (Foster & Charles, 2017). One of the most cited theories of social resources was proposed by Billings and Moos (1981), who defined social resources as an interpersonal network, including family, friends,

workplace, and community, from which individuals acquire crucial support. Social networks impact behavior through four related pathways: social support, social influence, social engagement, and access to resources and material goods (Berkman, Glass, Brissette, & Seeman, 2000; Negi, Michalopoulos, Boyas, & Overdorff, 2013). Social support exerts both direct and indirect impact on individual well-being (Cohen & Wills, 1985; Saracino, Kolva, Rosenfeld, & Breitbart, 2015). Strong social support networks promote mental stability and clarity and mitigate the burden of adverse experiences (such as the death or illness of a loved one, job loss, or another traumatic event) in one's life (Muñoz-Laboy et al., 2014).

Social and Community Support

For individuals experiencing stress, social support provides different types of aid, including instrumental aid (e.g., material/financial), emotional aid, and informational aid (Thoits, 1986). Therefore, in the face of adverse experiences, adequate social support can reduce the stress responses and buffer the impact of adverse experiences on psychological well-being (Cohen & Wills, 1985; Thoits, 1982, 1986). Thoits (2011) further categorized social ties, which refers to one's connection with/contact to the members in his or her social network, into two groups. Although the social ties in the primary group tend to be intimate, informal, and enduring (e.g., family, friend, relatives), social ties in the second group are more formal and less personal (e.g., co-worker, people from church). An individual can reap psychological benefits from both primary and secondary support groups. However, inmates with mental illness often lack social ties, which often result in adverse effects on the psychological being of recently released prisoners (Listwan, Colvin, Hanley, & Flannery, 2010). Pettus-Davis (2014) found that incarcerated men who had mental health concerns reported fewer positive social support resources and more substance abuse problems before their incarceration. Also, inmates who had mental health problems and substance use disorders anticipated fewer social support resources post release.

Spirituality and Religious Support

Religion or spirituality is another essential mediator between negative experiences and mental health outcomes (Schieman, Bierman, & Ellison, 2013). Specifically, a higher level of religiosity while in prison enhanced the psychological adjustment of the inmates (Clear & Sumter, 2002). Thus, religion can be viewed as an essential social support resource for inmates (Clear, Hardyman, Stout, Lucken, & Dammer, 2000). In recent years, the value of religion-based programming among inmates has been recognized, and established evidence has demonstrated the role of religion in preventing recidivism (Clear et al., 2000; Sumter, 2006). Johnson's (2004) 8-year study with male prisoners post release found that participating in Bible studies during incarceration decreased recidivism at two and three years post release.

As 95% of state or federal inmates will return to their respective communities, understanding the different types of support necessary for reentry and community

reintegration in formerly incarcerated men is critical to easing their transition from incarceration to release and minimizing mental health symptomology. In this analysis, we describe the mental health symptoms of a sample of 225 formerly incarcerated Black and Latino men and evaluate the types of perceived support they received during incarceration as predictors of their psychological well-being. The research questions were as follows:

Research Question 1: What patterns of mental health services were reported by formerly incarcerated men of color?

Research Question 2: What type of support (i.e., social, community, financial, or religious) has a stronger influence in positively impacting levels of psychological well-being and mental health among formerly incarcerated men?

