PERCEPTIONS OF PROVIDERS AND MENTAL HEALTH TREATMENT EFFICACY OF INCARCERATED INMATES/PAROLEES

A Project

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by

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Division of Social Work

Abstract

of

PERCEPTIONS OF PROVIDERS AND MENTAL HEALTH

TREATMENT EFFICACY OF INCARCERATED INMATES/PAROLEES

by

Asia Alexander

This study explored the facets of effective treatment and the way in which providers perceive the treatment they provide. As a qualitative exploratory study encompassed around grounded theory, a non-probability snowball sampling method was employed to obtain ten qualifying participants. Subjects responded to interview questions in regards to mental health, treatment efficacy, and experiences working with those incarcerated. Data analysis revealed varying conceptualizations about treatment approaches and modalities. Pertinent emerging themes surfaced among the data while it was being collected. One significant result involved the notion of rapport building preceding the actual treatment. This study demonstrates the necessity for further research into the treatment approaches being utilized in forensic settings and how the providers perceive such treatment as well as the need for social work professionals to comprehend in its entirety the complexity mental health providers employed by corrections and rehabilitation face. Implications for social work practice and policy are discussed.

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so special. I truly feel blessed to have this network of family and friends to share this accomplishment with.

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Chapter 1

INTRODUCTION

It is clear from the news to the personal experiences some may have, that crime and incarceration is a problem. However, one aspect that is often forgotten or unknown is the connection between mental illness and crimes committed. The vicious cycle repeats itself for many unfortunately, either those entering prison are doing so because they have committed a crime due to having a mental illness or those who were incarcerated get released from prison having now acquired a mental illness during their incarceration period. For many of them their mental illness is not discovered until they are in custody. The researcher is interested in studying mental illness and crimes committed which comes from her own experience of knowing individuals who have been incarcerated and her previous knowledge of mental illness through her psychology undergraduate studies. The researcher is also interested in the perceptions of providers about mental health treatment efficacy for those who are incarcerated. Research in this domain will build upon the ways in which inequality can be lessened through successful treatment plans and interventions. As a social worker, it is an obligation and duty to ensure the safety of others. Safety is an important aspect in life that many wish to obtain. Safety can be increased and fear of criminals decreased if these individuals were better understood. Many of those incarcerated are also diagnosed with a mental illness as previously stated. It is not clear whether they went in with a mental illness or came out with one, but one thing is clear and that is the greater the chance of keeping these parolees and their mental condition stabilized the less likely they are to offend.

This chapter will further introduce the male inmate population by recapitulating the research question being deemed in this project. There will be a consultation that addresses the overall purpose of the study as well as the theoretical framework guiding the research. This chapter in addition will provide a section that explores the assumptions and justifications for the research. Furthermore, the chapter will discuss the limitations of the project and present summaries of the chapter in progress and the ones that come to follow. The following section of the background offers greater insight into a commonly misunderstood social dilemma of the male inmate.

Background of the Problem

Today there is a substantial amount of people living amongst others with a mental illness and there is also an overcrowded population of inmates in jails and prisons. What society fails to see is the intersection between the two. According to the Council of State Governments (the justice center) in collaboration with the National Institute of Corrections and The U.S. Bureau of Justice Assistance (2012), the nation's prisons, jails, probation and parole agencies oversee an enormous amount of recidivism in regard to mental disorders and substance abuse disorders in the criminal justice system. It is said that providers in this field often see many of the same individuals who are at risk of arrest because of the behaviors exhibited by these individuals associated with their mental disorder (CSG, NIC, BJA, 2012). It is estimated by the National Institute of Corrections (2013) that on any given day approximately sixty-four percent of people booked into our nation's 3200 local jails are diagnosed or have diagnosable mental illnesses. The National Institute of Corrections also suggested that other possible risk factors of these individuals

that include violent behavior may be a result from exacerbated psychotic symptoms. The National Alliance on Mental Illness (n.d.) stated, approximately twenty percent of state prisoners have a recent history of a mental health condition.

Mental illness not only affects prisoners and inmates but society as a whole as well (Lamb, Weinberger, Gross, 2004). Besides the apparent direct effect of safety on hand with the general stigmatization that most give criminals, one hidden effect that many do not think about is the indirect effect that mental illness gives rise to on our economy. We as a nation hold those persons to a double standard. They are told to be a law abiding citizen and respectable person in the community and to do that they are to obtain and hold employment as well as some sort of roof over their head and possibly create a family. What they are not told is that as soon as they receive that label, which they will, of criminal, whether past or present, the likelihood of them getting a job or housing unit is drastically decreased. Society expects these cons to do better when they are released from jail or prison yet squander every chance they could have at obtaining that thus leading to recidivism (Wheeler & Patterson, 2008). It is often undiscussed that these particular individuals more often than not have a mental health diagnosis, which usually contributes to their decompensation thus perpetuating and reinforcing their bad behavior. According to Spjeldnes, Jung, Maguire, Yamatani (2012), “nearly nine million people cycled through an approximate 3,500 jails (p.130).” More recently, while the Unites States has incarcerated a total of almost two and a half million, it is often unknown or forgotten just how many of those inmates have a mental illness (Kupers, 2015). Besides an ever-growing population in our jails and prisons, serious mental illness

also effects the economy. Serious mental illness costs America $193.2 billion in lost earnings per year (NAMI, n.d). This statistic is a clear and prime example of the importance in addressing mental illness.

Statement of the Research Problem

Due to the expansion and growth of the male inmate population, who require specific treatment needs, it necessitates the need for cultural competence in social workers and other mental health care providers. While the mental health for these inmates remains a pertinent concern, looking at the mental health care provider is crucial in determining treatment efficacy. Male inmates are a very vulnerable population who at times can be difficult to work with, even so, one can assume that their unique cases can assist in informing social work research. Social workers and mental health care providers share accountability in their part toward treatment affecting this population and the ability to identify strengths and areas for improvement in their scope of practice. Appropriate staff should be aware of the pros and the cons that come along in working with this forensic population. Any deficiencies in the capability to provide effective treatment to male inmates on an unbiased, jaded, non-countertransference level remains an issue that should concern contemporary social work practice.

Purpose of the Study

The purpose of this research project is to collect and analyze data related to the perceptions of the providers in their treatment efficacy. Furthermore, common themes and similarities may emerge across the board in the provider's perception of treatment. Additionally, the information gathered with be organized into categories. Appositionally,

the researcher may find that there are several perceptions by the providers rather than common themes between the providers. The providers and future mental health care staff can benefit from the findings of this study in consideration to treatment efficacy what is seen as working and what is not. The researcher is interested in the commonalities between the providers in regards to their view of how treatment is effective and carried out. The purpose of this research is to discover the perceptions of the staff that work with this population and to discover what have been effective methods to treatment approaches. Effective treatment approaches would assist these individuals to be mentally healthy and stable, which increases their chances of safely reintegrating back into the community and decreases their chances of reoffending.

Research Question

This study explores the research question: What are the perceptions of providers about mental health treatment efficacy for those who are incarcerated?

Theoretical Framework

With all of the social inequalities and dilemmas inmates and parolees face, conflict theory may provide a framework to help guide the research the researcher is administering. Conflict theory, especially when focused on by sociologist, tend to contest resources or gains (Schlee, 2004). This theory attempts to address social disparities and while Schlee acknowledges that most theorist who have studied conflict theory look at resources being fought over, it is also important to look at the actual contenders.

Conflict theory also seeks to explain the need for identity work such as an “actor” changing his reasoning and needs to fit that of the group or alliance being formed to keep

others out and exclude those from trying to share in certain benefits. On the flip side, those who do not base their decisions off of reason base them of off consequences. The decision to choose has consequences as does the decision to not choose- it's a catch 22 (Schlee, 2004).

In terms of inclusion versus exclusion one must always be prepared that it is possible for one to be an opponent in one scenario and yet an ally in another. The identification of one is based off of cost-benefit ratio and social structures and their cognitive representations. They are ideological work and subject to change (Schlee, 2004). This too plays a role in conflict theory.

More recent theorist, after Marx, used conflict theory to focus on the limitations it posed in regards to functionalism. Conflict is viewed as inevitable and a part of life in all social systems (Lecroy & Rank, 1983). With this in mind, it is no wonder why prisoner's functioning is explained by this theory and what contribution understanding incarceration might lend to the improvement of social systems and conflict theory.

Application of Conflict Theory

In terms of the study being conducted, conflict theory is quite applicable. Conflict theory can easily be applied to the roles that inmates and parolees play in society because criminals in a sense are minorities, and the majority are those who are not in the incarceration system. It is quite apparent that those incarcerated or who once were incarcerated experience unevenly distribution of resources or unjust power on a day to day basis. Inmates and parolees are so belittled that they do not even get to use their name as they are remembered by a number. Inmates are able to work in prison for a minimum

wage of approximately eight cents an hour. People who commit the same crime but are of different races, will get different sentences. For instance, a Caucasian man with cocaine (usually powder) in his possession will receive a shorter sentence than an African-American with crack cocaine in his possession. If we take this a step further, not only is their injustice in sentencing among races, there is inequality between different crimes and how that can affect the stigmatization thus making it harder for them to integrate back into society once inmates are released. For instance, for someone who is a 290 (sex offender) that person is required to register as such, and has a difficult time finding jobs and housing. A person who "did their time" for murder and gets released from prison, unless telling someone, no one would ever know thus be able to pass judgment and discriminate even further beyond the fact that they were in prison. For both individuals, they will experience hardships due to having a record, however, the 290 registrant will most likely have a harder time because not only do they have a record but that record is known to the public. This is all applicable to conflict theory because this effects these individuals on multiple levels of their life. They are told upon release to integrate back into the community and become law abiding citizens but are shown no mercy, and many struggle to make ends meet and more often than not cannot make it on their own. Society perpetuates this cycle by making everything for this group an obstacle. This theory may address such conflict. In the application of mental illness and this theory, it too promotes an understanding that assists in addressing the conflict. Misunderstood and stigmatized are just a few ways to describe those diagnosed with a mental illness. For many of them, they feel alienated and now imagine that person not only feeling that way mentally but

also physically because they are behind bars in a jail cell. Mental illness is becoming more relevant as time goes on. Conflict theory lends a hand to understanding it because with ignorance comes conflict. The lack of awareness with mental illness in our society and yet trying to evoke sympathy in non-diagnosed individuals is a recipe asking for conflict. Conflict theory may address mental illness by establishing first and foremost that different patterns of thinking as inevitable and strive to ensure equality because just as class can divide a community so can lack of empathy. As mentioned earlier not only are criminals a minority are so are those diagnosed with a mental illness, they are seen as an outcast. This theory can help close that gap.

Definition of Terms

The following terms are applied within this research project and are common to the sphere of incarceration. These terms may require definitions and are briefly described.

Mental illness: "The direct effect defined as the specific influence of concurrent delusions or hallucinations on the criminal offense. Or defined indirectly as any other symptom-based influence, such as confusion, depression, or irritability (Peterson, Skeem, Kennealy, Bray, Zvonkovic, 2014, p.440)."

Corrections: "Inmates in federal, state, and local prison systems (Kelly, Ramaswamy, Chen, Denny, 2015, p.89)."

Recidivism: "Going back to jail versus staying in the community (Spjeldnes, Jung, Maguire, Yamatani, 2012, p.138)."

Comorbidity: "Individuals with both a mental health and a substance use disorder (Brady, Kreb, Laird, 2004, p.84)."

Stigma: A mark of shame or discredit; an identifying mark or characteristic-specifically: a specific diagnostic sign of a disease (Merriam-Webster Learner's Dictionary, online).
Efficacy: The power to produce an effect (Merriam-Webster Learner's Dictionary, online).

Assumptions

The objective of this research proposal is to address several assumptions that encompass mental health issues many of those incarcerated face. The first assumption is that individuals who are incarcerated and have a mental illness have a different experience than those who are incarcerated absent of a mental illness such as the reason the crime was committed or the level of understanding the crime that was committed. Another assumption, is that it is assumed that these individuals should be treated the same as those in good mental health and receive the same sentencing for similar or same crimes. Not to mention, these individuals are tried in the same court as everyone else when they should be tried in the adult mental health court system. The last assumption made by the researcher is that the services and treatment plans provided to these individuals are helpful and a starting point because for most this is the first time they are hearing their diagnosis.

Justification

Under the aforementioned assumptions, the goals of this research would include having a better understanding of how providers view their treatment with the inmate-patients. Another goal would be to determine what approaches are commonly used and effective within this challenging population. An objective of this research would include

gaining insight into the treatment efficacy and how that impacts the provider and patient. The focus of the male inmate population remains significant to social workers on a couple of different levels. First, the forensic population is one population that is vulnerable and stigmatized. Second, the male inmate population especially upon release from prison has the ability to effect the well-being of themselves, others and society.

