APPLICATION OF THE RECOVERY MODEL
IN COMMUNITY MENTAL HEALTH AND CRIMINAL JUSTICE

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B.A., California State University, Sacramento, 2008

PROJECT

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF SOCIAL WORK

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2010
APPLICATION OF THE RECOVERY MODEL
IN COMMUNITY MENTAL HEALTH AND CRIMINAL JUSTICE

A Project

by

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Division of Social Work
Abstract

of

APPLICATION OF THE RECOVERY MODEL IN COMMUNITY MENTAL HEALTH AND CRIMINAL JUSTICE

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This study explored the attitudes and perceptions of two different groups of professionals who work with people who have serious and persistent mental health disorders. The two groups were social workers who work with the recovery model in community mental health settings and criminal justice personnel. Five members from each group were selected to participate in face-to-face interviews. The purpose of the qualitative, exploratory study was to gather information about those who are working in criminal justice and mental health to see if a difference existed in the attitudes of the two groups. The study found that although the group of social workers had more training and understanding of mental health symptoms and treatment, the two groups had similar conclusions about the difficulties facing people who had both serious mental health issues and legal involvement. Both groups recognized the need for more supportive services and the need to reduce the stigma surrounding mental disorders. The two groups were in agreement that direct contact with people about their disorder, education, and social movements all operate as factors necessary to challenge attitudes and perceptions about
serious and persistent mental disorders.

_______________________, Committee Chair
Teiahsha Bankhead, Ph.D., LCSW

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Date
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Chapter 1

THE PROBLEM

Serious mental illness and the number of inmates held in jails and prisons in the United States have increased to the point that many are calling the problem the ‘criminalization of mental illness’ (Markowitz, 2006; Sims, 2009; Moore & Hiday, 2006). The estimates of how many are incarcerated fluctuate depending on the methods used to define the mental health problems (Moore & Hiday, 2006). Estimates of inmates with a mental disorder range from six to twenty-two percent (Moore and Hiday, 2006), with several sources citing the number of inmates with serious mental disorders at approximately sixteen percent (Bernstein & Seltzer, 2003; “Mental Health Initiatives”; Markowitz, 2006; Sims, 2009). Another half million people with serious mental disorders are on probation (Markowitz, 2006).

The criminal justice system, in recent years, has responded with the creation of mental health courts as a diversion for those with a mental illness who have entered into the criminal justice system (Bernstein & Seltzer, 2003). The courts work to reduce the incarceration and re-arrest rates, while making services available that would possibly have averted the offense (Bernstein & Seltzer, 2003).

The mental health professionals in community agencies and the criminal justice personnel, which includes attorneys, public defenders, judges and prosecutors, as well as law enforcement officers, have differing perspectives of those who appear in court on charges. Mental health professionals are likely to have been exposed to and are working
to integrate a recovery philosophy in their agencies. Their education and training has been different in content, with a focus on diversity and vulnerable populations. They also are trained in advocacy, both in casework and as a part of cause advocacy, which focuses on a macro level rather than a micro-person oriented approach (Payne, 2005).

The person with a legal or criminal justice background has a perspective focused on legal issues, or public safety concerns (Bernstein & Seltzer, 2003). The criminal justice background, often a precursor to a law degree, focuses on criminal behavior, investigation, systems of law and public safety concerns (CSUS Criminal Justice Course Catalog). Little is offered on diversity or vulnerable populations, although coursework includes contemporary issues (CSUS Criminal Justice Course Catalog, 2010). Both professions must find common ground when working with people who have been charged with an offense and have a serious mental disorder.

**Background**

Beginning in the sixties and seventies, the processes of ‘deinstitutionalization’ and ‘normalization’ began (DiNitto, 2005; Anthony, 1993). The movement toward ‘normalization’ started in Sweden and was initially focused on supporting people with developmental disabilities to live in the community independently, even when that meant providing additional services to make that possible (DiNitto, 2005). Soon the term encompassed those with psychiatric disabilities (DiNitto, 2005). Developing at about the same time, new psychiatric drugs made it possible for patients to stabilize and experience enough symptom reduction to leave the state hospitals and return to communities (DiNitto, 2005; Markowitz, 2006). The medications were not enough to ensure success,
ex-patients needed psychosocial rehabilitation services which addressed supported living, crisis interventions, case management, and advocacy (Anthony, 1993).

In 1972, the Supreme Court ruled in *Wyatt vs. Stickney* that people should not be in institutions unless it was the least restricted living situation possible (DiNitto, 2005). This meant that when someone was well stabilized on their medication and capable of living with families, or in a supported environment such as a board and care home, this right was upheld. Another Supreme Court ruling in 1985, about the rights of those with intellectual disabilities, *City of Cleburne, Texas v Cleburne Living Center*, reaffirmed this trend (DiNitto, 2005).

Community Mental Health Settings were expected to provide rehabilitative services to support the individual in transition, provide inpatient and outpatient care, crisis care, partial hospitalization, and education (DiNitto, 2005). This promise was never wholly realized. Although the federal government had ended a century of non-involvement in the mental health care provided by the states with the signing of President Kennedy’s Communities and Public Construction of Mental Facilities Act of 1963, the funding to fully support the effort to build CMHCs for the three thousand planned catchment districts failed. Congress in the 1970’s had become distracted; services designed for children, seniors and those who had substance abuse issues did not have the funds appropriated for their creation (Sharfstein, 2000).

The resultant rise in the homeless population over the last four decades is attributed by some to the failure of the system to provide the services critical to stabilization (Bernstein & Seltzer, 2003; Lamb, Weinberger, & Gross, 1999). The
estimates of those who are homeless and have a problem of a major mental illness is approximately one third, but if factoring in substance abuse disorders, the numbers climb to seventy percent of this population (Markowitz, 2006).

There are criticisms that the failure of the mental health system delivery, the stigma surrounding mental illness, and the lack of affordable housing in many areas exacerbate the multiple problems (Lamb, Weinberger, & Gross, 1999), and for those being released from jails or prisons, the double stigma of having a mental disorder and time in jail creates another barrier to housing and employment (Hartwell, 2003 as cited in Brucker, 2006). Although many of them have committed serious crimes (Torrey, as cited in Markowitz, 2006), many more have been arrested for crimes that have to do with their quality of life (such as arrests for riding the streetcar without a ticket, disorderly conduct, or loitering), and their inability to handle the symptoms of their mental disorder (Markowitz, 2006; Brucker, 2006). Most receive little in services except medication (Bernstein & Seltzer, 2003). Research shows that those with serious mental disorders are far more likely to end up arrested, than someone who does not have a disorder for the same offense (Markowitz, 2006; Bernstein & Seltzer, 2003).

Initially, the CMHCs were funded by the federal government with decreasing support expected to be needed over the years. The notion was that other funding, including third party payers, would fill in the gaps, though they were to provide services to those who did not have the ability to pay- they were intended to be a “mental health safety net” (DiNitto, 2005; Sharfstein, 2000). In 1980, The Mental Health Systems Act provided more coverage for adults and children with serious mental illnesses, and
contained many of the suggestions of President Carter’s Commission on Mental Health.
In 1981, President Regan overturned this legislation when he took office and much of the funding became block grants to the states. Federal support was diminished (DiNitto, 2005).