Method

Study Procedures and Participants

This study utilized a cross-sectional research design. Data used for this analysis were collected from a previous study that examined cancer health disparities, criminal justice experience, mental health, support type, physical health, substance use, and ethics among 259 formerly incarcerated men (Valera, Cook, Darout, & Dumont, 2014). The current study focused on mental health outcomes and support types among 225 formerly incarcerated men only because 34 men had missing values. The study focused on recruiting men aged 35 years and older as most of the individuals who enter community supervision in New York are more likely to be in their 30s and older, and it has been established that social supports become increasingly more important as individuals age. The inclusion criteria of the parent study included the following: (a) self-identify as a male, (b) aged 35 years or older, (c) released in Bronx County, New York, (d) currently under parole or probation, (e) self-identify as Black or Latino, and (f) be able to provide informed consent. The informed consent protocol was approved by the first author's university institutional review board, and a Federal Certificate of Confidentiality was obtained. A research assistant obtained written informed consent approval from all eligible men who were interested in participating in the study. This process involved reading the informed consent documents to each participant, answering questions and concerns about the study, and signing the consent form. Participants were compensated U.S. $25 for completing the survey. Detailed study design and outcomes of this study are published elsewhere (Valera et al., 2014; Valera, Fullilove, Cali, Nunes, Chiongbian, Clark, & Covey, 2015).

A nonrandom, purposive and snowball sampling approach was used to recruit potential participants through word of mouth, distributing flyers, and posting advertisement about the study in selected agencies that provide social services to new releasees, criminal courts facilities, and community centers frequented by individuals under community supervision (Muhib, Lin, Stueve, Miller, & Ford, 2011). The men who completed the surveys were invited to participate in semistructured interviews

concerning their experience in the criminal justice system, with a particular focus on the mental health and support services they used during incarceration.

Standardized Measures

The General Health Questionnaire–12 (GHQ-12) has been consistently used to measure psychological well-being. This instrument has been used to document the severity of mental health problems in the past 4 weeks before participating in a study (Pevalin, 2000). The GHQ-12 is a 12-item measure on a 4-point scale (1 = *better than usual* to 4 = *much less than usual*). The minimum total score is 12, and the maximum total score is 48. One example of a question on the GHQ-12 is, "Over the past few weeks, have you been able to concentrate on whatever you are doing?" High scores represent worst perceived levels of well-being.

The Brief Symptom Inventory (BSI) is a 53-item 5-point Likert-type scale (0 = *not at all* to 4 = *exremely*) and validated standardized measure to assess psychopathology and psychological symptoms intended for use among adults and adolescents, including criminal justice populations who exhibit psychological symptoms (Derogatis, 1993; Valera et al., 2014).

The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item standardized instrument that uses a 7-point Likert-type scale response (1 = *very strongly disagree* to 7 = *very strongly agree*) to assess respondents' perceptions of social support concerning family, friends, and a significant other/partner (Zimet, Dahlem, Zimet, & Farley, 1988). The instrument has been validated in several studies with women and men. Zimet et al. (1988) and original colleagues' study of the MSPSS among women reported Cronbach's alpha for the subscales and the entire measure from .85 to .91, indicating that the measure was reliable, and test–retest values ranged from .72 to .85, suggesting a good and stable measure.

The Brief Community Social Support (BCSS), is a short, 5-point Likert-type scale questionnaire (1 = *strongly disagree* to 5 = *strongly agree*) to understand an individual's perceived sense of community. This measure was developed to gather information on the dimensions of needs fulfillment, group membership, influence, and emotional connection (Peterson, Speer, & McMillan, 2007). This measure has been validated on a sample of community residents in the midwestern region of the U.S., with the Cronbach's alpha totals for the following domains equalling needs fulfillment: .86; group membership: .94; influences: .77; and emotional connection: 87. An example of two BCSS measures includes the following: "I can get what I need in this neighborhood" and "This neighborhood helps me fulfill my needs."

The Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ) is a 4-point, six-item questionnaire that assesses the strengths and ties of religion and faith traditions with answers of "strongly disagree" to "strongly agree" on the Likert-type six-item questionnaire (Sherman, Simonton, Adams, Latif, Plante, Burns, & Polling, 2001). The SCSRFQ includes the following agree/disagree statements: "My religious faith is extremely important to me," "I pray daily," and "I look to my faith as a source of inspiration." This measure has been validated among cancer patients as well as

Table 1. Descriptive Statistics for the Study Variables (*N* = 225).