This phenomena of several inmates having a mental illness pertains to the study of social work because it has a direct effect on society. It is a social worker's duty to ensure safety for all and the well-being of individuals. Many people suffering with a mental disorder are homeless and in poverty. It is these individuals that are likely to commit a crime for basic needs at times and at other times because of survival. Crimes committed especially violent crimes effect the community and puts everyone at risk. The data on the prison population effects everyone as a whole because it is the public's tax dollars that are shoved into this institution of imprisonment. Once released from prison, parolees are expected to integrate back into society. How is that possible if housing becomes hard to find because not many people are willing to rent to those who have a criminal background regardless of the crime, not to mention most parolees cannot pay for rent even if they found a place because most employers do not want to hire an ex-convict. It is a vicious cycle and revolving door of offending and re-offending because the message that is sent, is that there is no place for you here. What tends to happen is that without monitoring and supervision medications are often forgotten to be taken or cannot be prescribed or the cost cannot be covered, and the list goes on and on, and the individual now off of their meds will likely commit another crime and possibly even

intentionally just to go back to prison for stability with a “I can get housing and food” mentality even if that means being behind bars again. For these very reasons, it is crucial for social workers to stand by their NASW Code of Ethics (2008) such as “ social workers’ primary goal is to help people in need and to address social problems as well as, social workers challenge social injustice” to ensure change and promote growth.

Delimitations

This is a qualitative research study that uses grounded theory. It is designed to be exploratory in nature and lacks quantitative analyses. The study has a small sample size of ten and therefore limits the amount of data that may be discovered. In addition, the study findings are not generalizable to the population due to the sampling size and the non-probability snowball nature of the sampling method. The method of sampling design was chosen due to the lack of mental health providers that work with this population in the Sacramento area. However, the information collected from this study may still contribute and assist others and future mental health providers in improving and developing effective treatment approaches and treatment methods with this population.

The study results is expected to have a range of themes that emerge and, with that comes the likelihood of the study remaining broad and general to accommodate the knowledge level of participants. Participants may vary in age, race, education, and religious convictions. The only requirement was that the participant worked with someone who is or has been incarcerated. All data collected by the researcher through the interviews conducted and the literature review will be used as the main guidance to interpret results in this study. With the interviewees, who were informed by their personal

experience with the population under consideration, their work experiences are the focus of the interpretation of the research findings.

Summary

Chapter one of this project is an introduction to the topic of treatment efficacy of mental health care providers with the male inmate population. In this chapter, there is also a review of the background of the problem, the research question being addressed, purpose of the study, the theoretical framework employed, in addition to the assumptions, justification, and limitations of the study. In Chapter two, there is a discussion of academic literature of male inmates and common phenomenon that accompany them. In Chapter three, the methodology of the research will be described. Chapter four will include a presentation of the findings of the research. Finally, in Chapter five, the conclusions and the implications of the study will be addressed.

Chapter 2

LITERATURE REVIEW

In this chapter, six major sections of mental health concerns and treatment options for those who are incarcerated is reviewed. In the first section, a history of mental health is presented. The second section addresses comorbidity. Recidivism is examined in the third section. In the fourth section, the criminalization of the mentally ill is explored. Treatment approaches are discussed in the fifth section. A sixth section includes the gaps in the literature review. Finally, the chapter concludes with a summary.

Historical Background of Mental Health Criminalization

Mental illnesses have been around since the beginning of time, as time progresses so does the knowledge on such mental illnesses that exist. It is now known that there is a correlation between those incarcerated and having a mental illness. Crime and the law have also been around for quite some time, however, the understanding of why some individuals committed those crimes are now better understood with the expansion of awareness when it comes to mental disorders (Chaimowitz, 2012).

Mental illness was originally seen as a personal demon. It was viewed as a curse and interventions such as exorcism or magic were needed to cure it. Dating back to B.C., places such as Egypt once had a strong religious push in healing where the priest and physician were seen as one (Deutsch, 1949). With the development of Greece, we see both Greece and Egypt exploring treatment options to essentially heal those with ailments through utilization of healing shrines and rituals. The idea of being visited by a bona fide

divinity was not uncommon in those days. Deities and the use of incantations i.e. herbs. Vegetables, ointments, precious stones, were also used for healing.

In these times being seized by madness (later known as epileptic furor) such as Hercules was explains murderous rampage (Deutsch, 1949). Hippocrates (460-370), laid a phenomenal foundation for rational and scientific treatment all under the term insanity. It was then when blood-letting was seen as a treatment at the time because he believed diseases were explained by humoral pathology in which case the four humors were unbalanced (black and yellow bile, blood, and mucus which in turn affected the heat, cold, dry and moistness of the body). On the other hand, Asclepiades of Prusa (born B.C. 124), treated mental patients under his care with dieting, massaging, bathing, and exercise. However, he recognized in terms of mental health, that sunlit rooms were beneficial for patients experiencing delusions and fears as he suggested the light allows them to perceive concrete reality. Prior to this, the norm was to place patients in the dark as it was believed it provided peace and quiet to the mind.

To put this phenomena in more perspective, there are several examples that date back to biblical times. For example, it is understood by some, that Jesus describes casting out demons and possession in the bible. It is even suggested in the Old Testament referencing King Saul that David was sent down to cast away his evil spirit by playing the harp- the first form of music therapy (Deutsch, 1949). In second century A.D., Aretaeus the Cappadocian (later to be discovered by Kraepelin), pioneered differentiating and classifying the relationship between melancholia and mania, manic-depressive psychosis, and later cerebral and spinal paralysis (Deutsch). In Greece and Rome, the

"enlightened care" shown to those with mental ailments, typically the slaves, were only "cured" if not through vis medicatrix naturae (the body's ability to heal itself), it is strongly suspected that they were put to death as seen as undesirable or intolerable burdens (Deutsch).

Jumping to the 16th century, we see methods such as trying to beat the lunatic into reason. In 1664, it was believed that witchcraft was to blame for being struck with disease (such as melancholy) or cured, as evidenced by Sir Thomas Browne (a doctor and author) and by Robert Burton's book, *Anatomy of Melancholy*. It is during that century that the Salem witch trials occurred. Starting in the late 1600's and more so seen in the 17th century, was the unfortunate birth of jailing "madmen" like a common criminal. This "unfortunate person" was confined until he regained his "senses" (Deutsch, 1949).

In 1848, a woman named Dorothea Dix who was known at the time as an advocate in the 19th century for the mentally ill, set forth an act to congress. The act was initially passed and then later vetoed by President Franklin Pierce. The act was called the 12,225,000 Acre Act. The act basically proposed that a certain amount land be handed over for the use of an establishment to house "indigent curable and incurable insane." Unfortunately, the President modeled so much of what is seen today, the rejection of such institutions to be the responsibility of the government (Bloom, 2010).

The 1900s is where we begin to see an emergence of those in the criminal justice field starting to recognize that perhaps not all criminals are the same and thus should be treated accordingly. It is here that we see the alternative to prison being that of a hospital. It was said by one individual that, "only with the irresponsible, against who the threat of

the law is vain, must the law have recourse to the hope of a cure by the psychopaths. Irresponsibility results from an absence of choice, that is, where mental disease or infirmity either inhibits the ability to choose or affects the understanding of the alternatives" (Harvard Law Review, 1916, p. 540). It was with this notion that changed occurred. It was stated that "our attitude towards the insane defendant has undergone a change. A hundred of years ago courts were presented with the alternatives of hanging the defendant or of casting him into a madhouse; there was little room for mercy in the choice. But today the defendant can be sent to the hospital in hope of a cure" (Harvard Law Review, p. 540). What a better way to show that we have come such a long way than this quote; however, we still have a long way to go in terms of treatment options and societal attitudes . Today there are quite a few state hospitals (prisons) that offer the additional support that some suffering from a mental illness may need. To further the thinking at the time, it was thought that mental health hospitals were the smarter alternative to prisons, as suggested by a Dr. Bowers, who introduced the first step in considering the criminal person also as a mental health individual and to understand the relationship between the abnormal mind and the abnormal act (Harvard Law Review). At the time this article was published, it was common to see disorders that were classified as paranoia, hysteria, and epilepsy (Harvard Law Review) all to be considered mental health disorders.

Comorbidity

Comorbidity is common in individuals who are or have been incarcerated. For many, not only do they suffer from a mental illness but they also commonly abuse drugs

or have multiple diagnoses (Friestad & Kjelsberg, 2009). The results from a nationwide study showed the implications of childhood stressors on the general welfare of individuals, including developing mental health problems and drug use (Friestad et al.). Until the ages of 16, childhood stressors in the study was defined as: growing up in a family with low SES and/or having less than that of their neighbors; having witnessed serious illness among close family members; experiencing physical or verbal abuse; parental drug problems; contact with child welfare authorities; and/or having a family member in prison (Friestad et al.). In another study, it suggested that those with the presence of an addictive disorder are increased almost three-fold by the presence of a mental health disorder (Burnett, Hawley, Maden, Scott, & Whyte, 2004). This can be explained by substances acting as a form of self-medication, relieving boredom of being an inpatient, and to lessen anxiety, and increase social contact (Burnett et al., 2004). According to Brady, Krebs, and Laird (2004), “It has also been estimated that 64% of jail inmates have used drugs regularly, 42% have received treatment for substance abuse, and 27% have served a prior sentence for drug law violations” (p.83). This study done by Brady, Krebs, and Laird , went on to solidify what the previous study aforementioned founded, which was the likelihood of those engaging in drugs and alcohol also having mental health problems. In one study where the focus was the relationship between mental disorders and cannabis use, it was found that 90% of those with a cannabis dependence also had a lifetime mental illness compared to 55% of the population that did not have a lifetime mental illness with cannabis dependence (Agosti, Levin, & Nunes, 2002). It was founded in another study, that co-occurrence of a mental illness and

substance use disorder are substantially high within the correctional population, particularly with alcohol and cocaine being the most used drugs. Posttraumatic stress disorder (PTSD), antisocial personality disorders and major depressive disorder were the most comorbid illnesses (Hoffmann & Proctor, 2012). Particularly in a study associated with PTSD and Driving under the Influence (DUI), the researcher explained the commonality of PTSD with first-time and repeat DUI offenders. PTSD is one of the most common psychiatric comorbidities and comorbid substance use disorder with PTSD is considered to have more symptom severity, worse treatment outcomes, and increased medical and legal problems than only having PTSD (LaBrie, Najavits, Nelson, Peller, & Shaffer, 2010).

According to Carragher, Eaton, Krueger, and Seijas (2015), comorbidity is considered more often than not to be the rule rather than the exception. Comorbidity becomes prevalent while discussing mental health disorders and in particular substance abuse because it is so common. Greenberg and Rosenheck (2014) found that there is a link between incarceration and substance abuse because not only is partaking in drug use a crime but also because substance abuse can lead to violent behavior. The most significant part of their study was the strong association between substance abuse and past incarceration.

The research involved around comorbidity is very telling. Either one of two things are happening, one, the offender is incarcerated due to a drug crime either distributing and/or in possession/using, or the offender is using drugs while in prison, surprisingly. It can be unclear as to which event occurred first, between the offender entering prison or

jail with an addiction problem or exiting prison or jail with an addiction problem. Many of those incarcerated get hooked on drugs because they have a mental illness and want to mask the symptoms or some mental illnesses are drug induced. Either way, it all goes hand in hand in with one another. There is a clear connection between mental illnesses, comorbidity, and incarceration. It is certain that the prevalence with those incarcerated and comorbidity especially substance abuse is high. Take for example, the statistic concluding the year of 2000, American prison and jails had a population of over 2 million offenders whom had a history of substance abuse and/or a mental illness (Garrity, Hiller, Leukefeld, Narevic, Staton, & Webster, 2005).

Though this is daunting information it holds importance because of the implications it provides. Some of the likelihoods that accompanies comorbidities upon release from incarceration are staying out of jail or prison and living a satisfying life (rare), returning to jail or prison (recidivism), or death. Suicide has been studied among post-released prisoners and a link was found between having a psychiatric diagnosis and substance misuse (Balyakina, Cardarelli, Ellison, Fulda, Malone, Shabu, & Sivernell, 2015). It is no secret that suicide is a problem in our country, and institutions are not excluded. Many inmates attempt suicide on the “inside” and it is not common to necessarily think of them committing suicide once on the “outside.” However, what is common upon release for these individuals are the hardships with finding employment or housing that they are faced with in the community from being stigmatized. Just like anyone else, anxiety or other symptoms may be provoked with having to balance these hardships. Here, is where one might use substances to cope. Or may slip back into old

habits, possibly selling drugs for an income. Thu perpetuating the vicious cycle of substance misuse that they all too often exhibit. This leads to recidivism.

Recidivism

It has been proven time and time again through studies, some which are noted here, that recidivism is at an all-time high. A study that reviewed fifteen states found that two-thirds reoffend within three years upon release which equates to about four out of every ten released becoming re-incarcerated (Hoke, 2015). Why is that? It has been said by a LCSW working in a prison, that many of these individuals releasing from a prison go out into the "real world" and realize that although they thought they wanted to be released they do not know how to cope with life's everyday stressors. This may cause them to reoffend intentionally to go back to prison or to start selling drugs or using drugs for example to deal, which may wind them back behind bars. This is the sequence known as recidivism being the result of compounding social factors (Hoke, 2015).