Today many who work with the people in community mental health settings have gradually come to adopt the ‘Recovery Model’ as a philosophical framework in their work. This philosophy has evolved since the seventies, which saw the rise of the psychiatric survivor’s movement. This movement used ‘consciousness-raising’, employed by the feminist movement to bring women together to share their common experiences, find their own power, and develop strategies for growth (“Mental Health Advocacy”, n.d.). These survivors also adopted the feminist principle that the personal is the political (Adame & Knudson, 2008), so the narrative framework has been important and valued in the stories shaping recovery (Cohen, 2005). The movement’s main message was that the consumer or survivor must have the right to choices, and a voice that is valued in the treatment plan.

The recovery model framework has four concepts: hope, choice, responsibility, and a meaningful role (Jacobson & Greeley, 2001; “Knowing a Recovery Culture”, n.d.). Hope is believing a better life is possible. Choice, or empowerment, as it is also referred to, means having the power to achieve that better life, responsibility is taking the steps necessary to realize that goal, and a meaningful role engages one in the community. A role is meaningful that is not solely defined by the mental illness (“Knowing a Recovery Culture”, n.d.). The shift in treating people in this way is to move from treating someone
as a collection of symptoms, rather than as someone who has symptoms. Anthony (1993) commented that the failure of the deinstitutionalization movement was that more was needed than an attempt to reduce symptoms. Anthony (1993) listed eight elements of essential services for clients: “treatment (symptom relief), crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help” (p. 524). This is still valid today.

The recovery concept has been acknowledged by family and consumer groups, as well as the Presidents’ New Freedom Commission (2003), as the guiding principle needed to work with people who have a mental disorder (Anthony, 1993, National Association of Mental Illness, 2002; Ashcroft & Anthony, 2008; the President’s New Freedom Commission, 2003). Recovery refers to the process of healing as the capacity to be living lives that bring satisfying activities and interactions with others. It does not necessarily mean ‘cure’ from symptoms, but suggests education and choices about how to manage those symptoms. These concepts of hope, responsibility, choice and meaningful role in the community are central to the recovery model.

One of the major focuses of recovery has to be human rights (Jacobson & Greenley, 2001). The focus is to reduce and eliminate the stigma of a mental illness, to providing equal opportunities in housing, education, jobs- including advocacy on every perspective surrounding mental health issues. Jacobson and Greenly (2001) see the ‘positive culture of healing’ as integrated with the concept of human rights, saying: “...the implementation of the principles of human rights in an organization results in a
positive culture of healing, and recovery-oriented services are services that emerge from such a culture” (p.484).

Statement of Research Problem

Little is known of the education and training of those who work with people who have mental disorders in the Criminal Justice arena. Although there are some individuals whose behavior is dangerous, the inmate who is unstable and experiencing hallucinations or delusions may be inappropriate for the jail or prison system. Criminal Justice personnel would likely benefit from more information about the mental disorders and collaboration with mental health workers. Social work sees the emotional, physical, and social health of the individual to be of concern, as well as policies which affect the individual and communities. Exploring the perspectives of those who work in these areas may indicate collaboration that will improve outcomes in Mental Health Court and in the community.

Purpose of the Study

The purpose of this exploratory study is to examine the attitudes of professionals about people with mental disorders who are also involved in the Criminal Justice system. This study may help develop common perspectives and identify interventions needed in those who work with people with mental disorders and in the Criminal Justice system.

Research Question

What are the perspectives of the professionals who use the recovery model in community mental health agencies and those who work in the Criminal justice field regarding their clients?
Theoretical Framework

The theoretical framework selected for this study is the Advocacy theory (Payne, 2005). Advocacy has been a recognized part of social work since the 1970’s (Payne, 2005). Through emphasizing the larger picture of an issue, Advocacy theory has been framed in policy development and analysis. As a part of social work casework, advocacy has been part of the process that social workers engage in with clients. Empowerment to enable the client to achieve the results for themselves has been the next focus of the advocacy work. In this study, advocacy is seen as needed from the time the client is identified as having a mental disorder, or identifies as possibly being a candidate for Mental Health Court because of behavior or comprehension problems. The framework of Advocacy theory allows a perspective that the client with a serious mental disorder who is involved in the Criminal Justice system may benefit from advocacy from both the community mental health workers as well as the Criminal Justice personnel. The theory reflects some of the basic concepts of the recovery model in promoting client self-determination, choices and hope, and a meaningful role in the community (“Knowing a Recovery Culture”, n.d.). Lee (2001) states that social work’s calling is to provide hope and power to people by the commitment to social justice and caring. Advocacy is the theory to implement such qualities in the vulnerable populations that come into the system at the door to the courtroom or from the holding cell.

The Advocacy Theory. Advocacy as a term derives from legal practice and is a function of social work, often associated with the use of empowerment theory. The concepts are connected to the recovery model concept discussed previously. It
incorporates the humanist perspective (Glassman and Kates, 1990, as cited in Payne, 2005) that affirms the natural worth and dignity of each person, the right to belong and be included, the right to be heard, and the right to question and confront professionals, among other things.

Advocacy represents arguing for the best interests of the client, in the legal sense and in the field of social work. This type of advocacy is considered case advocacy. The forensic social worker is often charged with balancing the needs of the individual with the needs of the society to be safe. This representation is multifaceted as well.

The advocacy theory has four related components. It means protecting those who are vulnerable, creating support that supplements stability, protecting claims or appeals, and advancing the self (Freddolino, 2004, as cited in Payne, 2005). The concept grew during the 1980’s to mean advocacy for those living with disabilities to increase their capabilities to live independently (Payne, 2005). The impetus of the advocacy theory applied in the collaboration of Social Workers and Criminal Justice personnel is to divert people with serious mental disorders from inappropriate placements in jails and prisons.

*Application of Advocacy Theory.* Advocacy theory brings the practical task of supporting a client through this Mental Health process and offering stabilization through following the conditions outlined in the Court’s term and conditions. The treatment plan, stable and secure housing, opportunities to connect with needed services, and the advocacy of both the attorney and forensic social worker provides the structure needed for personal empowerment, advocacy, and some of the elements of recovery.
The recovery model offers hope, choice, responsibility, and a meaningful role. The theory emphasizes hope for recovery from the problems that have plagued the client. The process of diversion from the traditional court offers this hope, as well. Choices are central to recovery, healthy choices to sustain recovery from the series of events that caught the person in a net of legal issues. The responsibility refers to the responsibility of the individual to use the resources offered wisely. The responsibility for the individual is to grow and build connections to their community that will sustain them. The meaningful role means the person will find a way to be in the community in a positive, contributing manner that contradicts the ‘role’ of mental patient.

Definition of Terms

Community Mental Health Centers (CMHC)-designed to serve the community, especially low-income individuals, the homeless with mental disorders, and children and adults with serious mental disorders. The CMHC provide crisis evaluation, short-term hospitalization, medication services, education and support for individuals and families about mental disorders, transitional supported housing options, and day treatment programs.

Consumer-someone who uses mental health services

Co-occurring disorders-Refers to two, or more, disorders occurring at the same time. This may mean a mental health disorder and a substance abuse disorder, but one disorder may be physical or developmental.