Measures	α	Possible range	Actual range	*M*	*SD*
Mental health					
General Health Questionnaire (GHQ)	.83	11-44	11-42	19.63	5.66
Brief Symptom Inventory (BSI)	.98	53-265	53-214	81.15	33.65
PTSD Checklist (PCL)	.94	17-84	17-84	29.51	14.65
Social support					
Perceived Social Support (PSS)	.90	12-84	12-84	63.34	14.08
Brief Community Social Support (BCSS)	.90	8-40	8-40	25.07	8.00
Santa Clara Strength Faith Scale (SCSFS)	.95	10-40	10-40	33.07	6.98
Financial support total	—	0-13	1-6	2.67	1.09

Note. PTSD = posttraumatic stress disorder.

young adults with a strong test–retest reliability (*r*s = .82-.93) and internal consistency (*r*s = .95-.97).

Financial support was measured by asking respondents about the source of their money from the previous three months (upon release from incarceration). Available answers included, 1 = *salary from work*, 2 = *Temporary Assistance to Needy Families (TANF) welfare*, 3 = *social security*, 4 = *supplemental security income*, 5 = *state disability*, 6 = *other*, check all that apply. Table 1 describes the descriptive statistics of the measures used in this study, including the total financial support score.

Per Nunnally and Bernstein (1994), a measure is reliable if its Cronbach's alpha is .70 or higher. As shown in Table 1, all the measures had Cronbach's alpha of .70 or higher, which indicated that the measures were reliable. The mean mental health and financial support scores were generally in the lower range, but the mean social support and spirituality scores were in the higher range.

In addition to the standardized measures used in this study, other instruments were developed by the lead author to explore additional topics. These topics include the following: participants' mental health during their last incarceration, which consisted of single-item questions about whether participants received treatment for certain mental health problems, including drug addiction, depression, or schizophrenia, among others; whether they had used mental health services while incarcerated (yes/no); or whether they were prescribed medication for their mental health condition (yes/no). The survey also asked about participants' spirituality/religious affiliation during their last incarceration and whether they had found God during imprisonment. Additional survey questions asked about the financial support participants received, including questions about the amount and sources of income, checking/savings accounts and military status.

Data Analysis

Descriptive statistics were computed for all measured variables to describe and interpret the data. Data were checked for missing values and outliers. Preliminary analyses were performed to make sure there was no violation of assumptions of linearity,

Table 2. Skewness and Kurtosis Indices for the Study Variables (N = 225).

Measures	Skewness		Kurtosis	
	Statistic	Index	Statistic	Index
Mental health				
General Health Questionnaire (GHQ)	1.28	7.87	1.41	4.37
Brief Symptom Inventory (BSI)	1.52	9.36	1.69	5.22
Social support				
Perceived Social Support (PSS)	−1.12	−6.92	1.40	4.32
Brief Community Social Support (BCSS)	−0.29	−1.82	−0.61	−1.88
Santa Clara Strength Faith Scale (SCSRFQ)	−0.99	−6.07	0.81	2.50
Financial support total	1.56	9.62	2.41	7.44

Note. SE for skewness statistic = .16; SE for kurtosis statistic = .32.

homoscedasticity, lack of multicollinearity, and normality. The main analysis included performing a multiple linear regression to investigate predictors of mental health outcomes (Aiken & West, 1991). Statistical significance was measured at the 95% confidence interval level ($p \leq .05$). Data analyses were conducted using IBM SPSS Statistics for Windows, version 23.

Missing Values

Within the final sample of 225, a few respondents did not respond to one or two items. The pattern of missing values was assessed via Little's Missing Completely at Random (MCAR) procedure. The findings indicated that the pattern of missingness was MCAR, $\chi^2(4,423) = 4,512.44$, $p = .171$. Therefore, missing values were imputed using the expectation maximization (EM) method (Tabachnick & Fidell, 2007).