A nuance discussed in a study on childhood maltreatment was that is a positive correlation between the mistreatment of a child and being at risk for mental health issues. It went even further to suggest that the use of physical violence and force can increase the likelihood of criminal behavior in the future (Bongseog, Jiung, & Young, 2016). A study done on recidivism showed the association between past delinquent behaviors predicting future delinquent behavior (Billick, May, & Osmond, 2014). Recidivism is another commonality besides comorbidity that inmates and parolees share. The amount of individuals that re-offend or get re-arrested is astounding. One study found that overall, the results expressed broad recidivism in relation to criminal background, poor human

and economic capitals, and psychological problems (Delisi, Hochstetler, Kuo, & Peters, 2014). A different study not only conveyed that same message but took it a step further to explain specifically what crimes were commonly re-committed and at what rate individuals experienced recidivism. During that study, it was stated approximately ninety percent re-offended at least once with nearly eighty percent re-offending two or more times. Common crimes that were seen were: burglary, drug use/possession, assault, larceny, robbery, and finally personal crimes such as rape or arson (Caudy, McGloin, Ray, & Sullivan, 2009).

One fact that holds truth in corrections is that most inmates share many things in common, some aforementioned. Another commonality inmates share is that if the Antisocial Personality Disorder diagnosis. A study conducted on one-time versus serial arsonists found that antisocial behavior was pertinent when evaluating recidivistic behavior (Dolan, Doley, Fineman, Fritzon, & McEwan, 2011). One way to curb recidivism is to prevent incarceration in the first place. By maintaining focus on adolescents with certain risk factors for juvenile delinquency such as antisocial behavior, society would save money through incarcerating less, victim damages, and alternative treatment to reducing recidivism for delinquency (Billick et al., 2014). Once an inmate is released back into the community, it has been found that those with a mental illness do not fare as well as those who got released without a mental illness (Matejkowski & Ostermann, 2015). To take that statement a step further it was also founded that those with the highest level of care i.e. enhanced outpatient (EOP) were more likely than those with a lower level of care i.e. correctional clinical case management system (CCCMS) to

reoffend (Kennealy, Louden, Skeem, Tatar II, & Winter, 2014). Kennealy et al., also stated that there is a recidivism rate amongst these offenders that is as high as sixty percent. An offender can return to custody in one of two ways. First, an offender can commit a new offense, and/or an offender can commit a parole violation (Louden & Skeem, 2013). An interesting facet around parolees, that has been observed, are that many of them especially with a mental health diagnosis, tend to abscond. Absconding is considered a parole violation which may cause that individual to receive either a warning or potential jail time. These are just some of the differences seen between parolees with a mental illness and recidivism versus parolees without a mental illness and recidivism. Though, both scenarios happen with both groups there is just a difference in the trends. Not to mention, what may have caused the offender to get arrested and any infractions that they may have picked up during their sentence (institutional misconduct) may not indicate or predict what crime may be associated with their recidivism.

It was proven in a study that a history of violence and a major mental illness can assist in predicting altercations within the prison system during the inmate's incarceration. However, it will not aid in predicting their recidivism crime once released (Crawford & Walters, 2014). When looking at recidivism within a specific disorder, one might find that a study was done on schizophrenia and homicidal recidivism. There appeared to be a link between the crimes committed i.e. homicide/murder and the diagnosis of schizophrenia (Golenkov, Large, & Nielssen, 2013). This study was conducted outside of the U.S., but there is some value in this association. It does not necessarily mean that all individuals with this diagnosis would commit a crime such as

this but that there was a correlation founded within this particular study. In addition to that study, another study founded, an offender with a personality disorder or a substance use disorder has a greater risk of reoffending (Basson, Indig, Larney, & O'Driscoll, 2012). Parallel to these particular studies a couple of researchers looked at recidivism in terms of cocaine use and medication adherence. They found that cocaine use had an impact on recidivism. They also found that medication adherence did not have much of an impact on reducing recidivism unless you had used this substance in the last month and was medication compliant then your chances of reoffending decreased by twenty-six percent compared to an offender who has not used cocaine in the last month and was medication compliant (Farabee & Haikang, 2004). As much as society likes to think that inmates are out of sight out of mind, institutions such as prisons come at a cost and it effects everyone. Not only do tax dollars get spent and are budgeted for inmate costs, but research shows the bulk of the cost for these individuals are in altering sentences and release policies (Hoke, 2015).

In the final study that the researcher reviewed in terms of recidivism it was learned that there are several reasons for re-offense to happen upon release. Some of those reasons include: learning the trick of the trade while incarcerated, the whole notion of gambler's fallacy, the idea of once a criminal always a criminal in the eyes of the justice system, the stigma faced by these individuals once integrated back into society and the list goes on and on (Blokland, Nagin, & Nieuwbeerta, 2009). With all that has been stated it is no wonder as to why some re-offend naturally and that is not even taken into account that a mental illness may be involved as well. Davis, Sheidow, and McCart

(2015) conveyed, adults with a serious mental health condition (SMHC) involved in the justice system, do not have any available interventions with strong evidence of recidivistic reduction efficacy and good mental health care. This only goes to show that there is much work from providers to be done. One study did however recommend and suggest that the use of resilience is a protective factor that can act as a buffer from reoffending (Daffern, Fougere, & Thomas, 2015). In that same light, another studied conveyed the importance and relevance of mental health courts by comparing offenders of treatment as usual versus mental health court treatment and it was founded that mental health courts involvement may reduce recidivism (Baucom, Desmarais, & Lowder, 2016). It is a fact that those with a criminal background have a harder time gaining employment thus engaging in criminal activity. Yet, finding employment would be one part of the pie in reducing recidivism. Another study done on recidivism founded that during young adulthood there is a correlation between employment and mental health with those in the justice system and that working is associated with delayed or reduced recidivism (Davis et al., 2015). Another concern a study posed was that positive family social support was linked to the reduction of factors known to predict higher recidivism rates: substance abuse, Black race, and younger age (Jung, Maguire, Spjeldnes, & Yamatani, 2012). As much as it may seem or as hard as it is, offenders do express a want to stop offending, ninety-seven percent in fact, and it is up to professionals of social and healthcare to ensure that they reach this desire (Lorizzo, 2012). Some current approaches and interventions that are being utilized and have been found to be effective in treatment will be further discovered in a following section.

Criminalization of the Mentally Ill

As stated earlier, the intersectionality of mental illness and crime has been around since the dawn of time. There are an enormous amount of stories that indicate the only reason a crime was committed was during psychosis in an individual or from a severe mental illness an individual has. For example, Andrea Yates drowned her five children because she believed that was the only way to prevent Satan from infiltrating their souls. Likewise, Eric Clark shot a police officer because he believed that aliens were impersonating government agents and that bullets were the only way to stop them. While Mrs. Yates was experiencing psychosis and had a history of hospitalizations and suicide attempts, Mr. Clark has paranoid Schizophrenia. Both trials were held in 2006, however the outcomes were different. While Mrs. Yates will spend the rest of her life in a psychiatric facility, Mr. Clark will spend the rest of his days in prison (Sims, 2009). The outcome makes all the difference if seen in mental health courts versus regular courts, which is where most people are tried. Morse (2011) stated, the court should only be able to convict and punish a citizen if they are competent to stand trial. He called this process the "desert-disease jurisprudence" referring to the ability of the state responding to dangerous people. The citizen has to be able to accept responsibility for the crime committed. Yet, a mental disorder per se is not sufficient criterion for special legal treatment. The defendant must not only have a mental illness but must also not understand the charges against him/her to be considered incompetent to stand trial. While somewhere along the lines Mrs. Yates had the luxury and opportunity for a retrial in 2006

and was able to receive proper mental health treatment, again Mr. Clark did not such as most soon to be inmates.

According to Gary Chaimowitz (2012), over the centuries there have been trends in the way mental illness is viewed and treated by society and regardless of the era, stigma is attached to it. Stigmatization is not the only issue those with a mental illness face. In another article by Han, Lee, and Matejkowski (2013) it was stated that people with serious mental illness are overrepresented in the criminal justice system. Amongst other findings that were proposed, it was found that having a criminal record actually acts as a barrier to mental health treatment. The relationship between being homeless whether that be sheltered homelessness or on the street homelessness was examined, and having a severe mental illness including major depressive disorder and schizophrenia, and the severity of symptoms within that disorder and if that predicted whether or not a violent or non-violent crime would be committed (Fischer, Shinn, Shrout, & Tsemberis, 2008). It was concluded from this study that being transient along with a mental illness did increase the likelihood of committing a crime however, based upon which homelessness you exhibited and the severity of the mental illness had a direct effect on the type of crime committed (Fischer et al., 2008). For instance, those who were on the streets homeless were more likely to try to ride light rail for free, trespass, panhandle, or partake in indecent exposure (Fischer et al., 2008). According to Borum and Franz (2011), police serve as gatekeepers to a person with mental illness because in the event that police is called to intervene during a crisis, that police officer makes all the difference between that individual going to jail or going to a mental health facility. It was also presented in

the study that a call to the police resulting in an arrest can worsen that individual's condition because jail acts as a form of disconnection with treatment and with the community, this is contributed to the trickle-down problem that effects the criminal justice system, people with mental disorders, and the community (Borum et al., 2011).

A significant predictor, in a community epidemiological study, has been self-reported criminal violence among men with a mental illness. Men with severe mental illness (SMI) have a weaker significance rate than those without SI, but it was still found that these men are likely to have criminal justice contacts, greater number of offenses, reoffend more quickly, and charged for a suspected offense. They are also more likely to receive additional days in jail (Becker, Andel, Boaz, & Constantine, 2011). Some causes of criminalization include: deinstitutionalization, restrictive civil commitment criteria, lack of adequate community support systems, and the role of the police (Lamb, Weinberger, & Gross, 2004). It is from these causes that certain recommendations were set forth. Law enforcement should undergo mental health training along with the coordination of police and mental health professionals. As previously stated, police are typically the first respondents to a crime scene and the fate of the offender rests in that police officers hand. If the officer at the very least can recognize symptoms of psychosis or what have you, then he/she can refer or transfer the individual to an appropriate care facility rather than jail. Treatment and community services after release for individuals are needed as well (Lamb et al., 2004). While in court, "Murder victims are no less dead because they were killed by schizophrenic or depressed offenders than by offenders with totally sound minds, and rape victims are just as violated by intellectually disabled

offenders as by other offenders (Bagaric, 2016, p. 3).” However, Bagaric further explains, it is widely assumed that mentally ill offenders are less blame-worthy because of the mental state they were in during the time of the crime committed. He concluded, that offenders who were mentally impaired during the commitment of the crime should have a penalty discount, they should be eligible for an additional discount based upon their harsh experience of imprisonment, and that there should be no mitigation penalty either from the time of the offense or at the time of sentencing (Bagaric). While what is proposed may or may not ever be in effect in our court systems, it is clear that a different sentencing structure may behoove the court systems as those who are mentally impaired should not face the same type of sentence or treatment as those who are not mentally impaired. In other countries there laws and punishment of crime vary from that of the U.S. In a penal code studied, from another country, it was observed that some offenders in the same predicament as offenders in the U.S. may have different types of punishment or sentencing. In particular, according to the Danish penal code, offenders who were psychotic or mentally retarded while committing an offense are not punishable in a prison yet are however, placed in a high level security treatment facility or cared for in an outpatient treatment program. Those however, who were not psychotic at the time of the offense but do suffer from a mental illness may receive an ordinary sentence or be committed to treatment it all depends on assessment of preventative criminal relapse (Gottlieb, Gabrielsen, Korner, & Stolan, 2013). This all boils down to either committing a crime during psychosis or just flat out having a mental illness that has not been treated or it causes destabilization which can enable a crime committed. Mental illness can be

defined in broadly (encompassing anger, impulsivity, etc.) or narrowly (hallucinations, delusions, etc.) (Peterson et al., 2014). Regardless of how different individuals may define mental illness, the majority of those found not guilty by reason of insanity have a primary diagnosis of Schizophrenia and were deemed to be experiencing psychosis during the time of their offense, as positive symptoms can easily be conceptualized as altering ones reality and motivating criminal behavior (Peterson et al.). One important take-away from Peterson's et al. study, is differentiating between mental illness and normative human emotional states and behavior. For example, anger is related to symptoms of psychosis and also known as a basic human emotion. However, anger can be seen in diagnoses such as personality disorders (emotional instability), mood disorders (irritability and anger attacks), Post-Traumatic Stress Disorders, and psychosis (delusions and command hallucinations). Another example given in the study was impulsivity. Impulsivity is known to be related to disorders such as Bipolar Disorder and Antisocial Personality Disorder. However, impulsivity is also seen in the general population, and can not only be seen as a mental illness symptom but also as normative personality trait (Peterson et al.).

The four justifications or goes laid out for criminal sanctions are retribution, deterrence, incapacitation, and rehabilitation (Sims, 2009). Sims proposes, that none of these goals are being met for the inmates suffering from SMI while incarcerated. The number one goal of course for those being released from prison or jail as stated multiple times before, is reintegration into the community. Inmates with a serious mental illness will have difficulty successfully re-entering the community. They encounter certain

challenges that inmates released without having a serious mental illness do not such as experiencing homelessness. These challenges become exacerbated with the presence of a comorbid substance abuse, which is strongly associated with criminal recidivism and treatment relapse (Baillargeon, Hoge, & Penn, 2010).