Deinstitutionalization- A return of the client to live as independently as possible in community settings, which was reinforced by a Supreme Court ruling in 1972 which
determined that people should not be living in institutions unless it is the least restrictive setting in which that person could live.

**Mental Disorder**—a clinically significant behavioral or psychological dysfunction leading to distress in daily life

**Forensic Social Work**—Social work in the legal or prison system

**Mental Health Court (MHC)**—a designated court for those with a mental disorder and a criminal offense

**Psychiatric Survivor**—an individual who identifies as having survived abuses of the mental health system

**Recovery Model**—a philosophy different from the medical model of working with people, instilling hope, choices, responsibility, and a meaningful role

**Social Control**—promotes conformity that may seem like coercion to the client who must agree to terms and conditions of Mental Health Court which requires compliance to the treatment ordered by the doctor, such as taking stabilizing medication.

**Suitability**—an evaluation, usually by the social worker, through Mental Health Court, which decides whether a person’s mental disorder has been complicit, or associated with the crime under review or investigation.

**Assumptions**

The assumptions to be included in this study include: 1). Mental disorders can have a debilitating effect on a person’s life, 2). Mental disorders are common, rather than uncommon, 3). People with serious mental disorders can live in the community with
reasonable accommodations, 4). Diversion from prison is alternative sentencing that works to reduce recidivism.

Justification

Mental disorders such as schizophrenia, schizoaffective disorder, bipolar disorder, and chronic depression can interfere with the ability to work and function without distress from psychiatric symptoms. Stigma and discrimination also exist for individuals with mental disorders. It is estimated that as many as one in five people in the United States have symptoms of a mental disorder in the United States in a given year. Treatments for mental disorders are available and are more effective if started early in the disorder. Medications are also available and are effective in reducing symptoms for many. For some individuals other services such as safe, affordable housing services or case management will support the ability to live in a community setting. Treatment options and court supervision are effective in reducing the revolving door of offense and re-arrest experienced by many who have a serious mental disorder, or co-occurring substance abuse disorder.

Delimitations

This study does not explore the different perspectives of social workers and criminal justice personnel with quantitative data. The study is focused only on two counties in the foothills of Northern California. As evidenced in the literature review, there was little to suggest that criminal justice personnel are offered any training on how mental disorders impact the populations with which they work. Another limitation in this study is that the researcher may create bias based on the snowball effect of choosing
individuals to interview who were a part of the internship. The researcher cannot guarantee that the information will be replicable or valid in larger, urban areas.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

The emergence of the psychiatric survivor’s movement over forty years ago signaled the beginning of what is now referred to as the Recovery Movement in mental health (“Mental Health Advocacy, From Then to Now”, n.d.). Social change normally takes place slowly, sometimes so gradually that one might not realize the change had taken place in their life span. In the years following the advent of the civil rights movement, social and political movements built on the examples and experiences of each other. The antiwar movement, the women’s movement, the gay and lesbian movement, the American Indian movement, the disability rights movement, and the welfare rights movement all shaped the years that came before people with mental illnesses, and their families, began to speak of their experiences (“Mental Health Advocacy”, n.d.). Chamberlin (1998) points out that in almost every country, someone with the “label” of a psychiatric illness can have their civil rights violated; be institutionalized for an indefinite period, be forced to take psychiatric medication, have a lobotomy, or be given electroshock treatments. In this new movement to define and claim responsibility for their own treatment are many who experienced those atrocities, adopting the term psychiatric survivors to mean just that-survivors of a system that infantilized, patronized, and controlled them in the name of ‘taking care’ of them (Chamberlin, 1998; Cohen, 2005). In the struggle to have a voice, those with psychiatric illnesses claimed the right to
define their condition in their own terms (Chamberlin, 1998; Carpenter, 2002). The “patient”, over the years, became the consumer, the member, the client, the psychiatric survivor, the person with a psychiatric disability (Hensley, 2005; Chamberlin, 1998). Autonomy became the central concept to frame the discussion of the rights of the mentally ill. The notion that the individual is free to make choices, as long as they are lawful, even if they go against the norms of the culture, is central in this democratic society. Concerns about the safety of the public and social control are the reasons those with mental illnesses are subject to involuntary treatment as compared to those with a ‘medical’ illness, who are free to decline treatment for their condition (Chamberlin, 1998; Carpenter, 2002).

Over time, the movement by ex-patients, consumers, and psychiatric survivors has insisted that the ‘medical model’ of defining mental illness does not work for them. They understand their disorders to be complex interactions of biological, psychological/emotional, environmental, and behavioral factors. They claim the right to define symptoms and choose their treatment options (Cohen, 2005; World Health Organization, 2001; Surgeon General’s Report, 1999; Carpenter, 2002). The symptoms are manageable for many, through psycho-education, and the support of family and peers (Ridgway, 2001; Chamberlin, 1998; Cohen, 2001; Adame & Knudson, 2008). Others speak of the need for medication, but choose the lowest dose possible to control more bothersome symptoms, or refuse to use medication and learn about the cycles of symptoms that they experience, along with anticipated, periodic hospitalizations (Lee, 2005; Chamberlin, 1998; Chovil, 2005). Psychiatric survivors also point to involvement
as activists in consumer groups and political action committees as another defining element of their recovery (Hensley, 2006; Adame & Knudson, 2008). One researcher relates that in a study of thirty-six psychiatric survivors interviewed, as many as sixty-nine percent noted social activism as a recovery tool (Cohen, 2005).

Psychiatric survivors voice their pain at being locked up, treated with drugs that affected their cognitive abilities as well as having other serious physical side effects, and told they had an illness that was intractable, as well as unremitting (Lee, 2005; Chamberlin, 1998; Cohen, 2005; Ridgway, 2001). Many insist their experience of mental disorder is that it waxes and wanes. Some people with schizophrenia report that it recedes in later years (World Health Organization, 2001; Cohen, 2005).

In gathering information about the experiences of psychiatric survivors, researchers have found that using a narrative approach has been beneficial (Ridgway, 2001). The narrative theoretical approach uses stories of their experiences to weave together the commonalities they have undergone, while allowing the telling to empower the individual by re-framing the elements of their history (Ridgway, 2001; Cohen, 2005).

In Cohen’s (2005) qualitative and quantitative study for the MindFreedom International Oral History Project, thirty-six psychiatric survivors, or ex-patients’ oral histories were analyzed and common themes were sorted into four general categories. Cohen (2005) remarks that the patient’s perspective is usually left out of the literature and the voices of the ‘experts’ are heard instead. Using a snowball sampling method, Cohen (2005) reasoned that those he found were likely more open about their psychiatric histories. Nearly all identified as psychiatric survivors and were generally over forty.
Eighty-six percent were white, and well educated. The study used twenty-two open-ended interviews and concentrated on two main issues. One was describing the process of recovering from times of significant emotional distress, the other issue emerged from the interviews-describe how you overcame violations of human rights from the system. There was also a survey of similar questions mailed to hundreds. Fourteen were completed and returned. In addition, the project received four free form essays, one thousand to fifteen hundred words in length, in response to a call for survivor histories (Cohen, 2005). The project’s material was coded into twenty-six subthemes and sorted into four groupings of trauma, social control, internalized oppression, and recovery (Cohen, 2005).