Assessment of Normality and Multivariate Normality

Univariate normality. Univariate normality was assessed via the skewness and kurtosis indices of the variables (Kline, 2011). Per Kline (2011) a variable is normally distributed if its skewness index is below three and its kurtosis index is lower than 20. As shown in Table 2, except for the total BCSS score, all the other variables were not distributed normally. Therefore, the positively skewed variables were transformed using a natural log function, and the negatively skewed variables were transformed using a power function (Tabachnick & Fidell, 2007). The skewness indices of the transformed variables were all below three and thus were used in subsequent analyses (although, for ease of interpretation, the original metric is reported for all descriptive statistics). Multivariate normality was assessed via the normal probability plot generated by the multivariate linear regression procedure (Judd, McClelland, & Ryan, 2009; Norusis, 1991).

Table 3. Frequencies and Percentages for the Demographic Variables (*N* = 225).

Variables	*n*	%
Age (years) group		
35-44	83	36.9
45-54	112	49.8
55-67	30	13.3
Ethnicity		
Latino	105	46.7
Black	109	48.4
Other	11	4.9
Highest level of education		
Less than high school	137	60.9
High school or GED	59	26.2
Trade school or some college	24	10.7
College degree	4	1.8
Employment status		
Unemployed but looking for work	137	60.9
Employed	21	9.3
Student	2	0.9
Has disability or other	64	28.5
Relationship status		
Single, never married	138	61.3
Married	41	18.2
Divorced or separated	38	16.9
Widowed	8	3.6
Children		
No children	68	30.2
Have children	156	69.3
Type of crime		
Violent	44	19.6
Property	46	20.4
Nonviolent	135	60.0
Type of facility		
Jail	87	38.7
Prison	138	61.3

Note. GED = General Education Development.

Results

Demographic Characteristics

Table 3 displays the sociodemographic characteristics of the sample. The men were between 35 and 67 years of age; the mean age was 47.27 (*SD* = 6.64); and Blacks and Latinos were about equally represented. The majority of the respondents did not finish

high school (60.9%) and were unemployed (60.9%), convicted of a nonviolent crime (60%), and in prison (61.3%). The majority were also single (never married; 61.3%) and had children (69.3%).

Mental Health During the Last Incarceration

Many respondents received treatment for drug addiction (60.4%) during their last incarceration. The results also reveal that those respondents who reported receiving treatment for drug addiction also reported receiving services for depression (46%), anger (28%), anxiety (26%), and bipolar disorder (21%). Only a small percentage (29.8%) used available mental health services (such as therapy) during their last incarceration. Only a few were prescribed medication (25.8%) to treat a mental health illness or a substance use disorder.

Religiosity During Incarceration

About half of the sample indicated they were Christian (50.7%), and 15.6% of the men reported Islam as the religion they practiced. Only a minority indicated that they had found God during their incarceration (16.4%).

Financial Support

Table 4 describes the financial support reported by the men. The majority of the respondents earned less than US$10,000 in annual income (83.6%), did not have a checking account (84.4%), did not have a savings account (88.4%), and did not have any military status (89.8%). Approximately 56.9% reported that their primary source of money during the last 3 months after release from prison or jail was from Temporary Assistance for Needy Families (TANF).

Predictors of Mental Health

Predictors of Psychological Well-Being

The findings in Table 5 indicate that perceived social support negatively predicted psychological morbidity, $\beta = -.26, p \leq .001$. Community social support also negatively predicted psychological morbidity, $\beta = -.15, p = .030$. Likewise, spiritual support negatively predicted psychological morbidity, $\beta = -.14, p = .029$. More specifically, psychological morbidity scores were lower when formerly incarcerated men reported higher levels of social, community, and spiritual support. The strongest predictor of psychological morbidity was perceived social support.

Predictors of Mental Health

The findings in Table 6 indicate that perceived social support negatively predicted adult mental health, $\beta = -.24, p \leq .001$. Community social support

Table 4. Frequencies and Percentages for the Financial Support Variables (N = 225).