Treatment Approaches

The goals of treatment should include: stabilization of the patient, independent functioning or enhancement thereof, and maintenance of internal and external controls that prevents patients from acting out violently and committing other offenses. Furthermore, treatment should include: the need for structure, management of violence, case management, appropriate living arrangements, and the critical role of family (Lamb et al., 2004). The World Health Organization (WHO, 2017) suggested in a study that the researcher reviewed, that a settings approach with a holistic assessment is best when addressing this population. As well as, while addressing this population, the clinician needs to look past pharmacotherapy and endure a caring, authentic, regular, and direct interaction with the patient (Dickinson & Goomany, 2015). There are several evidence based practices that a clinician can pull out of his/her treatment tool box during treatment with a client or patient. Many of the same approaches used in the community in therapy will also work in a prison setting, because inmates are just like anyone else when it comes to treatment, humans. One common treatment approach utilized in corrections is CBT. CBT focuses on thoughts, emotions, and behaviors. To apply this to a specific situation and population within corrections, let's look at sexual offenders. Sexual offenders, like anyone else at times, experience cognitive distortions, except their

cognitive distortions are sexually driven. Besides that they may also fantasize about their victim and their crime and soon to perceive the wrong idea. CBT addresses these thought distortions, fantasies, and perceptions (Chesterman & Sahota, 1998). CBT also helps those with anxieties and/or depression. Its goal is to alleviate the distressing feelings, dysfunctional thoughts, and disturbing behavior. It can begin to do this by identifying and disputing the patient's automatic thoughts that generate the unfortunate phenomena mentioned above. CBT can even be used when looking at recidivistic behavior, as that is an epidemic, aforementioned. It does this by examining the antisocial cognitions and maladaptive emotions that surface from them. With that said, the main focus of intervention is not just in the patient feeling well but also a development on interpersonal skills and gaining acceptance on community norms and responsible behavior as they are integrating back into the community (Carr & Rotter, 2011). Other interventions that may work with this population are thinking for change and moral reconation therapy. Thinking for change allows the offender to learn how to problem solve and to work through their problems rather than to reoffend. While, moral reconation therapy looks at higher levels of moral reasoning. Using all of these in conjunction with one another may impact the offender greatly in reducing recidivism (Carr et al., 2011).

Many treatment approaches that are utilized in the treatment of inmates are in place because of the common phenomenon that occurs in prisons. For example, the amount of suicidal ideation that occurs in settings such as this. A study looked at suicidal ideation in U.S. prisons and found that intermediate care patients preferred staff visits to their cell whereas the general population did not. Both groups did however, enjoy family

visits and staff interactions. Very few favored the typical treatment approach to suicidal attempts which is the admission to a mental health crisis observation cell. Neither group fancied talking to a correctional officer about suicidal ideation (Chlebowski, Kaufman, Knoll, & Way, 2013). Two other common features that have been noted in inmates are criminal thinking and antisocial attitudes, values, and beliefs (Wilson et al., 2014). Criminal thinking can be addressed through CBT as that looks at thoughts. Being that the diagnosis of personality disorders in prisons are common, that is also a phenomena that has been explored in terms of interventions. The norms of society on the "outside" most certainly differ than the norms of the inmates on the "inside." For instance, common behavior that is observed within prisoners are hostility, suspiciousness, social withdrawal, and self-centeredness. These may be necessary adaptations for survival in a prison, however, to staff they are classic behaviors of a personality disorder. Part of the inmate code and the behaviors associated with it can mimic symptoms like that of personality disorders to include: paranoid, narcissistic, antisocial, and borderline. As a clinician trying to work on problematic behavior with an inmate it is important to remember that the turnover rate is rapid between movements from one yard to another or even to different institutions. An assessment of whether or not the inmate is decompensating is first and foremost key. If there are signs of decompensation such as: low insight, non-adherence to treatment, and risk they may present to themselves or others, then a transfer to a state hospital may be required. Some of the challenges associated with this population are: disengagement, violence and aggression, and being noncompliant to treatment (Mullins & Paler, 2012). A prison setting is not the appropriate level of care of

treatment for decompensation such as this and requires a long-term treatment option that is suitable for the job, i.e. a state hospital, until it is further deemed that the inmate is back at a baseline that could thrive in a prison setting again. With that in mind the most pertinent clinical intervention is to focus on are the axis I from the Diagnostic Statistical Manual (DSM-IV) now the principal diagnosis in the DSM-5 i.e. current dysfunction first, before moving on to other diagnoses if the individual has more than one. More often than not many inmates have a personality disorder and that falls secondary in treatment unless the personality disorder is associated with dangerous behavior (Rotter, Way, Steinbacher, Sawyer, & Smith, 2002).

Other treatment approaches that are utilized in prison settings are that of groups. There was a study done that examined a group called reading for life, a group ran in a prison. A group such as this one elicits personal narratives while discussing or in comparison to the stories and poems presented in the group (Billington, 2011). Groups have had much success in multiple settings including prisons. It can be beneficial to enter into a therapeutic relationship outside of just one on one sessions with a clinician. Here, an inmate can see that other inmates experience either the same or similar situations and how they handled or addressed it which may or may not be the appropriate way to do so which could also be addressed at that point by the facilitator. This is also an opportunity to feed off of one another in a positive and well-being kind of way. There are several types of groups offered in prisons that can tailor to the specific needs of an inmate and benefit said inmate in their treatment. In certain programs in certain prisons, groups are used and coupled with individual therapy so that the inmate's treatment is maximized and

their mental health needs are met on more than one level. From a social aspect, this provides the offender a time at which they can converse and receive that normalcy of being human. Social interactions have been proven to positively affect the well-being of a person, and this group allows that as well as having a metal health component topic that will aid in the mental health treatment of the inmate.

Picking apart an inmate's symptomatology for treatment can and is usually difficult. Another treatment approach to symptomatology is medication. Medication can not only minimize symptomatology, but it can also increase insight, and the satisfaction of treatment. In fact, the study concluded that the therapeutic relationship between the patient and clinician has a strong influence on medication adherence (Bressington, Gray, Lathlean, & Mills, 2008). Lewis (2000) stated in her research, that there are two types of psychotic inmates, thus needing mental health treatment. The first type are those inmates that stay quite in their cell and do not pose a threat or appear to be in need of attention because they themselves do not believe that they are ill. The second kind of inmate is the one who is floridly psychotic. This inmate will act out either aggressively to others or harmfully to himself because of his inability to follow direction, listen to others, or retain information for negotiating with staff. This researcher went on to describe how different diagnoses or presenting problems can be as much as possible effectively treated through the use of medication. Those who are acutely psychotic from substance use their symptoms may mimic those of Schizophrenia and anti-psychotic medication (neuroleptics) may be the best route to go until stabilization where the patient can be weaned off. Inmates with a Bipolar Disorder will need rapid stabilization of manic

episodes if they are presenting as manic, and medication can assist with that as well. Those with Major Depressive Disorder are often also treated with medication, avoiding Tricyclics due to the inmate possibly cheeking their medication to sell later. For those inmates with anxiety disorders the best treatment is usually CBT. However, if the inmate has Obsessive Compulsive Disorder (a type of anxiety disorder) the best approach may be SSRI's with attention to cell matching so that the inmate is not coupled with a hoarder but rather an overly neat inmate. If the diagnosis was PTSD, Zoloft may be best and tackling insomnia and suicidal behavior as those tend to come with the disorder. Insomnia should be treated with anon-addictive drug. By far the most common diagnosis in prisons are personality disorders. Disorders that fall under this umbrella are at times the most difficult to treat. If an inmate has a diagnosis from cluster A, then they are likely to be paranoid and treatment can become difficult especially through the use of medication, if they are willing to take it. If the inmate is diagnosed from cluster B then they are likely to attempt suicide often or engage in self-harming behavior which can hopefully be reduced through pharmaceutics. The less medication the better in terms of multiple mediations prescribed, and should be tapered upon stabilization (Lewis, 2000).

Most importantly one must not forget that not all offenders will be incarcerated with a life sentence. For those who do not have life or extremely long sentences and expect to parole one day, and dealing with a mental illness, will need a plan for reintegrating back into the community. One intervention that can assist and aid these individuals is the community corrections supervision that acts as a middle-man between prison and society. In this type of program or treatment, the inmates live together in a

corrections setting but outside of the prison walls. This enables these men to receive job placements, counseling, and allows enough time for them to work on living a life out in the community. After the being released from prison, these men are at high risk for recidivism or death such as homicide, drug overdosing, or suicide. It must be remembered that these men have a mental illness and many have co-occurring substance disorders. The utilization of illness self-management is an evidence based practice that is set in place to help these men out prior to reentering society. These men are given information and taught skills to help them succeed post incarceration. This much like a therapeutic group can promote well-being through the essence of going through this program with peers, reminding the offender that they are not alone. The treatment is tailored to the care of these men with a focus on them as vulnerable groups and how to combat recidivism (Kelly, Ramaswamy, Chen, & Denny, 2015).

Gaps in the Literature

In general, the studies the researcher reviewed seemed substantial and varied across the board. The generalizability was there for most areas however, specific locations, age, and ethnicities could be further explored. Some limitations that were highlighted throughout the research were: self-report being used in a comorbid study, which may not be reliable. It was also pointed out that the research conducted were from individuals who were previously incarcerated and not currently incarcerated as it is not ethical to conduct research in an actual prison. It is also important to note that some specific disorders were not included in all of the research such as Schizophrenia and

Obsessive-Compulsive Disorder, and disorders such as Major Depressive Disorder were used instead (Greenberg & Rosenheck, 2014).

Another limitation discussed was the lack of time used to collect the data. A longitudinal study may benefit the researcher, as it would be beneficial to have a profound amount of data gathered to truly understand this population (Doley et al., 2011). The use of examining only male inmates as used in a vignette in a study provided a limitation because the findings could only be generalizable to that men rather than men and women to fully understand the scope of the problem. This particular study also expressed a limitation in focusing on the drug cocaine in their recidivism study as opposed to looking at many other less severe drugs that are often are used by these offenders (Louden et al., 2013).

As a whole, if the researcher were to combine all of the information that was gathered many issues surrounding mental illness and crimes committed were addressed. However, one gap that the researcher would like to address that none of the other articles under review did not would be that of location. The researcher would like to conduct a study that was tailored to Northern California more specifically Sacramento, as it is the state's capitol and also holds sentimental value for this city.

Summary

In conclusion, the research question posed in the introduction is a valid question to ask that needs an answer and understanding interventions used can be beneficial on all levels not just the systemic one. There are many points at which change can be made. Not only is the individual suffering from a mental illness effected but so is the criminal justice

system, the community, the parents and families of those of the mentally ill, and possibly the victims of a crime committed either against them or in their presence. The key thing to understand is that all of this can be lessened if more time is taken to learn about mental illness and how to combat it. The utmost important lesson that can be taken from this research is that those who have a mental illness do not necessarily belong in a jail or prison but in a hospital or treatment program that can produce a success plan for the individual that will guide and direct said person on how to conduct themselves and integrate back into the community. Many programs that offer services to parolees with a mental illness see an array of recidivism and comorbidity yet also see some lives changed for the better. By offering services such as housing, job options, income stability through SSI or SSDI, helping the individual obtain Medi-Cal, making sure the parolee is med-compliant, having them attend groups that teach skills that are useful and beneficial to said person, all make a difference in how successful one may be in conjunction to the willingness and readiness that person is to participate in such a program. With further exploration of the provider's treatment efficacy, one can gauge the type of treatment and level of care the inmate-patient is receiving and move forward in better treatment practice and treatment planning. The next chapter will address the methodology.

Chapter 3

METHODOLOGY

With a steady framework of current research in regards to inmates experiencing mental illness, this chapter describes the methods the researcher used to answer the research question. The layout of the methodology section includes the restatement of the research question, description of the study design, the restatement of variables, description of study population, description of sampling method, identification of the measurement instrument, statistical analysis plan, and the data collection procedures. This chapter concludes with a section describing the safety measures involved with the protection of human subjects.

Research Question

Prior to the exploration of the methodology, it is crucial to identify the research question that guided the entire research. This project explores this primary research question: What are the perceptions of providers about mental health treatment efficacy for those who are incarcerated?

Research Design

The design of this study is a qualitative content analysis study, using both latent and manifest coding of content. This content analysis design is used because the phenomenon under consideration is an understudied topic. It is a design focused on exploring the information under study. With content analysis, the researcher will create categories and derive themes from the interview communications. This design seeks to explore distinct associations between practitioner efficacy and mental health services to

those incarcerated. The researcher conducted a content analysis qualitative study that set out to address the research question above. In order to accomplish this, the researcher administered an interview with the study participants. The researcher constructed a simple set of self-report interview questions in which participants were instructed to completely answer to the best of their ability based upon the instructions. To ensure the anonymity of the participants, the researcher did not write down the participants name on the interview questionnaire sheet.

Like anything else, there are accomplishments and limitations to this type of research design. By conducting an interview it assisted in some strengths such as easy administration, cost free, and the ability to obtain accurate information with this type of approach. With the interview questions being precisely the same for each participant that aided in the reliability of this instrument based on its uniformity. However, some limitations that arise with verbal interviews would include, the possibility that time runs out depending on how long an interviewee speaks on a subject, may not feel comfortable answering a question aloud, or may introduce the likelihood of social desirability bias. The following subsections further explain the qualitative approach, exploratory studies, grounded theory and content analysis.