Weber et al. (2008), using an Early Trauma Inventory Scale and the Posttraumatic Stress Disorder Scale, studied ninety-six patients with psychiatric diagnoses such as major depressive disorder, schizophrenia, drug addiction, and personality disorders with thirty-one subjects without psychiatric diagnoses to determine if stress loads in childhood affected psychopathology in psychiatric patients with these different diagnosis (Weber et al., 2008). The Early Trauma Inventory Scale identified stressors such as physical violence, emotional neglect, general trauma, and sexual abuse. The study divided the periods into early childhood stressors (before six), the period before puberty, the time between puberty, and the current age (adulthood stress). They examined the effects of high stress loads through studying affective symptoms, posttraumatic stress disorder symptoms, and the severity of the disorders by using regression analysis and comparing groups with high and low stress loads. They found a high correlation between high stress
loads in childhood and prepuberty with symptoms of negative affect in adulthood (Weber et al., 2008).

In evaluating the four areas of stressors, emotional neglect was reported across all the group and periods. The conclusion was that high stress loads alone would not cause a mental disorder, but that it may be a variable in developing negative symptoms. For example, in Post Traumatic Stress Disorder, PTSD, symptoms and affective disorders were strongly related to early life stress and a “building block” effect shows that with higher numbers of, or more severe, trauma, the probability of developing PTSD symptoms or psychosis is higher (Weber et al., 2008). The WHO report (2001) stated also on the effect of early developmental stressors is associated with persistent brain hyper-reactivity and the increased possibility of depression later. This information is confirmed by others who have written about trauma and its effects (Herman, 1992/1997; Straussner & Phillips, 2004).

Social control is described by psychiatric survivors in several ways. Lee (2005) speaks of being aware of additional stimuli besides the ones considered normal-sight, sound, taste, touch, and smell. In describing a twenty-year relationship with living with schizophrenia, Lee says that although medication is necessary, it does not alleviate all the symptoms of the disorder. Learning to live with the residual effects is a choice, available through psycho-education about the schizophrenia and a doctor who will listen (Lee, 2005). Spirituality is another aspect of the extra-sensory experiences that Lee identifies, describing a condition of having ESP, extra-sensory perception, and an awareness of the omnipresence of God, even sometimes a foretelling of a future event. Lee (2005) says,
“Mysticism is at work as I am spiritually uplifted to God when I ponder at the beauty of creation of life in earth or at the far reaches of the universe” (Lee, 2005, p. 76). Who is to say that the experiences Lee describes are real, or illusionary-caused by his schizophrenia?

Hensley (2006) writes that being viewed as ‘consumer’ initially helped to empower her towards self-determination, but that the term promotes a stigma or burden, on a societal level as well as on a personal level. Consumers use up goods, rather than having a reciprocal relationship with life. The term ‘psychiatric disability’ describes a part of her life that exists alongside her other perceived roles of clinical social worker, daughter, doctoral student. She argues that to have a ‘psychiatric disability’ allies her with others to create political coalitions, and further acknowledges the challenges that are a part of living with a disability (Hensley, 2006).

Social control may limit the ‘right’ of some with a diagnosed mental illness from marrying, retaining custody of their children, or even being considered eligible for transplants in organ databases (Chamberlin, 1998). Social control may also ensure that those whose disabilities makes them unable to work be segregated in housing situations and disadvantaged by poverty- as noted by the World Health Organization’s report (2001). The report stated poverty was not necessarily a causal agent of mental disorders, but that when examining poverty as the lack of resources, as well as lack of money, they pointed out that: “Poverty and associated conditions such as unemployment, low education, deprivation, and homelessness, are not only widespread in poor countries, but also affect a sizeable minority of rich countries” (WHO, 2001). The higher incidence of
mental disorders and substance abuse disorders among lower income populations may be attributable, in part, to the ‘drift’ into poverty that occurs for many who have serious mental disorders and are unable to work. There is some evidence that the path of mental and behavioral disorders is determined by socioeconomic status. There is a large gap between the services available to those who are poor, and those who have resources, in getting treatment for mental disorders (WHO, 2001). Early treatment of mental disorders leads to more positive outcomes (WHO, 2001; Little Hoover Commission, 2000; Surgeon General’s Report, 1999).

The WHO report also commented on the effect that racism has on mental disorders, affecting the health of both the individual who is the target of racism, and the one who practices the behavior. The effects of violence against women is mentioned as another factor affecting their social, psychological and physical health (WHO, 2001).

Sexual abuse in psychiatric survivors is high. In one emergency room study, the number was estimated to be as much as seventy percent of patients seen (Herman, 1992/1997). Dianna Russell interviewed over nine hundred woman in the 1980’s about their experience of domestic violence and sexual assault. The results showed that one in four women had been raped and one in three women reported being sexually abused as a child (Russell, 1990, as cited by Herman, 1992). Traumatic events, especially those that are not dealt with immediately, led to significantly more symptoms of post-traumatic stress syndrome later (Herman, 1997). Re-traumatization occurs when traumatic events are experienced evoking the symptoms, or reactions that were generated by the first traumatic event, even if that original event has been repressed or distorted by protective
memory (Straussner & Phillips, 2004). Even events that happen prenatally change the development of the brain and create vulnerability to a disorder that may not be expressed until adulthood (The Surgeon General’s Report, 1999).

*Defining Wellness and Mental Health*

The World Health Organization, in 1948, defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948, p. 28, as cited in Ryff and Singer, 1998, p.1). More than sixty years have passed and the struggle to reframe physical and mental health in positive language continues. Most of Western medicine looks through a framework defining health as the absence of illness (Fleury, 1998). The word dis-ease is also reflective of this language of deficits; the beginnings of the body mind split comes most likely from the entrance of ‘science’ and the medical model which emphasized the goal of restoring the body to neutral. Even the research focuses on the negative health states, such as anger, anxiety and negative stress factors, rather than on exploring the parameters of positive health (Ryff & Singer, 1998). The Surgeon General’s Report (1999) identifies mental health as inseparable from physical health. The report characterizes mental health as:

the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem (The Surgeon General’s Report, 1999).
Ryff and Singer (1998) address the issue by proposing that positive human health is essentially a philosophical question which they regard as ‘key goods’ - having purpose and connections to others, and having self regard and mastery. Their analysis is similar to what the recovery movement determined is essential to promote a recovery orientation - a sense of hope that recovery is possible. Healing, in that the person reaches the self they want and the control over themselves, empowerment, responsibility and choices, and connection - meaningful roles in the community are other qualities required (Jacobson & Greenley, 2001, Ragins, n.d.). The concept embraces the idea that the recovery is a process, not an end-result. The idea of recovery is one that allows the individual to define those ‘key goods’ that are necessary for a good quality of life. The language of the WHO report is similar to the recovery movement and the Surgeon General’s report: “self-efficacy, autonomy, competence, subjective well-being, self-actualization of one’s intellectual and emotional potential” (WHO, 2001, p 5). In discussing the role of psychological factors that might have a bearing on developing a mental illness, the WHO report speaks about the importance of early attachment experiences for the child; and the influence of the social environment, which can have positive or negative outcomes for a child. Finally, the report says that maladaptive behaviors in adjusting to a stressful situation may predispose someone to a condition such as anxiety or depression. The interrelationship between poverty and mental disorders is multifaceted. Whether the slide into poverty causes mental and behavioral disorders, or whether the disorders result in poverty is not clear, but those living in poverty seem to have a higher incidence of mental and substance abuse disorders (World Health Organization, 2001; Surgeon General’s
Report, 1999). Cultural interpretations of what is mentally healthy may be derived from values that are expressed differently across cultures (The Surgeon General’s Report, 1999).