Variables	n	%
Annual income		
US$0-US$10,000	188	83.6
US$11,000 or more	37	16.4
Has checking account		
No	190	84.4
Yes	35	15.6
Has savings account		
No	199	88.4
Yes	25	11.1
Sources of money for past 3 months[a]		
Salary	23	10.2
TANF	128	56.9
SS	8	3.6
SSI	45	20.0
Disability	12	5.3
Other	45	20.0
Military status		
Veteran	17	7.6
Family member of veteran	4	1.8
Reserve or National Guard	2	0.9
No military status	202	89.8

Note. TANF = Temporary Assistance for Needy Families. SS = social security; SSI = supplemental security income.
[a]Ticked off as many choices as they could.

Table 5. Predictors of Psychological Well-Being: Multiple Linear Regression Results for the Psychological Morbidity (GHQ) Model (N = 225).

Variables	B	SE	β
Perceived Social Support (PSS)	−.00	.00	−.26***
Community support (BCSS)	−.01	.00	−.15*
Spiritual support (SCSFS)	−.00	.00	−.14*
Financial support	−.04	.05	−.05*

Note. Model $F(4, 220) = 11.01$, $p < .001$, $R^2 = .167$. GHQ = General Health Questionnaire; BCSS = Brief Community Social Support; SCSFS = Santa Clara Strength Faith Scale.
*$p < .05$. **$p < .01$. ***$p < .001$.

also negatively predicted mental health, $\beta = -.17$, $p = .006$. Likewise, spiritual support negatively predicted mental health, $\beta = -.17$, $p = .013$. Accordingly, mental health scores were lower when former inmates reported greater social, community, and spiritual support.

Table 6. Predictors of Mental Health: Multiple Linear Regression Results for the Mental Health (BSI) Model (*N* = 225).

Variables	B	SE	β
Perceived Social Support (PSS)	−.00	.00	−.24***
Community support (BCSS)	−.01	.03	−.17**
Spiritual support (SCSFS)	−.00	.00	−.17*
Financial support	.02	.06	.02

Note. Model $F(4, 220) = 11.46$, $p < .001$, $R^2 = .172$. BSI = Brief Symptom Inventory; BCSS = Brief Community Social Support; SCSFS = Santa Clara Strength Faith Scale.
*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

It is well established that mental health concerns disproportionately burden a significant number of individuals who are incarcerated. The literature suggests that one way of offsetting the deleterious effects of prison life among inmates is to build and use available social support resources prior to incarceration and during community reintegration (Muñoz-Laboy et al., 2014; Pettus-Davis, 2014; Valera, Bachman, Wilson, & Reid, 2017). The purpose of this study was to determine what types of social support—perceived social support, community support, and religious support—factors significantly predict mental health and well-being outcomes among formerly incarcerated men of color in New York City.

Inmates and Reported Substance Abuse

The univariate results suggest that the majority of the sample reported receiving services for at least one psychiatric disorder. The most commonly reported service received was a treatment for drug addiction. In addition, the overwhelming majority did not report using mental health services, such as counseling or therapy, despite taking medication for depression, anxiety, anger, and bipolar disorder. This finding is consistent with existing research. A systematic review of the mental health of inmates demonstrates that substance abuse and depression are highly prevalent among the prison population (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Gates, Turney, Ferguson, Walker, & Staples-Horne, 2017). This finding is concerning, given that both disorders are associated with increased risk of suicide, self-harm, violence, and victimization among inmates, during and after release from prison (Fazel et al., 2016; Gates et al., 2017; Ineme & Osinowo, 2016; Majer, Beasley, & Jason, 2017). It is not unusual for inmates to have untreated or undertreated needs due to a lack of mental health services (such as counseling and group therapy) available in the prisons (O'Hara et al., 2016). Future research should examine the extent to which services were needed for psychiatric disorders, but because of limited space and resources, the inmates were not able to receive services.