Qualitative Approach

Qualitative research is characterized by focusing on the meaning and interpretation of the data being collected. Qualitative methods are ideal for examining topics were little is known, making sense of complex situations, gaining new insight, constructing themes and gaining a deep understanding of the phenomena. The overall

purpose of qualitative methods are: understanding the use and meaning of language; describing and interpreting participants' views; and developing theory (Becker, Cheater, Smith, 2011). In this study, a qualitative approach will explore the factors that impact treatment efficacy with providers working with those who are or have been incarcerated.

The attributes that accompany qualitative research include: the beliefs that people create meanings through social interactions and understand or experience these realities differently, and a commitment from the researcher to discover and describe multiple human realities in order to fully understand a phenomenon (Sherrod, 2006). Through the interviewing process themes should emerge that may be similar or differ across disciplines that all work with the same type of populations, those who have been or are incarcerated.

This type of data collection involves a lot of written data. Some of the benefits to this type of data is the easiness to administer it as it can be done conversationally and can be recorded for easier interpretation at a later time. This type of data also allows for elaboration and thorough answers. However, this type of data may be a little harder to collect due to the diversity of providers participating and their schedules to have the time to sit down and discuss their profession and efficacy in treatment. This type of data collection method may also interfere with providers answers as some may respond differently verbally than they would in a written format.

Exploratory Studies

This study utilized qualitative interviews to discover the nature of provider's perceptions of their treatment efficacy working with the forensic population. This

particular method of data collection was selected to further gain insight into provider's perceptions with a population that lacks knowledge and complete understanding in the research and literature. The results of this study, guided by the research questions, are intended to further the breadth of information necessary to ensure proper treatment to the targeted population in the future. While this design of study is essentially permitting the exploration of an unknown or less familiar topic it can also become a setback by possibly adding more phenomenon that come up during the interview that need to be explored.

Grounded Theory

Grounded theory is one of the several approaches used to enhance qualitative studies. Grounded theory is based on the assumption that it is common for those with similar circumstances to tend to make sense of their social world in very similar ways. Grounded theory explores human interactions and that social process as opposed to just describing it. The purpose of grounded theory is examine social processes and develop a theory related to a topic that has no theoretical underpinnings (Becker et al., 2011). This approach will aid this study in better understanding the interactions between the provider and inmate/parolee in terms of their treatment efficacy.

Content Analysis

Upon completing data collection and transcribing that data in a qualitative study, the researcher can start to synthesize the written data in such a way that it organizes emerging themes and categories. Content analysis includes data analysis which is an interpretive process that ensures participant's accounts are accurately represented (Becker et al., 2011). This type of analysis involves subjectivity. Content analysis involves a

preparation stage, organizing stage, and reporting stage. Under each stage involves additional steps. Content analysis is known for its coding both manifest and latent coding. Manifest coding assists in developing categories while latent coding assists in developing themes (Bondas, Turunen, Vaismoradi, 2013). Both types of coding are under the organizing stage. This is where the bulk of the interpretation occurs. In this study both types of coding will be utilized. However, the latent coding may be more pronounced. This design seeks to explore distinct associations between practitioner efficacy and mental health services to those incarcerated.

Some of the concerns and limitations of content analysis, is that the findings may be simple and low quality findings which may or may not be true. One strength and way to counteract that limitation is that content analysis has the ability to exhibit transparent structures that can provide future researchers with clear and user-friendly methods (Bondas et al., 2013).

Study Population

The target population (n=10) is comprised of ten providers who work with and are around those who are incarcerated or those who have been incarcerated. For this study, provider means professional who works on a regular basis with the intended population the researcher is studying. Professionals may include mental health supervisors, clinicians, recreational therapists, custody, etc. This study population was not specific to any gender, race, sexual orientation, age, or religious backgrounds. The demographics of the participants were based on five criteria: age, gender, ethnicity, their degree, and

number of years in the field. For the purpose of maintaining confidentiality, additional demographics were omitted. This study was limited to English-speaking participants.

Sample Population

The population under review held two qualifications that would impact the sampling method. First, participants had be a provider that worked the male inmate population (past or present) meaning currently incarcerated or parolee. Second, participants had to work with a patient who held a mental health diagnosis. To ensure effective access to this specific population, participants were recruited through non-probability sampling. There are three types of non-probability sampling that are common to use in qualitative research, one specifically being snowball sampling (Rubin & Babbie, 2014). Snowball sampling was used in this study. Snowball sampling allows the researcher to gain participants through a referral process (Rubin & Babbie). Despite the benefits of snowball sampling such as it being cost-friendly and the flexibility that comes with it, it has its drawbacks. For instance, two potential issues with this type of sampling method and with qualitative research in general are the subjectivity and generalizability of the population under study (Rubin & Babbie). The researcher will enroll ten participants in this study.

Instrumentation

The measurement instrument used in this study, was a set of sixteen question asked in a semi-structured interview for data collection. The first ten questions were open-ended questions to gain information seeking facets into a provider's perception in treatment efficacy to attribute to the lack of knowledge on the research topic. The

following five questions are demographic questions and the last question aids in recruitment for providers utilizing the snowball sampling as aforementioned (See Appendix B). All questions were administered face to face in a convenient location chosen by the respondent. The researcher may have asked follow-up questions if elaboration was needed. The average duration of an interview was approximately thirty minutes. All interviews were digitally recorded to ensure the interview was captured in its entirety.

The use of grounded theory allows an openness for the participants and gives the researcher grounds for discovering the unexpected through the responses (Rubin & Babbie). What can come up with using an interview method are thorough answers and possible additional questions coming up which can lend a hand to further insight into the matter. One advantage to this type of approach is the ability to converse and elaborate on any topic being discussed and to ask for clarification if any answer is unclear. However, a disadvantage that may arise could be social desirability bias, the interviewee trying to please the researcher and possibly say what he/she believes the researcher would want to hear. Yet, this type research still allows for further exploration on the subject matter which is crucial to the mental health field.

The instrumentation utilized in qualitative research can also hinder the validity and reliability of the measures. A semi-structured interview may not be the best indicator of a reliable measure because it is most likely that the following interview will not yield the same results each time. This would make it more difficult to replicate the study. Thus this type of technique is likely to produce more random error. Validity is another facet

that can be questioned in the instrumentation of a qualitative research design study. The main reasons validity is weakened through this type of study design are the fewer participants that participate in this type of study versus quantitative, and the fact that this is not considered to be a standardized measure.

While conducting face-to-face interviews the researcher is to ensure professionalism at all times. To demonstrate professionalism in the interview process the researcher will wear appropriate attire and behave in a professional manner. The researcher will build rapport through professional and appropriate conversation. The researcher will adhere to social norms such as being respectful and courteous. The researcher will remained focus and utilize effective listening while also displaying good eye-contact. The researcher will be sure to conclude by expressing one's gratitude towards the participants for sharing their time and experience in the field with the researcher.

Data Gathering Procedures

The method of obtaining participants was through snowball sampling. The researcher asked the participant if he/she knew anybody who would also be interested in participating in the study; and if he/she could give the researcher that provider's contact information. This was done by question sixteen on the interview questions (See Appendix B). If so, all prospects were contacted and explained the purpose of the study. If both parties agreed on participation then a time, date, and place was constructed to conduct an interview. All variables of just mentioned varied from participant to participant.

Upon initial contact, a consent form was given to the participant at the beginning of their meeting (See Appendix A). The participant was asked a series of questions, sixteen, and was given ample time to answer said question from their perspective and given their experience. The researcher asked the participant for their permission to be audio taped. The researcher thanked the provider for their time and participation in the study at the end of the interview session.

Data Analysis

Upon completion of all interviews, the researcher gathered and collected the data for the text as it was transcribed into a word processing program. All raw data was transcribed with the exclusion of any identifiers that would omit anonymity and confidentiality. Data was transcribed by hand. Data were coded under themes and categories of factors that contributed to the perceptions of providers in treatment efficacy. This type of coding identifies common themes and notable differences. The system scanned for manifest content and inspected for latent content of the most frequent coded ideas within the themes.

Protection of Human Subjects

In order to conduct an ethical research study, the researcher submitted an application to California State University, Sacramento, and division of Social Work, with the intention of obtaining approval from the Institutional Review Board. The study gained approval under the review category of "exempt," which indicates minimal risk for their participation in this study. The research project was approved and assigned a human subjects protocol number 16-17-013. In this human subjects application, the design and

the methods selected to carry out the study were describe. No subjects were sought out and no data was collected until final approval. The researcher then ensured the participants that their data from the questionnaire would be kept confidential and provided them with an informed consent form. The consent form included the purpose of the study, the notion that the benefits of the study were intended to outweigh the costs, the compensation for the study, the option to decline participation or drop out of the study, the confidentiality nature of the study, and the debriefing process. It was explained to the participants that their data would be coded by a number and not by name to ensure their anonymity. The researcher also explained that the only people to see the data from this study would be that of the researcher and, the researcher's faculty advisor. Confidentiality was maintained during collection with the interview questionnaires placed in a sealed envelope and locked in the trunk of the researcher's car during transport and placed in a locked box at the researcher's home upon arrival. All data was destroyed upon completion of the study or by August 31, 2017. All information regarding the rights and privacy of human subjects were explained and understood before initiating the study.

Summary

Chapter three chronicles in depth the methodology section of this research project. In includes a detailed explanation of the approaches and methods used in this qualitative study such as content analysis, grounded theory, and exploratory studies. The chapter also describes the study and sample population as well as reiterating the research

question. Data collection and data analysis are furthered explained. Lastly, the human subjects safety and privacy is addressed.

Chapter 4

DATA ANALYSIS

This chapter will present the study results through detailed description of the most significant data points regarding conceptualizations of mental health provider's treatment approaches, experience treating the inmates, and their perceptions of treatment. Each of these themes will be reported through manifest and latent content of the data, including direct quotes from participants that illustrate the common themes. To protect the confidentiality guaranteed to the study participants, data will be reported with participant pseudonyms: Smith, Jones, Walker, Miller, Wilson, Moore, Anderson, Thomas, Clark, and Lewis. The chapter will first explore the demographic information of the research participants. Next, the emerging themes of the study will be outlined and discussed. The chapter will conclude with a summary of the data extracted from the participants.

The primary objective of the study was to further expand the knowledge on the following research question: what are the perceptions of providers about mental health treatment efficacy for those who are incarcerated? The purpose of exploring this specific question was to increase insight into the way providers view their level of effectiveness while providing treatment to inmates. The participants were asked five basic demographic questions following a series of ten open-ended questions that occasionally prompted clarification and follow-up questions (See Appendix A). All open-ended questions were created to elicit information on the participant's clinical judgment of their effectiveness in treating inmate-patients, as well as what successes have been made and what has been a miss in the mental health field in a prison environment. In addition to the

themes developed from the research question, interview data were coded for meaningful conceptualizations of treatment efficacy among the participants.

Demographics of Study Participants

Interviews were conducted with ten clinicians, three male and seven female all whom work with inmates. All except two participants were over thirty-five years of age, one was thirty-five years of age, and one was under thirty-five years of age. Half of the participants identified as Caucasian and the other half identified as non-Caucasian. Six out of the ten participants have a post-Master's degree whereas four of the participants have a Master's degree. Seven out of the ten participants have worked in the mental health field for more than five years, and the other three participants have worked in the mental health field less than five years. The following pseudonyms were employed in the reporting of interview data: Smith, Jones, Walker, Miller, Wilson, Moore, Anderson, Thomas, Clark, and Lewis.

Meaningful Conceptualizations of Treatment Efficacy

Considering the complexity of providing treatment to an inmate-patient (Galanek, 2013), it was not surprising to discover the nuances that some of the participants reported and described. The perceptions of the participants treatment efficacy varied among one another however, they all were able to identify some successes and some areas for improvement in one way or another. Coinciding with the literature, most participants reported several difficulties that can arise and come along with working with this population (Lee, & Prabhu, 2015). Part of working with inmate-patients includes discovering what treatment works best for each individual inmate, attempting to treat the

symptoms that come along with a diagnosis, and putting the treatment into effect and measuring the outcome. All ten participants to some degree perceive the treatment that they provide to the inmate-patient confined by having to follow the prison guidelines injunction with providing mental health treatment.

Treatment Provided

Five of the ten participants in the study reported individual and group therapy as the identified type of treatment provided. The other participants responded in terms of more specific treatment provided. Jones stated, “I provide interpersonal therapy, and more behavioral-based.” Lewis similarly identified behavioral treatment in response to the type of treatment provided. Wilson discussed the need to control behavior as well and added that regulating and stabilizing mood was important. Walker explained that the type of treatment provided was targeted treatment of the inmate’s chief complaint or presenting problem. Thomas expressed that short and long-term therapy is provided including crisis intervention and case management. Although some of the participants were more specific than others while describing the treatment provided to their inmate-patients they all provide some form of psychotherapy.

Treatment Approaches

Eight out of the ten participants recognized cognitive-behavioral therapy (CBT) as being an effective treatment approach to use with their inmate-patients. Walker stated, “I think with a lot of my patients I use CBT because it’s one of the types of treatment that we know can work for a lot of people, for lots of different problems.” Moore admitted that CBT is typically the treatment approach that is used with most inmates. Consistent

with the literature, CBT is known to be an evidence-based modality and an intervention used to decrease distressing feelings, disturbing behavior, and dysfunctional thoughts (Rotter & Carr, 2011). Clark stated:

> So with CBT, I find it really effective in this setting because I am able to structure my sessions really well. The inmate knows what to expect every time we do a check-in, we collaboratively work on goals, we set an agenda, we prioritize the agenda, and then we go in order. Depending upon how long I want the session to be, I'll set a limit on how many things are on the agenda but we put the most important things on. We do a summary of the session, feedback, and I assign homework and we'll check-in on the homework in the next session.