The Surgeon General’s report (1999) emphasizes that mental disorders are real health conditions, that there are effective treatments available for them, and that those who have more problems and less resources do face more problems accessing and using the ‘fragmented’ health system as it exists in the United States. The report also acknowledges that the treatment people do receive in different practice settings may not always reflect the best practices and that people living in rural areas may have even more difficulty accessing services (The Surgeon General’s Report, 1999).

In early 2001, President Bush announced a new initiative to increase access to people with disabilities, including those with psychiatric disabilities. A little over a year later, the President’s New Freedom Commission was formed to examine the problems in the country’s mental health system, and make concrete suggestions that the government could address at once. The commission reported just over a year later, in July 2003, that the mental health system delivery was rife with problems- unmet needs and many barriers to treatment (Mental Health Commission, 2003; DiNitto, 2005). The goals proposed by the Commission were to adopt a recovery model of treatment. The interim report indicated that the “system is not oriented to the single most important goal of the people it serves—the hope of recovery” (Mental Health Commission, 2003, p. 4).
Catchment Districts and Epidemiology

In a report from the National Institute of Mental Health, Insel and Freeman (2005) cite the Epidemiological Catchment Area Study of the 80’s and the National Comorbidity survey in the 90’s as the first comprehensive attempts to estimate the degree or incidence of diagnosed mental disorders in a national representative sample. The studies established processes of collecting epidemiological information in this country, developing instruments and reliable scales to assess mental disorders in a standardized way (Insel & Fenton, 2005). Through the Epidemiological Catchment Area (ECA) study, it was discovered that mental disorders were very widespread in the population. This study estimated that over thirty percent of individuals in any given year have a mental disorder, and that most mental disorders began much earlier than previously thought. What was not projected was the impact of these disabilities in terms of lost productivity, life satisfaction, or functioning (Insel & Fenton, 2005).

There are almost 4.8 million adults each year affected by mental disorders (Kessler et al., 1996). Nearly one in five people in the United States has a mental disorder, with about fifteen percent also having a co-occurring substance disorder, according to the Surgeon General’s Report (1999), often these individuals meet the criteria for another disorder, as well. Severity of the disorder was ‘strongly related’ to having more than one disorder (Insel & Fenton, 2005). It was determined that of those with a serious disorder, nearly six percent reported that they could not perform their usual daily activities because of their mental disorder or a substance abuse problem (Kessler et al., 1994, as cited in Insel & Fenton, 2005)
In discussing mental disorders, it is necessary to refer to the diagnostic criteria of the Diagnostic and Statistical Manual for Mental Disorders (2000), the manual from the American Psychiatric Association, used for diagnosing mental illness (Insel & Fenton, 2005). The DSM-IV-TR (2000) text revision is divided into categories that explain the symptoms of each mental disorder and list the criteria for selecting the diagnosis. The disorders are grouped into sixteen categories, starting with the disorders first seen in childhood, although many in this classification may not present until adulthood. This is true of some of the disorders located in categories normally occurring in adulthood and sometimes diagnosed in children. The organization of many of the categories has to due with clusters of symptoms, such as mood disorders, schizophrenia, bipolar disorders, and substance abuse disorders (DSM-IV-TR, 2000) The criteria for making the diagnosis are listed for each disorder and information about etiology, familial patterns, and differential diagnoses are given for each disorder, as well (DSM-IV-TR, 2000).

The definition of mental disorder that the Surgeon General’s report (1999) settled on was that the disorders were conditions that produced alterations in thinking, mood, or behavior, along with some distress and/or an impairment in function. Both the Surgeon General’s report (1999) and the President’s New Freedom Commission on Mental Health (2003) described the mental health system as ‘ailing’. Over a twelve-month period, almost sixty percent of those defined with a ‘serious’ mental disorder failed to receive mental health services. Of those with impulse control or substance abuse disorders, almost half ever received any services. Of the number of those who did receive services,
almost forty percent reported that the services were only ‘minimally adequate’ (Insel & Fenton, 2005).

**Deinstitutionalization and Community Mental Health**

Beginning in the 1960’s and continuing throughout the next decade, legislation began to address the issues surrounding mental disorders and the responsibilities of the states and federal government to provide better outcomes (Sharfstein, 2000). The number of individuals in mental health institutions in 1960 was over 535,400. (314 beds per 100,000 residents). In the next thirty years, the numbers had dropped to 98,000 (40 beds per 100,000 residents), according to the National Institute of Mental Health (NIMH, as cited in Markowitz, 2006). The Treatment Advocacy Center, founded by E. Fuller Torrey, reported the number of beds available in psychiatric hospitals in 2005 had further declined to 17 beds per 100,000 residents (“Severe shortage of psychiatric beds”, n.d.).

The ‘Mental Retardation Facilities and Community Mental Health Centers Construction Act’ was passed in 1963 (Sharfstein, 2000). It was expected that the community centers would provide support to enable the discharge of patients from institutionalized settings to live in the community. President Kennedy signed the bill shortly before his assassination and President Johnson came through with amendments, which provided staffing grants (Sharfstein, 2000). In 1965, the Medicaid/Medical program was established to provide some services for those with low incomes. Initially designed to cover only limited services from nursing homes and psychiatrists, it was expanded in 1971 to cover out-patient treatment, day care settings, and more (Little Hoover Commission, 2000).
The Community Mental Health Centers (CMHC) programs were designed to be supplemented after several years by third party payers, which did not occur (Sharfstein, 2000). Communities were helped to start the centers and other financing was expected to fill in. Catchment areas were drawn up to serve between seventy-five and two hundred thousand people (Sharfstein, 2000). There were 3,000 catchment areas to begin, and the expectation was that they would extend throughout the country by the 1970’s (Sharfstein, 2000). They were expected to offer “inpatient and outpatient services, day treatment, emergency services, and consultation and education services” (Sharfstein, 2000, p. 4; DiNitto, 2005). These centers were to provide essential services. This was expanded in 1975 to include special programs for children and seniors, provide housing for patients who were released from mental hospitals, and pay for screening services for courts and other agencies to help target those who needed it (DiNitto, 2005). In fact, the funding was never enough to take care of the issues they identified. President Nixon tried to discard the program, but was stymied by Congress, which passed more conditions for the centers, but not the necessary funding to pay for the new services (Sharfstein, 2000). President Carter’s Commission on Mental Health, which was chaired by his wife, Rosalyn Carter, re-evaluated the CMHC program, and additional money was used to revitalize the program to address the needs of the thousands who had been released from institutional settings (Sharfstein, 2000).