The results further show that a good number of respondents suffered from a comorbid condition of a substance abuse disorder and several psychiatric disorders. This finding is consistent with existing literature that suggests that a large percent of former inmates have symptoms of or have been diagnosed with mental health disorders that co-occur with a substance abuse disorder (Gates, Turney, Ferguson, Walker, & Staples-Horne, 2017). This finding reinforces the need for increased mental health interventions that treat co-occurring conditions not only during incarceration but also once they reenter their communities. However, this may be a challenging task given that men released from prison often experience extensive financial hardship (Western, Braga, Davis, & Sirois, 2015), which may preclude them from having the financial means to access mental health services.

The Effect of Social Support on Psychological Morbidity

Our results suggest that increased social support, community support, and spiritual support were significantly associated with lower levels of psychological morbidity. This finding is consistent with existing research that shows that religious support has been associated with reducing psychological morbidity (Maschi, Viola, & Koskinen, 2015). Religion may provide formerly incarcerated men with intrinsic meaning, which helps them deal with guilt and loss and in structuring a new way of life. Meanwhile, participating in religious or spiritual groups during incarceration provides inmates social support and access to interactions with outsiders (e.g., clergy, pastor).

However, the existence of perceived social support had the most significant impact on mental health. This finding may relate to the age of the participants in the sample. Family relationships play a substantial role in helping older inmates cope with a multitude of challenges. For example, secure family ties are associated with increased recovery from mental illness and also decreases the likelihood of the onset of mental illness (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Other research points to the risk of increased psychological distress when older inmates experience separation from family members (Baidawi & Trotter, 2015). Formerly incarcerated individuals are more likely to lean on family and friends (as opposed to parole officers), in part because they may feel that they cannot rely on parole officers for emotional and moral support, as the parole officers' role has shifted from one of support to one of surveillance in recent years (Clear, 2008).

Limitations

The findings from this study have several limitations. The sample size was relatively small, at 225 former inmates. Although our study participants were racially and ethnically diverse, it included only Black and Latino men who are under community supervision in New York and is not representative of other populations (e.g., women, White men) involved in the criminal justice system, therefore limiting our ability to generalize our findings to other jail and prison populations. The research described here should be replicated with other study populations by increasing the sample size, examining inmates returning to other areas such as rural communities, and should include

non-Hispanic White men and women of all ethnicities. It is necessary to include female and White male former inmates in future studies because they may experience unique access to and use of mental health care services and support networks.

Implications for Future Research and Programming Activities

Moving forward, involving personnel inside the criminal justice system (such as staff in jails, prisons and community reintegration offices), in providing and encouraging the use of social, community, and religious support services, may help to produce better mental health outcomes in formerly incarcerated men of color as they transition to mainstream society. Screening individuals for depression and anxiety, and ensuring that they are aware of the social, community, and religious support services available to them, is a first step in addressing this need. Often, the lack of spaces available in community programs for formerly incarcerated individuals limits access to social support programs; therefore, it is vital that there are enough programs available that are properly staffed and receiving funding. It would be ideal to tailor some of these support programs to individuals with mental health issues, such as depression, so that they can receive even more psychological benefit from the programs.

Instructing criminal justice system personnel about the importance of social, community, and religious support programs for this vulnerable incarcerated population is imperative in making the participation effort beneficial. Community psychologists and social workers can assist in this effort to reach out to the community and religious leaders to request they visit and lead inmates and former inmates in religious services and support groups. Fostering relationships with inmates, community and religious leaders, and leadership inside the criminal justice system is integral to increasing social support upon community reintegration. Doing so may improve the mental health outcomes of formerly incarcerated men of color.

Conclusion

Taken together, the results indicate that former inmates may have poor support networks that may result in poor mental health status. As a result, this population could face significant challenges as they attempt to reintegrate into society. It is well established that individuals who are linked to stable support services are much better positioned to accomplish a successful reentry (i.e., experience a reduced recidivism rate) and maintain a sense of general well-being and positive mental health status (Valera et al., 2017). The dire need for such supportive care is highlighted in this study by the contrast between the postrelease experiences of participants with, and without, social support networks and access to mental health services.

Declaration of Conflicting Interests

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