While Lewis believes CBT is the most effective treatment that can be "administered in this environment," there must also be a willingness to participate in treatment and psycho-education which must first happen. Amongst CBT, other treatment approaches mentioned were attachment theory, dialectical-behavior therapy (type of CBT), reality theory, specialized therapy, client-centered therapy, humanistic theory, and acceptance and commitment therapy (ACT). Many participants discussed utilizing a combination of theories and therapies as all do not work for everyone and treating each inmate-patient as a case-by-case situation.

Treatment Based on Profession

Seven of the ten participants overall believed that the type of treatment provided to the inmate-patient does not vary based on profession. There seems to be a consensus of similar treatment being provided with the way in which it is administered varying. It was

also common for the participants to believe that what largely impacts the differences in treatment would be the training and background in which they received. It was also repeated by the participants that “each clinicians own style” is another contributing factor to the way in which treatment may vary.

However, three clinicians did believe that the treatment may look different based on profession. Miller expressed that psychologist are probably more psychodynamic driven whereas social workers would be more eclectic. Moore suggested that psychologist are not trained to look at the whole person and environment like social workers are. Clark added that as a clinician the job description for that would be different than that of a psychiatrist or recreational therapist.

A couple other participants, while answering no to the overall treatment delivery varying, still explained what they thought would be different. For example, Wilson commented on marriage and family therapists (MFT) being trained on doing family therapy, so if an MFT did work in the prison the treatment might look different. Wilson stated, “There’s a smattering of people doing different kinds of treatment.” For instance, while Jones agreed with many of the other participants that there is not much of a difference in the treatment different professions provide, it was stated that “social workers are more well-rounded in case management.” However, Jones added that social workers are also just as capable as psychologists to provide effective long-term therapy. In fact, it was mentioned that from psychologist to psychologist it varies as one may favor psychodynamics another may favor behavioral therapy. Walker also not believing that there is much of a difference in treatment delivery, explained that social workers may

be more humanistic, and look at family systems and external factors. Again, it was added that even with that said, psychologist tend to do a good job looking at that as well. It was found that out of the participants, all but one of the social workers interviewed either thought there was a difference in treatment based on profession or said there was not, but still added a side note to their response.

Experience Treating the Inmate-Patient

Interviews conducted on the sample of mental health provider's working with those who are incarcerated conveyed the difficulties experienced in treating the inmate-patients. Much of the research literature provides evidence eluding to mental health not only being impacted by a diagnosis an inmate-patient may carry but also by the prison environment itself which includes isolation, violence, family disconnection, illicit drugs, and so much more (Goomany, & Dickinson, 2015). A primary objective of this study was to explore the interview data for noticeable factors that contribute in treating the inmate-patient. Some barriers to effectively treating the inmate-patient discussed were the role in which their mental health plays, the presenting problem such as symptoms of depression, and substance use problems. The following subsection describes this phenomenon gathered from the data in greater detail.

Role Mental Health Plays in Committing the Crime

According to 50% of the sample, mental health plays a huge role in committing the crime. The other 50% believed it varies dependent upon the symptoms, situation, and the individual. Regardless, all participants saw to some degree mental health playing a role or how it could play a role in criminal activity. When asked the participants all has

something very telling to say. Smith shared that some guys in the middle of their episode or at onset were pushed toward their psychotic symptoms like Schizophrenia or auditory hallucinations and if they were not experiencing that they may not have committed the crime. Even more telling however, Smith added that many of the guys in prison may not have had a "full-blown mental health issue" but may have had a long history of trauma. Smith stated, "Complex trauma is not exactly a diagnosis although I think it should be" as that too can play a role. Jones stated, "I've definitely talked to guys where I thought this guy was so psychotic or this was definitely going on when this happened." Jones attributed much of the problem being behavioral and suggested that axis II personality disorders were playing just as big as a role if not bigger than the axis I disorder.

Mental health can also be a "direct result of environmental and socioeconomic factors." Walker discussed that concept along with many patients being disadvantaged at an early age. Walker stated, "I think a lot of clients would either not be in prison or it would be a different circumstance were it not for them experiencing mental health issues." Wilson believed that having a mental illness for the inmates may have not only made it more difficult for them to regulate their behavior but it also may have made it easier for them to get caught. Moore summed up mental health and crime being related to "substance abuse, the metal illness, and the criminal mind." Miller not necessarily mentioning substance use did however mention how psychosis such as "hearing voices, or when they're manic" can mimic the presentation of someone under the influence because they are not "in their right mind." Thomas suggested part of the problem could be that the inmate was "paranoid or thought people were trying to hurt him." Similarly,

Clark stated, “voices tell them to hurt somebody or to hurt themselves” can play a role in their commitment offense. Lewis believes a person getting arrested, sentenced, and found guilty can alter the way one thinks and induce psychosis. Lewis stated, “If a person is in an altered state of mind and they’re more impulsive and agitated, they’re more likely to get themselves in trouble.” Lewis suggested intermediate interventions rather than just jailing or incarcerating these individuals. Anderson stated, “Many of them will not make it in the community if they do not have the appropriate support they need which most of them unfortunately don’t.”

Experience Treating Depression

A universal theme that emerged from the interviews conducted was the prevalence of depression in the inmate-patients as well as the possibility of symptoms being feigned. All participants have experienced working with inmates who claim to have depression. A sub-theme that emerged from the prevalence of depression among inmates included many inmates having situational depression opposed to having clinical depression. Another important factor contributing to the treatment of depression that some participants mentioned was that of medication compliance.

According to Clark, depression is one of the easiest disorders to treat. Some of the treatment approaches used to treat depression by Clark included “behavioral activation and cognitive restructuring.” On the contrary, many participants find depression difficult to treat in partial because of the environment the patients are in. Jones impersonating an inmate-patient stated:

> Well I'm never going to get out of prison, like I'm never going to have anything more than this, this is my life, everything that I've aspired to do is now null and void because I have life in prison.

Jones acknowledged that it is understandable to feel depressed if that is one's circumstances and recommended helping the inmate-patient find meaning and purpose. Miller explained the depression an inmate-patient experiences may vary dependent upon the level of hopelessness, loss and grief that has been experienced, and if the inmate-patient is not medicated the symptoms may be worse. Jones also brought up the medication Effexor and how it can be effective but also how some of the inmate-patients abuse their medication. Jones added in the community more resources and options are available such as suggesting a client go for a walk which in this setting would be equivalent to recommending an inmate go to yard. Moore stated 99% are "depressed ranging from mild to severe with psychotic features."

Walker alongside other participants noted that depression can be one of the easiest disorders to "fake" or "malinger." There are however ways to measure the effectiveness of a clinicians treatment plan, which Walker and Lewis discussed. Walker has utilized the Becks Depression Inventory in the past to gage an inmate-patients improvement (Beck & Steer, 1984). Walker admitted that the cases in which the most success was made were in cases where the inmate-patient was experiencing situational depression versus chronic long-term depression. Lewis discussed in detail how depression can "manifest into suicidal ideation, self-injurious behavior, or suicidal attempts." The use of CBT has been successful in decreasing some symptoms of depression. To measure the success that has

been made, Lewis utilized a scaling system as well as observing less crisis bed admissions that had been logged.

Experience Treating Alcohol and Other Drugs (AOD)

Across the board, treating AOD issues were deemed to be difficult by the participants in this study. A common theme was not only that it is difficult to treat but that it is also unlikely for the inmate-patient to even admit to abusing substances. Another barrier mentioned by the participants, is the lack of resources available in the program at which they work, to provide effective treatment to their inmate-patient. It is clear that AOD issues are prevalent within the prison system. Substance misuse is high among the mentally ill, mentally disordered offenders, and in medium secure units (Scott, Whyte, Burnett, Hawley, & Maden, 2004). Much like substance misuse being high in medium security, it is also high in maximum security based on the participants of this study's response to AOD issues.

Walker discussed AOD being a factor in mental health as well as a potential contributing factor to prison entry. Many started using at an early age for example, "since age 5" and are not only abusers but "addicts." An interesting fact that was mentioned which coincided with many other participants was that an inmate-patient can easily discuss past AOD issues but may be reluctant to share current AOD issues. Walker stated, "It is a part of so many peoples story that's in prison." Jones explained:

> It's really difficult when A) they're not willing to admit that they have a problem or B) they're not willing to admit that they're still using or C) they have no

> interest in changing that they use because it's the way that they're coping with getting through their prison sentence.

Miller believes substance use can get in the way of treatment and stated, "drugs and alcohol either was a predisposing factor, precipitating factor, or maintaining factor."

It is ironic to think that drugs and other substances are available in prison. Anderson said it best that prison is actually "not a controlled environment." Drugs are used to self-medicate and treatment may be harder for those who have a life sentence. Clark mentioned that AOD issues mostly come up during pre-parole preparation discussions. However, it was shared by some of the inmate-patients that pruno was consumed over New Year's Eve. Moore confessed that the most commonly used drug shared by the inmate-patients has been marijuana and was not an issue for them as they thought of it as an "herb." Besides that sniffing paint, huffing gasoline, alcohol, and "everything" has been discussed as a past method to get high by the inmate –patients in the substance abuse group that was offered at the prison. Moore felt that the group was successful however, the group at which this was discussed was an old group that Moore used to run in another program. As aforementioned, there are less resources available in certain programs in the prison.

Another important factor that is effected by AOD issues is that of recidivism. Two of the participants touched upon this factor. Lewis discussed that AOD is so difficult to treat because many do not want to admit that they have a problem. In order to work on the problem it must be seen as a problem. It is for that very reason that some inmates end

up going back to prison. Wilson concurs and added that the inmate-patients personality disorder may also be driving some of the behavior. Wilson stated:

> The criminal lifestyle is almost universally about drugs. It is very common for the sale of drugs to be highly associated with gang activity. And even people who are stealing in houses and that sort of thing are probably doing so to support drug habits.

Wilson continued by discussing prison culture and divulging that many who are currently using drugs or alcohol will not tell you their "source because then the drugs would dry up from the source and tattle-telling in prison is considered pretty terrible and can get you harmed."

Perceptions of Treatment

After analyzing the data extracted from the interviews of the participants it was apparent that many of them on some level do not believe that all of the treatment they provide is truly effective for all the inmate-patients that they see. As stated earlier, providing treatment in a correctional setting is tricky and comes with several challenges. Carpenter and Spruielll (2011) stated, "A clinician in a correctional setting must also take into account the law, in a milieu that is too often focused on retribution or ineffective and inconsistent jurisprudence rather than rehabilitation and treatment (p.367)." A primary objective of this study involved reviewing the data and uncovering the participants perceptions and views of the progress that has been made in mental health, contributions that has been tried and successful enough to be replicated by other practitioners,

approaches that would be beneficial that has not been tried, and the participants individual perceptions of how they view inmates.

Progress Made

One of the ways that prison mental health care has tried to improve is driven by the notion of trying to emulate a community based model of what mental health care should look like (Hoke, 2015). Much of the treatment that is provided as aforementioned by the participants include: group therapy, individual therapy, short-term therapy, or long-term therapy. This type of treatment may also be seen in the community. However, as previously discussed mental health care providers face different complications than a provider in the community would. A general theme that rose from the participants interviews was either none to little progression has been made in the mental health field specifically in the prison since they have started, or when they did respond it took a while. Still, many managed to think of at least one progression that they have in fact seen since they have started in their profession. Some participants even explained ways in which the progression has moved backward in a sense.

Five of the participants specifically addressed the progress that has been made or lack thereof within the prison systems, while the other participants spoke in broader mental health terms. Jones discussed some of the nuances that accompany working in a prison such as in headquarters, there is a big push toward the numbers and even though they mean well and have good intentions in treating the inmates there tends to be more focus on the results rather than the person. Another aspect that was brought up, was that empirically validated treatment is better for insurance companies. While Jones believes

that is great if that particular treatment works, “that’s not always the best for everybody, and not everybody fits in that box.”

Walker mentioned that one of the setbacks that has been hindering potential treatment is the technology, “It feels like the 1980s.” One thing that a client might be able to utilize in the community and so much of society does utilize that inmates can’t is the internet i.e. cellular devices, laptops, etc. While that is completely understandable, it can put an inmate-patient at a disadvantage compared to someone in the community who could access therapeutic apps on their phone, as suggested by Walker. For example being able to utilize a mindfulness app, meditation, or breathing techniques. Thomas expressed one of the progressions made in mental health specifically in the prison was the passage of prop 57 and how that can benefit some of the inmates. Miller discussed the use of utilizing more case formulations in the treatment plans in the prison as a major progression that has been made. Miller explained the better we can understand the patient the more likely you will be able to treat the patient. Smith added that the goal in the metal health system in the prison is to always get an inmate-patient to a lower level of care and is unsure if that is “good or bad.”