Deinstitutionalization came at a time when advocates were trying to ensure those in institutions had a basic, decent level of care (DiNitto, 2005; Markowitz, 2006). The average stay in the state mental hospitals at this time was measured in years; for some
people it was a lifetime (Sharfstein, 2000). At the same time that the philosophy was developing that people should not be ‘warehoused’ in these settings; pharmaceutical companies began developing drugs that did allow individuals some symptom relief from their mental disorders (Sharfstein, 2000). The intent was to provide treatment in community settings (Markowitz, 2006). The objectives of the Centers remained the same, but the funding was impacted by the expense in the sixties and seventies of the Vietnam War; even later funding did not keep up with inflation (Sharfstein, 2000). Services are often rationed to those who have a ‘serious’ mental disorder, turning away others who may have benefited from earlier treatment when the disorder was less pronounced (Little Hoover Commission, 2000).

**Mental Health Delivery System Today**

In 1980, the Mental Health Services Act was signed-and rescinded the next year, when President Ronald Reagan was elected and assumed office (DiNitio, 2005). With the trends marked by Reagan’s election, the emphasis on the role of the federal government shifted to the states (Sharfstein, 2000). The funds for the CMHC’s were funneled through block grants to the states, which were not required to provide essential services. The states designed a blueprint which covers three years of services targeting individuals with serious mental disorders, the homeless with mental health problems, and children with serious mental health disorders (DiNitio, 2005).

Today, the public mental health system is composed of private providers, who accept payment from the government, CMHCs, Veterans Hospitals, and state psychiatric hospitals (DiNitio, 2005). The health care system often provides mental health treatment
from primary care doctors, and pharmaceutical companies have been able to market directly to consumers (Surgeon General’s Report, 1999). The advances in understanding mental health, the role of the brain, and the stressors, which may contribute to a mental disorder, are unfolding every day (Surgeon General’s Report, 1999). The disorders which change thinking, function and mood are better addressed with current medicines, yet, the cause of many disorders is still not exactly known. Or, as the Surgeon General’s Report says, “The precise causes (etiology) of most mental diseases are not known” (Surgeon General’s Report, 1999, p. 49). There is widespread agreement that the factors influencing mental disorders are biological, psychological, and social, as is true for most health and sickness (Surgeon General’s Report, 1999). The biopsychosocial approach to examining mental disorders allows for an understanding of the multifaceted dimensions of comprehension needed for diagnosis and treatment.

In today’s marketplace, the tensions between the federal and state levels of care are still polarizing mental health service delivery. Communities need to have active interaction and housing for those discharged from hospital settings, availability of good psychiatric medications, acute inpatient beds, educated family practice doctors, and more educated mental health professionals in communities (Sharfstein, 2000). In the current climate of decreased spending for mental health services, innovative approaches are considered. In California, this led to a ballot initiative to tax one percent of every million dollars of income, to be used for new mental health services.
Creation and Implementation of California’s Prop. 63

Before the creation of California’s Proposition 63, also known as the Mental Health Services Act, the California legislature passed two bills that would portend a new way of addressing the subject of mental health. AB34 and AB2034 were recognized as model Assembly bills by the President’s Commission on Mental Health in 2003 (Mental Health Services Act, 2004). The implementation of these bills indicated an awareness that mental health, substance abuse and homelessness are intertwined in their cause/effect relationship. The success of this approach led to a collaboration of activists, mental health directors, and disparate others to bring about the passage of a proposition that would tax one percent of the earnings of those who make more than one million dollars to respond differently with serious mental health issues. The bill did not just tax to raise money; it required creative thinking to address problems long underfunded in the California counties, and creative thinking to be accountable in program evaluation (Mental Health Services Act, 2004). It also was a bill passed by popular vote in California; indicating that the people of California did understand that mental illness crosses all the lines, all boundaries—and affects more than two million adults and children. This proposition was to fulfill a promise made to take care of people in our communities thirty years ago when deinstitutionalization took place.

Echoing phrases from the Surgeon General’s Report (1999) and California’s Little Hoover Commission (2000), the Mental Health Services Act states that recovery from a mental disorder is possible for most people, especially when there is early, effective, and integrated levels of intervention (Mental Health Services Act, 2004). The funding was to
begin almost immediately, for new infrastructure, for focus groups and for programs that also included the participation and involvement of “consumers”, who began the movement with their upraised voices in the eighties (The Surgeon General’s Report, 1999, Mental Health Services Act, 2004).

Evolution of the Recovery Model

The concept of recovery has evolved through years since the first of the psychiatric survivors began writing and speaking of their experiences. It is a process, not a destination (Deegan, 1997). Recovery is an approach that allows for hope, believes that hope is not an unrealistic dream, but a way of life shaping the journey to be self-determining and live with understanding of and compassion for oneself (The Surgeon General’s Report, 1999). Recovery is living with a meaningful role in the community and working with people in agencies who support the process of living well (The Surgeon General’s Report, 2000; Ragins, n.d.; Deegan, 1997). Recovery may still mean having symptoms, for some it may mean having hospitalizations periodically, but it also means reducing the stigma that exists about having a mental disorder, and having the power to define your experience in your own terms (Deegan, 1997). Patricia Deegan (1997) speaks of her experience of having schizophrenia, in a very moving way, as a process of healing. Deegan understands relapse, not as a failure on her part to control her disorder, but as ‘breaking out’ of fears to a new level of ‘breaking through’ to new abilities to trust and love (Deegan, 1997)

There are many people now writing about this concept of recovery, and how to apply it in our programs; how to transition from the medical model that traditionally has
said that serious mental disorders are lifelong and require the expertise of professionals (Deegan, 1997; Anthony, 1993). Among those who have embraced the concept of recovery and have studied how it might be implemented in a systems model, is William Anthony (1993). Anthony writes of the necessity of having certain elements of recovery philosophy in place to reflect services that fully embrace recovery in all its dimensions (Anthony, 1993). He mentions that the current recovery vision is built on the work arising from the National Institute of Mental Health in creating community support systems. They identified and provided needed services to people who had previously been hospitalized in state institutions for long periods, and supported those now living in the community (Anthony, 1993). People with serious mental disorders needed supportive services beyond just medication, or addressing symptom relief. Essential to the success of those living in the community were crisis intervention, case management, rehabilitation services, advocacy, fulfilling activities and roles in the community, protection of client rights, and basic support (Anthony, 1993). Anthony (1993) points out that these important services were building on the World Health Organization’s rehabilitation model from the eighties. Essential to understanding the recovery concept as it is used today, is knowing that it does not mean that the person will be retuned to their former level of functioning. It refers instead to an attitude about regaining personal choices and self-determination (Anthony, 1993; Deegan, 1997; Ragins, n.d.)

None of the concepts are so startling. They require mental health professionals, families and those who are touched by mental disorders in some way to understand that people are not their illnesses, but rather have an illness that leads them to explore just
what ‘recovering’ and ‘being well’ means to them (Deegan, 1997). It requires using a wider lens of perspective, rather than the tunnel vision of the disease, or medical model. It requires a shift to a holistic vision that sees each person as a sum of their parts, rather than parts to be fixed. One of the more difficult tasks of recovery is to find acceptance. It is seeing all the parts of the self, without making a negative judgment (Spaniol, Koehler & Hutchinson, 1995 as cited in Spaniol and Gagne, 1997). Finding a way to accept ‘what is’ is crucial to acceptance, and no easy assignment.

**Recovery Model and the Medical Establishment**

Psychiatrists and doctors in medical school must learn the recovery concept and learn how to incorporate the principles into long-term perspectives of healing and psychosocial rehabilitation. They are called on to enter into partnerships with patients in this process (McQuistion, Goisman, and Tennison, 2000). State hospitals are being invited to provide an environment and interventions that “promote wellness and recovery in addition to crisis stabilization” (Swarbrick, 2009, p. 343). Calling recovery and wellness a ‘paradigm shift’ in state psychiatric hospitals, influenced by research and the first person accounts of those who have lived the process of recovery, Swarbrick (2009) sees that the role of state hospitals is to promote belief in recovery and wellness as a part of their mission with patients. The skills for supported living can be taught, and she says that wellness creates both internal motivation and active participation to become skilled at managing problems and crises.

In a study conducted at a psychiatric hospital, based on concepts of empowerment developed by Joel Handler, Linhorst and Eckert (2003) examined whether increased
decision making by psychiatric patients resulted in a broader sense of empowerment. They studied three hundred and fifty patients, about eighty percent of whom were diagnosed with schizophrenia (Linhorst & Eckert, 2003). Many were also there as forensic patients. Using documents and focus groups, they determined that patients were capable of increasing their sense of empowerment in decision making, although they pointed out that skill training is sometimes required in people who have not have much previous experience of decision making. One of the areas that they examined was treatment planning, in the residential units and in mental health policy (Linhorst and Eckert, 2003). One of the barriers identified to actually having clients participate in treatment planning was the lack of training and support given the staff. Many patients, as well as staff, did not see the value of increasing their participation in treatment planning. The atmosphere did change, though, over time. Because of the nature of the facility, choices in where clients could live were limited, but they found that clients did have say in the organizational planning, which generally was focused on decisions that affected their daily lives, rather than major policy changes. In the area of mental health policy making, there were no decision-making opportunities for clients. The conclusion of the study was that it is possible to empower people with serious mental disorders in psychiatric settings and they believe this study may help guide the way to increasing the levels of decision making in ‘powerless’ populations (Lindhorst and Eckert, 2003).

Chovil (2005) warns of the learned helplessness that many clients acquired as a result of long hospitalizations. He points out that people with schizophrenia were likely experiencing learned helplessness because of longstanding psychosis and that the
hospitals may have been responding to and reinforcing the learned dependence. He believes ‘unlearning’ the learned helplessness is critical for recovery and argues that medication is necessary, but only as a part of the solution (Chovil, 2005).

As the transition towards community based care continued, it became apparent that those with serious mental health issues were being arrested and incarcerated in jails and prisons in repeating cycles, often for low-level crimes (“New Study Documents High Prevalence”, n.d.). Many of those working in the Criminal Justice system saw that the caseloads increasingly revealed the solutions for dealing with them to be inappropriate. They began to explore different avenues (Bernstein & Seltzer, 2003).

*The Development of the Mental Health Courts*

In 1999, the collaboration of the Council of State Governments (CSG) and mental health professionals across the county gave birth to the Consensus Project (Bernstein & Seltzer, 2003). The Project was a combined two-year effort with those they refer to as ‘agents of change’- legislators, sheriffs, county mental health directors, prosecutors, advocates, crime victims, and judges. They examined how existing systems needed change, and how programs could be modified to meet the needs of the community and those who have a severe mental illness (Thompson, Reuland, & Souweine, 2003; Bernstein and Seltzer, 2003; Lamb, Weinburger, & Gross, 1999).

The concerns stemmed from the increase in those who have severe mental disorders in jails and prisons. It is estimated that approximately 250,000 people with mental disorders are incarcerated (with perhaps another half a million on probation), and that as many as half of them are for non-violent offenses-such as disorderly conduct or
trespassing. Their report says that sixteen percent of those who are in state or local facilities have a mental disorder and do not receive any treatment beyond medication (Bernstein & Seltzer, 2003). Many say it is difficult to estimate accurately the number of those in the criminal system who have a mental disorder, but point to the disintegration of community services that have not served those who needed resources of stable, affordable housing, medication and case management to successfully live in community settings (Thompson, Reuland, & Souweine, 2003).

Under the Americans with Disabilities Act, the states must not discriminate against people with disabilities, including those who have a psychiatric disability, and must provide reasonable accommodations (Bernstein & Seltzer, 2003). Mental health courts are conceptualized as one accommodation. There is no one model for mental health courts; each jurisdiction is free to create their own version. Some mental health courts exclude those with violent offenses; some courts limit accessibility to those who have only misdemeanors (Bernstein & Seltzer, 2003). There is some evidence that police arrest those who have a mental illness far more often for offenses that those without a mental illness would be arrested (Bernstein & Seltzer, 2003). During the two-year study by the Council of State and Local Governments (CSG), they found that those with a mental illness are often treated more harshly in court for the same offenses, perhaps due to a misunderstanding of the nature of the illness, or because of fear. In the process of the CSG investigation, they found that people with a mental illness were also more likely to receive a longer sentence, or be refused bail (Bernstein & Seltzer, 2003)
Mental Health courts are largely patterned after the drug courts (Bernstein & Seltzer, 2003: Moore & Hiday, 2006). The general idea is the court will order treatment for the offender and the offender agrees to conditions, similar to parole. Sometimes probation is involved and is part of the oversight process (Lamb, Weinberger, & Gross, 1999). Many of the courts require the client to enter a plea of guilty so that if they are noncompliant to the terms and conditions of the court, they may be remanded to custody (Bernstein & Seltzer, 2003). There is also the charge leveled at the court that it is coercive in requiring the client to follow the treatment plan of the doctor, which normally means staying on the prescribed psychotropic medication (Bernstein & Seltzer, 2003).

There are about one hundred mental health courts operating in the United States since the movement began (Moore and Hiday, 2006). They were created in response to a criminal justice system overwhelmed with the numbers entering the system, to prevent recidivism, and to reduce the burden on courts and jails, while addressing public safety (Moore & Hiday, 2006). They usually have seven facets: a separate docket from traditional courts, a judge who presides over the proceedings, a dedicated prosecution and defense team, a collaborative team which has joint-decision making responsibilities between the criminal justice and mental health professionals, participation by individuals who agree to follow the treatment prescribed, monitoring by the court (which includes sharing of information by the team), and the promise of dismissed charges at the completion of the time period, or an avoidance of incarceration (Moore & Hiday, 2006).
Studies of Mental Health Court Outcomes

There is little research available on the effectiveness of the mental health court systems. Since there is not a set structure for the court, it is difficult to measure empirically the results of the diversion (Moore & Hiday, 2006).

Moore and Hiday (2006) analyzed the re-arrest rates and the severity of the offenses compared to those who committed similar offenses and were seen in a traditional court. They reported that there have been several descriptive articles, but only three published studies since the advent of mental health courts in the 1990’s (Moore & Hiday, 2006). The first, Trupin and Richards (2003), compared those who chose to be a part of mental health court with a group who did not. Although it is recommended that clients have the option to “opt out” and return to regular court at any time, not all mental health courts allow this (Bernstein & Seltzer, 2003). This study concluded that those who were in mental health court had significantly fewer arrests in the nine months studied than the group used for comparison (Trupin & Richards, 2003).