The other participants divulged some progression that has been made in the mental health field in general. Smith reiterated the importance of understanding complex trauma and how that used to be a concept that was rarely discussed and now it is more known and widely accepted. Smith also brought up a great point, that one huge progression has been the upgrade from the DSM-IV to the DSM 5. That change has allowed for progression in the way in which we “diagnose, look at people, and

conceptualize about people." Anderson and Thomas both mentioned that some of the progression made in the mental health field is surrounded by a higher level of awareness around the stigmatization that mental health carries and the accessibility others have to learn about mental illness now. Clark and Lewis both agreed that part of the progression made in the mental health field has been around treatment approaches. While Clark believes an improvement has been made by "steering away from psychodynamic" and being more open to other treatment approaches; Lewis believes by just gaining a better understanding of the treatment approaches already set forth is progression. Lewis stated, "at this point we are able to validate a lot more of the techniques." Lewis explained, "Breaking down and further engagement in the modalities in greater detail" helps see if a treatment approach is effective or not.

Contribution Made

Many of the interview responses for contributions made to have that participants "go-to" treatment approach used by other practitioners varied. Smith and Jones both found informing others of topics they know well to be a contribution made. While Smith believes informing others about the effectiveness of viewing an inmate-patient from an attachment perspective is key, Jones believes informing others how to address transference and counter-transference is important. Walker believes it is important to prepare an inmate-patient for parole if that inmate-patient has an earliest possible release date posted.

Lewis sees value in narrative therapy as well as CBT. The main message Lewis wanted to convey is the importance of remaining versatile. Clark expressed excitement in training a fellow clinician on DBT skills. Clark claimed:

> Just spreading the wealth, spreading the knowledge when invited to or when I see it valuable and useful. I'm really compassionate about it and really excited about it, so when people see that excitement they see hope. And they see in my opinion, the possibility of this can work for and we can be on board too. If someone is so excited about it then you know it works for someone at least so maybe I'll give it a try. That's like opening up doors of possibility, for new ideas and options for people.

Clark continued by sharing that the clinician used in this example is also co-facilitating a DBT group with Clark as well and is doing great.

Miller believes strengths-based is a great tactic to be utilized by other practitioners. Thomas expressed client-centered and rapport being the first techniques to be utilized prior to any other treatment modalities. Similarly, Anderson also felt that rapport is an important contribution that has been made and should be repeated by other practitioners. Building trust is an important aspect and part of rapport building. Anderson explained that it can take a long time to build rapport but it is essential in providing effective therapy. Anderson continued by recommending "patience" and using the "patient's knowledge of themselves." Anderson stated, "It might be so frustrating at some point, when you get there, you start to see the real progress, and it kind of enlightens you and it's so rewarding to see the progress made." Anderson believes through this process

you truly get to see the "root" of the behavior and though it can be stressful, you realize this person never had the "chance or capacity to connect with somebody." Moore recommended and suggested the best contribution that could be made to other practitioners would be to approach inmate-patients with kindness, love, respect, and genuinely. Some of the research suggest that an important aspect of one's training is to "offer a view of persons that enables them to build on individual strengths to help address deficits (Varghese, Magaletta, Fitzgerald, & McLearen, 2015, p.203)." This allows for acknowledgment and an opportunity to address such deficits in an attempt of rehabilitation.

Beneficial Approach Not Yet Tried

Nearly half of the participants agreed that incorporating some sort of social support from loved ones outside of prison and increasing the level of communication with those who are inmate-patients inside the prison would be beneficial. The other participants all suggested different approaches proving it is a clinician-by-clinician basis with no other common theme besides social support integration. Lewis would appreciate trying a multi-modal approach in which case a follow-up with family would be conducted. Lewis stated, "I think that we would probably be more successful in reducing some of the (negative) behaviors. By doing that, we're actually holding the inmate accountable." Lewis believes monthly updates on keeping the family in "the loop" would be beneficial.

Miller also believed having a family-focused approach and increasing one's ability of connectedness and purpose would be beneficial. Miller added solutions-focused

and incorporating more music, art, and work might help as well. Thomas suggested bonding experiences and stated, “We can do mostly everything here; we just can’t do it with all the tools.” True DBT was also mentioned as a treatment approach that cannot be practiced in its entirety specifically with “borderlines.” Along similar lines of social support, Jones believes peer support would be beneficial. Jones expressed that it can be easier for some inmate to talk to one another about certain things that they may not tell their clinician on a count of not wanting to be a “snitch.” Jones also recommended more interactive therapy, and structured art. Smith suggested a regimented trauma protocol if it were ever possible, and prolonged exposure. Smith believes trauma is prevalent however, can understand why it would be tough to administer in prison yet knows how useful it could be. Smith stated:

> It needs to be long-standing, it is a time consuming process. You don’t go through it quickly, and you never know sometimes how long a guy is going to stay in one program or move. The level of vulnerability and openness that you would expose their trauma wounds to and then send them back out into the environment where they can’t really be vulnerable and have to suck everything up makes it more challenging.

Wilson suggested reality therapy and motivational interviewing especially for those with an antisocial personality disorder. Walker believes being more direct in therapy and getting straight to it rather than becoming so easily sidetracked. It was also suggested that the utilization of written material and homework would serve the inmate-patients well. Anderson discussed wanting a less disruptive and more structured

environment as that would be more beneficial for treatment and gave the department of state hospitals (DSH) as an example of an ideal model in terms of structure. Moore believes retraining of the custody staff would be beneficial. Clark would approach inmate-patients from a more humanistic and gestalt perspective utilizing supportive therapy without goals, unconditional positive regard, and working on building rapport and strengthening that therapeutic alliance. As mentioned by Wilson, one approach that is not as often used and could be beneficial to offenders is that of motivational interviewing. Supported by the literature, motivational aids in increasing motivation to change and in reducing recidivism (Austin, Williams, & Kilgour, 2011).

Perception Changed Within Oneself

A couple of emerging themes that came out of the interviews in regard to the participant's perception of inmates were: their perception has not changed much, or they have come to more of a realization than a changed perception. Four of the participants shared that their perception of an inmate has remained the same during their time working in a prison. Smith entered the prison with the perception that most inmates have a trauma history and turned out to be correct. Smith did however, come to the realization that manipulation is so prevalent even for those who are trying to help the inmate and are likely to be manipulated as well at some point. It is extremely hard to tear down the walls of some inmates. Moore expressed that the perception of inmates being people who made major mistakes, still remains the same. Lewis also did not believe that a change in perception has occurred but did admit with the amount of malingering that occurs in this environment and setting, it was hard to not become more "jaded."

Jones came into the prison thinking everyone was over-diagnosed with a personality disorder. A realization that was discovered, was that guys feign their symptoms as a way to get their needs met and with that understanding Jones became more empathetic. Miller had the perception that there is not much of a life in prison, and has come to change that perception because they do have a life in prison, and can find meaning and purpose. Miller also came to the realization that there are no absolutes and that there is no need nor is it right to judge any on the inmates. Anderson's perception has changed in that the amount of empathy when started has increased. Anderson has also come to a realization that many of the level IV inmates that are seen who have life sentences did not acquire such sentences by committing a horrendous crime but through recidivism and getting into trouble while in prison thus acquiring more time needed to be served. Clark's perception has changed by an increased amount of compassion, understanding, and disgust. What goes along with that belief is the realization of the impact not being able to have sex which manifests into a repeated cycle of indecent exposure (IEX). Having experienced an IEX, Clark arrived at the three changed perceptions above.

Wilson arrived at the prison with the perception of inmates being "wild, out of control, impulsive maniacs, with drug addiction and their criminality being a result of impulsivity or the result of methods to get drugs." Wilson has now come to realize that "most of what they do is a part of a worldview, a perspective, the way they perceive themselves in the world." Walker since entering the prison, has changed the perception of inmates being "a scary person" to an inmate just being another person. Wilson supported

that misconception by explaining that there has only been a few inmates that could be considered “vile.” Miller also supported that notion by stating, “They’re not throwaway people, and so very few are so heinous that they can’t be helped or even thought of as humans.” Wilson also explained other perceptions that have changed such as the level of scariness at a maximum security prison and what it is to be a person who committed a serious crime. None of these items are as “scary” as they first may have seemed. Miller concluded with everyone having a story. A study conducted specifically with sex offenders, did show that the providers working with the inmates perceived the inmates to be manipulative (Collins & Nee, 2010). That can in turn effect the treatment provided. It is important to remember and to practice much of what has been stated above, that these individuals are still only human. Regardless of having a positive or negative perception of an inmate it can strongly impact the treatment provided.

Summary

In this chapter, the data retrieved from the study was analyzed and discussed. Chapter four described conceptualizations of mental health provider’s treatment approaches, experience treating the inmates, and their perceptions of treatment. The following chapter presents a description of the conclusions and recommendations. The limitations of the study and the implications for social work practice and policy are also considered.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter summarizes the conclusions of the study and their implications on social work practice and policy. This chapter includes an outline of the main themes including conceptualizations of mental health provider's treatment approaches, experience treating the inmates, and their perceptions of treatment. This chapter should convey how the significant themes relate to one another and the mental health provider's treatment efficacy. This chapter will additionally highlight the limitations of the study and review necessary recommendations for practitioners and the future research studies to be conducted on this topic.

Conclusions

The results of this research project should be noted as it builds upon the knowledge that can contribute to the field of social sciences as it lacks qualitative data on effective mental health treatment delivered in prisons. Taking into consideration the vulnerability and complexities of providing effective mental health treatment in a level IV prison (Galanek, 2013), it is recommended more research be conducted to further and gain a better understanding of what particular treatment approaches work best with this population. Many research outlets have endorsed CBT being an evidence based practice that typically works well in a correctional setting. However, there are so many other treatment approaches that have been proven to be effective. This project was implemented to gather authentic data on the mental health provider's perceptions of how effective the treatment they offer in the prison is. A foundation was made on the basis of

conceptualizations of mental health provider's treatment approaches, experience treating the inmates, and their perceptions of treatment.

Every participant in the study reported some level of difficulty providing effective treatment given the setting at which they work. However, what specifically was seen as a barrier to the type of treatment modality or techniques they would like to administer to their inmate-patient varied. For instance, some participants touched upon the constraints set forth by the prison guidelines as a barrier to treatment whereas other participants brought up the inmate-patient as the barrier to treatment. Regardless, it was unanimously clear that providing treatment in a forensic setting posed more challenges than one would face in the community. The results of this study revealed that each inmate-patient is case-by-case and that each clinician has their own style and favored theoretical orientation some of which including an eclectic approach.

Nearly every participant responded differently while defining what type of treatment they felt they provided to their inmate-patient. For example, many participants partake in individual therapy as well as group therapy. More specifically, some participants explained some of the treatment is more behavioral-based. One participant expressed treatment provided being targeted treatment that aims at addressing an inmate-patients chief complaint or presenting problem. Another participant described treatment in terms of short and long and added that treatment included crisis intervention and case management. The results of this study demonstrated that while all participants provide some sort of psychotherapy the way in which they define and explain it differs.

The results of the study offered evidence that many different treatment approaches are utilized by the participants. In many interviews, cognitive behavioral therapy (CBT) was discussed as being an effective treatment modality used with the inmate-patients. As supported by the literature, CBT is a known evidence-based practice that aims at decreasing problematic feelings, behavior, and thoughts (Rotter & Carr, 2011). This data is pertinent in providing a better scope as to what tends to be more successful in treating the inmate-patients. Additionally, this study supplies evidence that treatment based on profession is not a critical factor in measuring treatment effectiveness. The actual background and training of the clinician weighs far more than the type of degree or title one carries. Furthermore, participants overall felt despite the acronyms that follow their name they all typically do the same job and are definitely all their for the same reason-to help treat the inmate-patient.

A deeper exploration into the experiences of treating the inmate-patient was very telling about prevalent disorders seen in a prison system and how mental illness factors into the crime committed. Half of the participants agreed that mental health plays a huge role in a commitment offense, while the other half agreed the role in which it plays varies and may not have been an absolute factor but more than likely a contributing factor. According to the phenomenon of the criminalization of the mentally ill, many individuals who have a mental illness are primarily housed in jails and prisons rather than in hospitals or community based programs (Bloom, 2010). However, whether it is a certainty or not that mental health played a role in committing the crime, it is understood

at the very least by the participants how it could have played a role in committing a crime, even if it did not in any particular case.

Two of the most common disorders seem amongst inmate-patients are substance abuse and depression. Substance abuse referred to as alcohol and other drugs (AOD) in this study was deemed as very prevalent by the participants. According to Hoke (2015), the strongest predictor of violence and crime regardless of mental status is substance use. Coinciding with that fact, the participants of the study explained their experiences in attempting to treat AOD issues. The common theme that was associated with AOD issues and prisoners was the tendency for the inmate-patient to not admit that he is using. The unwillingness to not believe they have a problem with AOD and the lack of resources provided in the prison was the consensus of why it is so difficult to treat AOD issues. That and the ironic factor that many are still currently using while incarcerated. Depression was universally seen as prevalent as well by the participants. One theme that emerged in discussion about depression was the possibility of symptoms being feigned and the concept of malingering. In addition, much of the depressive symptoms observed tended to be situational (partially from the environment i.e. prison) and not as much clinical depression.

Results of this study offered additional knowledge to the perceptions that have changed within the participants since working with this population. Many participants came to realizations about working in a prison and discussed that along with if and how their perceptions may have changed. Some of the concepts discussed included the perception of an inmate being “scary” and how that is not necessarily the case, the over

diagnosing of personality disorders which was not necessarily the case, and the idea of inmates being “wild, and out of control, etc.” when in fact in has to do with their worldview. Some of the realizations that were shared included: becoming jaded with the amount of malingering that goes, seeing just how manipulative inmates can be (although it can serve a purpose), and the strong effect of not being able to have close connections and sex can have on them.

The results of this study also contributed to what works well with this population and what does not. In addition, what methods may be beneficial with this population that are not yet in place. Some of the progress made in the mental health field that was discussed by the participants included moving from the DSM-IV to the 5, prop 57, and moving away from psychodynamic theory. Some of the setbacks discussed were the importance of pushing paper which may inadvertently put the patient on the backburner, and lack of technology and resources available in the prison. Some of the strides the participants believe they have made include: informing others of topics they understand well, teaching others clinical skills i.e. how to practice DBT skills, and working from a positive mindset. A major theme discussed across the board was the necessity of human connection and the effect that it has on inmates not being able to experience that any longer. That was the main approach identified as being beneficial that cannot be implemented in this prison setting with the patients whom reside in a lock-up unit.

Perhaps the most significant aspect of this study was the importance placed on bonding. This study provides evidence that a very important aspect of administering therapy is the therapeutic bond and building rapport before treatment can even be

initiated. Vital to treatment is communication, and showing one another respect, authenticity, kindness, and unconditional positive regard. Rapport acts as precursor to treatment which is a prerequisite to increasing stability and decreasing symptomology. In most scenarios, participants reported perceptions of effective treatment provided equated to measurable goals (objective), patient reporting (subjective), and by observation such as behavioral change. This study corroborates the transparency of barriers presented by participants in providing effective treatment working in a correctional mission setting, as well as the successes that can occur in this setting despite that.

Recommendations

Based on the findings of this thesis project, recommendations can be made to researchers of future studies and practitioners of social work, and the mental health field. Research and practice related recommendations are contemplated in the following two subsections.

Future Research

The primary purpose of this study included collecting data that provided insight into the perceptions of provider's effectiveness in administering mental health treatment in prison. The study results convey the necessity for future research in areas related to treatment in a forensic setting for the population being considered. One specific area of future research would be the usefulness inmate-patients seem to find in being manipulative and malingering as that is a common barrier tin treatment. The study findings suggest that while those concepts serve a purpose for the inmate-patient it also hinders the therapeutic process. Future research could further investigate the relationship

between malingering and the negative effects that is has on treatment. Other areas of future research may include resistant or inmates that do not want to program or participate in treatment and how that effects their mental health. In may also be beneficial to look deeper in the motivation driving feigning symptoms or misusing substances as that is known to interfere with treatment as well.

Future studies that desire to further investigate the research question proposed in this thesis project could elicit a stronger study design by changing some of the measures this researcher chose to use. First, one could interview a greater number of participants to increase the sample size. In addition, a researcher could not only conduct research with provider's who work in a level IV prison but also who work at a lower level prison. Not to mention, a clearer view of treatment could be solicited if the researcher interviewed providers working with different levels of care and not just one as this researcher primarily did. Finally, a distinct and clearer difference in interview questions would possibly aid in more explicit responses from the participants, as some questions asked by the researcher were broad and somewhat left to interpretation. An interview with concrete questions may advance the responses yielded. Additionally, demographic questions could be expanded and one could aim to include more of a variety of ages, ethnicity, and experience working in this field.

Practitioners of Social Work and Mental Health

Clinical recommendations derived from this study include a demonstration of the accumulated cultural competence exhibited in treatment approaches to inmate-patients. It is recommended that social work and mental health practitioners work from a theoretical

framework that they feel comfortable with and are knowledgeable in so that they can justify why that theory was selected for that inmate-patient in their case formulations. It remains critical that practitioners recognize the importance of rapport building as a necessity in treatment. Many participants in the study spoke to the way in which rapport or lack of it can effect treatment. It supports the importance of human connections and forming relationships including professional ones.

Social work and mental health practitioners are encouraged to be authentic and versatile in the treatment that they provide. Most mental health care providers expressed the importance of being genuine and approaching the inmate-patient with some level of understanding their struggle. However, it can be a difficult task if the practitioner is trying to provide treatment and the inmate is not engaged or participatory. As social work and mental health practitioners provide treatment, it is recommended that they work from a humanistic framework. A clinician with compassion and empathy may be more successful in providing treatment that includes the inmate-patient being receptive of the treatment. It is highly recommended that clinicians are mindful of their own biases, perceptions, and counter-transference, and actively participate in self-reflection.

Limitations

Limitations of this study can be greatly represented by the setbacks related to the qualitative approach to research. A qualitative design was utilized to collect pertinent information on the perceptions of provider's treatment efficacy. The sample obtained for the study was limited by sample size and location, consequently effecting the generalizability of the findings. Furthermore, the sample was acquired through non-

probability snowball sampling, a method known to weaken the validity of a study. The study design employed face-to-face and phone interviews for data collection, an approach understood to elicit social desirability bias. Qualitative approaches utilizing semi-structured interviews are difficult to replicate and analyze, thus constricting reliability. The subjective matter of qualitative research precipitates a susceptibility for biases in the study design, data gathering, and the interpretation of data.

Limitations directly encompassing this study include the difficult nature of conducting research in a prison setting. Collecting data about therapy with inmates may only contribute so much to the general knowledge of mental health treatment because it is not generalizable to the public. For example, nuances that a provider may experience in prison that a provider in the community may not could include: a greater likelihood of an antisocial personality disorder getting in the way of treatment, a greater safety risk such as gassing (throwing bodily fluids) or attempted batteries or assaults including indecent exposure (IEXing), and the amount of manipulation and malingering occurring. As aforementioned, other limitations include the interviews primarily consisting of one treatment team, all interviews conducted at one prison site, and mainly with providers who work with a certain level of care. These demographics included all providers working in a level IV prison, with an inmate-patient who has a designated enhanced out-patient (EOP) level of care, and primarily with inmate-patients in a lock-up unit.

Implications for Social Work Practice and Policy

Research studies have helped increase awareness with the stigmatization of the mentally ill and more specifically the prevalence of it within our prison systems and

inmates. Perhaps this is partially due to the enormous amount of inmates incarcerated who have a mental health diagnosis. It would appear that society is aware of the impact crime and safety has on the community which drives the notion of the importance of rehabilitation. Regardless, of why an individual commits a crime, it remains crucial to ensure that the likelihood of the offender reoffending once released is reduced through their time served but often unknown the role their mental health played in committing the crime.

On a micro level, the ability to provide effective treatment to an inmate-patient through psychotherapy assists in that inmate successfully integrating back into the community; if one learns how to manage their symptoms and acquires basic coping skills to utilize at their disposal. As time progresses, hopefully there will be an even better understanding of effective treatment approaches and what tools can be utilized by the clinician in their sessions to not only stabilize the inmate-patient but to truly rehabilitate them. Granted, the inmate has a date and is not serving a life sentence, and the inmate-patient is willing to participate in treatment.

On a mezzo level, different disciplines work together in the prison requiring collateral contacts and meet to discuss level of care for an inmate-patient at a team meeting called interdisciplinary treatment team (IDTT). If it deemed by the team that an inmate-patient needs a higher level of care (LOC) then a referral is sent to the department of state hospitals (DSH) which offers services to the inmate-patients that the prison cannot offer. This ensures that the inmate-patients are adequately getting their mental health needs met. This increases interdisciplinary communication and cultural

competence. This contributes to stabilizing an individual to the point the one can return to prison and actively participate in treatment and ultimately manage their symptoms.

On a macro level, social workers and mental health care providers collaboratively work together on ensuring their following the mandate given to them under the court order (Coleman v. Brown). It is the mission under such courts that ethical, professional, and effective mental health care services are established, and offered at different levels of care for those in the prison system (CDCR, 2017). This supports the notion of having access to health care services being a basic human right. Becoming an active member in the National Association of Social Workers (NASW, 2008) continues to remain integral in affecting policy change and advocating for such vulnerable populations. Implications for this study include ensuring the health, safety, and stability of all inmate-patients by measuring the effectiveness of treatment provided and how providers view the treatment they provide. This research study is significant to social work practice because it applies the ethical guidelines governed by the National Association of Social Work (NASW, 2008) such as: providing service to those in need and addressing social problems, acknowledging the dignity and worth of a person, recognizing the importance of human relationships, and practicing competence.

Conclusion

The purpose of this study was to explore the perceptions that the providers have about the effectiveness of the treatment they administer. It was the researcher's goal to uncover the way in which treatment was viewed and how effective it was. The study findings indicated a plethora of conceptualizations about treatment efficacy. Results

highlighted and reported contributing factors that helped and harmed the therapeutic process. Furthermore, emerging themes, treatment modalities and interventions that tend to be successful were discussed. Future research recommendations were presented as well as recommendation to practitioners of social work and mental health. The concluding chapter contains the implications of the research practice and policy on the micro, mezzo, and macro level of social work. One crucial implication remains that effective treatment is contingent on the individual's willingness to program, and a therapeutic bond be established before treatment can occur. Despite this study containing limitations in design and generalizability, the findings offer insight into effective treatment approaches and methods to use with this population.

Appendix A

PARTICIPATION CONFIRMATION/ LETTER OF INFORMED CONSENT

STUDY TITLE: Perceptions of Professionals on Treatment Efficacy and Mental Health Services with the Forensic Population

My name is Asia and I am a second year graduate student in the Division of Social Work program at California State University, Sacramento. I would like to invite you to participate in this research study because your opinion matters to this study. The goal of this study is to identify factors that may prevent timely, efficient mental health services by the forensic population.

If you choose to participate in this study, your participation will consist of being digitally recorded in an interview of approximately 30 minutes in length. There are no direct benefits to you by participating in this study. However, the knowledge gained from this study may benefit the forensic population by improving access to services and therefore improve the quality of mental health services for this population.

There are no known risks to participation in this study. Your identity will remain anonymous at all times and the information you disclose in the interview will be kept confidential.

Among the measures taken to ensure confidentiality are the encryption of all electronic data collected (data stored behind a secure firewall). Hard-copied data will be maintained in a safe, locked location and will be destroyed by August 31, 2017 after the study is finalized, together will all electronically collected data.

You are more than welcome to withdraw your participation in the study should you chose at any time. By signing this letter of consent you are not waiving any legal claims or rights. Your signature below indicates that you have read and understand the information herein provided and agree to participate in the study as well as consent to be digitally recorded.

I am highly appreciative of your time. Please feel free to contact me at asiaalexander@csus.edu. You can also contact Dr. Maria Dinis, the advisor to this project, at (916) 278-7167, or at dinis@csus.edu. For questions about your rights as a participant in this research study, please call the Office of Research Affairs, California State University, Sacramento, (916) 278-5674, or email irb@csus.edu.

I have read the descriptive information on the Research Participation Consent form. I understand that my participation is completely voluntary. My signature indicates that I have received a copy of the Research Participation Consent form; and I agree to participate in the study.

I, _____, agree to be digitally recorded for interviewing purposes of this study.

I, _____, agree to participate in the research study.

Signature: _____ Date: _____

Appendix B

Interview Questions

Perceptions of Providers and Mental Health Treatment Efficacy

1. What type of treatment do you provide to your client/patient?
2. Does the type of treatment vary based on profession, in your opinion?
3. Do you find a particular treatment effective?
4. What role does mental health play for inmates in committing the crime?
5. What has been your experience treating Depression among inmates/parolees?
6. What has been your experience treating AOD issues among inmates/parolees?
7. What perceptions have you changed within yourself about this population?
8. What approach do you think would be beneficial with this population that you have not yet tried?
9. What progression has been made in the mental health field since you started in this profession?
10. What contribution do you think you have made to have your treatment approach used by other practitioners?
11. What is your age range? (Please circle) Under 35 years old or over 35 years' old
12. What degree do you have? (Please circle) Less than a Bachelor's Degree or Bachelor's Degree or Master's Degree or Post-Master's
13. How many years have you worked in the field? (Please circle) Less than 5 years or Greater than 5 years
14. What is you gender? (Please circle) Male or Female or Other. Please Describe_____
15. What is your ethnicity? (Please Circle) Caucasian or Non-Caucasian
16. Do you know of any other providers or clinicians that work with those who are incarcerated or on parole whom you think might be interested in participating in this study? If not, thank you very much for your time. If yes, please give me their name, contact phone number and/or email address.

Name	Contact Number	Email
1.		
2.		
3.		

Appendix C

Human Subjects Approval Letter

CALIFORNIA STATE UNIVERSITY, SACRAMENTO
DIVISION OF SOCIAL WORK

To: Asia Alexander Date: October 28, 2016

From: Research Review Committee

RE: HUMAN SUBJECTS APPLICATION

Your Human Subjects application for your proposed study, "**Perceptions of providers on treatment efficacy of incarcerated inmates/parolees**", is **Approved as Exempt**. Discuss your next steps with your thesis/project Advisor.

Your human subjects Protocol # is: **16-17-013**. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Research Review Committee members Professors Maria Dinis, Serge Lee, Kisun Nam, Francis Yuen

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