The Broward County Mental Health court in Florida was one of the first to form in the 1990’s (Boothroyd, Poythress, McGaha, & Petrila, 2003). The court tries to maintain a ‘non-coercive’ stance with clients. It rarely uses incarceration as a sanction, and clients are able to refuse Mental Health court placement or return to traditional court at any time. Outcomes analyzed from the Broward study also found that Mental Health Court participants received more services than the control group (Boothroyd, Poythress, McGaha & Petrila, 2003). These tended to be hospitalizations or more intensive housing services. They concluded that the process was equitable in comparing the outcomes of
African Americans and Caucasians (these were the two groups with enough representation to study). Mental Health court also provided the pathway to treatment for many of the clients. Although their study is still ongoing, they did conclude that the service tended to reflect the effectiveness of this non-coercive Florida court (Boothroyd, Poythress, McGaha, & Petrila, 2003).

The last study, by Cosden, Ellens, Schnell, and Yamin-Diouf (2005), in Santa Barbara, California, was the longest of the three studies at eighteen months. The study assessed clients with serious mental disorders by random assignment. One group had assertive community treatment and the other had more traditional, less intensive services. The group of individuals with mental health court participation had fewer convictions for new crimes after a year than the other group. The charges were often violations of probation, but the control group tended to have new offenses.

Criticisms of Mental Health Courts

There are complaints that those in mental health court tend to serve more time for their offenses than if treated in traditional court (Bernstein & Seltzer, 2003). The Bazelon Center for Mental Health Law, in a study of twenty mental health courts, concluded that three things were essential for the fair and effective functioning of a mental health court (Bernstein & Seltzer, 2003). First, the court must have resources available in the community to which the clients will be referred. Second, there must be alternatives available to arrest and diversion to prevent the jails and court from being overwhelmed with minor infractions and to prevent the system from becoming the entry to mental health services that the community is failing to provide. Finally, the courts must be
cautious, lest they become the coercive agent that gives out harsher consequences than traditional courts, or becomes more harmful to the client to get housing, jobs and healthcare by establishing a criminal history (Bernstein & Seltzer, 2003).

Thompson, Reuland, and Souweine (2003) state that community integration has been possible for many who have a serious mental illness. The difficulty is that the mental health system has failed to provide access to clients for needed services. The need for related resources such as affordable housing must be part of the solution. It is estimated that twenty to twenty-five percent of the homeless population has a serious mental illness (Bernstein & Seltzer, 2003).

Involvement with social workers who understand the dynamics of self-determination and support the stabilization and recovery of people who have been ‘falling through the cracks’ in the systems of care is crucial (Thompson, Reuland & Souweine, 2003). Bernstein and Seltzer (2003) observe that the drift of those with serious mental disorders into the criminal justice system has served to benefit the public mental health agencies by moving the burden of this “hard to serve” population to state corrections. The taxpayers are paying for more expensive incarceration, instead of utilizing the money on services in the community (Bernstein & Seltzer, 2003).

Social Workers and Criminal Justice Personnel

The Recovery philosophy is grounded in four simple concepts: hope for recovery, choices, responsibility, and meaningful roles in the community. Most clients who have a serious and persistent mental disorder are stabilized on psychotropic medications, but psychiatric rehabilitation and support are necessary, as well, for success in maintaining
recovery in the community (Bernstein & Seltzer, 2003; Lamb, Weinberger, & Gross, 1999). Many of those with a serious mental disorder have a history of being resistant to psychiatric treatment before their entrance into the court system. For some people, the nature of their disease involves a component of denial that leads them to stop taking medication after they have stabilized (Lamb, Weinberger, & Gross, 1999). There are studies which have verified that about seventy percent of those who have a severe mental illness also have a co-occurring disorder, usually substance abuse (Thompson, Reuland, & Souweine, 2003; Bernstein & Seltzer, 2003).

Lamberti (2007) points out that one study which evaluated the recidivism rate of offenders indicated that there were three key elements to prevent re-offense: “competent mental health care, access to mental health and other social services, and legal leverage” (Lamberti, 2007, as cited in Sims, 2009, p.1069). Some argue that requiring a defendant to be in mental health court without the option to return to regular court is discriminatory, based on their (perceived) mental illness (Bernstein & Seltzer, 2003).

Forensic social work or case management with this population is challenging. There may be resistance on the part of the client to treatment, or fear on the part of the social worker, who is working with someone who may have violent behavior. If the caseload is reasonable, the social worker can more closely monitor the compliance of the client to the treatment plan and intervene if there are signs of decompensation (Lamb, Weinberger, & Gross, 1999).
Social workers are taught to assess clients from an ecological perspective, acknowledging their behavior is shaped by the environment surrounding them (Hutchinson, 2003).

Those who are in the criminal justice field encounter clients in different settings, usually after their behavior has led to contact with the police. Police officers are the first to be called for help in the community. They are available around the clock; when other professionals are not. Rather than taking the offender to the hospital for a psychiatric evaluation when there is disturbing behavior, the offender is often taken to jail (Lamb, Weinberger, & Gross, 1999). Often the community resources are non-existent, or are stretched so thin that the cycle of offense, sentence and release are repeated regularly. Criminal Justice personnel are limited by lack of training to respond effectively to the individual with mental health disorders, whose behaviors may be threatening, or frightening to the responding officers (Lamb, Weinberger, & Gross, 1999; Thompson, Reuland, Souweine, 2003).

More training is needed for the first responders and more effective interventions at the scene with trained crisis workers accompanying police would be beneficial. The Consensus Project developed guidelines for jurisdictions to better prepare for identifying and treating people who have committed crimes as a result of a mental disorder (Bernstein & Seltzer, 2003). The guidelines suggest that courts divert individuals from jails and prisons whenever feasible, and that the mental health courts be staffed with those who have an understanding of serious and persistent mental health issues. Information must be shared between professionals who understand the commitment to
confidentiality and the civil rights of the defendant. The forensic mental health treatment team must have resources to provide to the individual, including access to appropriate housing (Thompson, Reuland, & Souweine, 2003).

*Gaps in the Literature*

One of the gaps noted in the literature is the failure to consider the special needs of women as offenders. The combination of a criminal offense, mental disorders and support for raising children is not addressed, although it is acknowledged by the WHO (2001) that women are perhaps more vulnerable to developing mental and behavioral disorders due to the additional stressors of their multiple roles.

One of the most important resources for stabilization for people with mental disorders is safe, affordable housing and community resources (Markowitz, 2006; Lamb, Weinberger & Gross, 1999; Thompson, Reuland, and Souweine, 2003)). Providing extra support for the person with mental disorder who is released from prison and reintegrated into the community has not been dealt with in the literature as well.

Also missing is the plight of rural communities and the overall lack of resources there. Many jurisdictions are too small to have access to community mental health professionals to collaborate in the process supporting those with mental disorders in the court system.

There is agreement that additional services are needed to support people with mental disorders stabilize, integrate and return to meaningful roles in their community (Anthony, 1999; Little Hoover Commission, 2000, Lamb, Weinberger& Gross, 1999),
but how this can be provided in an economy which is reducing even the most basic mental health services is not covered in the literature.
Chapter 3

METHODS

Introduction

This chapter will describe the methodology used for this study, including the population being examined. This researcher has come to believe that those who work in the criminal justice system hold very different perspectives concerning people with serious mental disorders who have involvement in the system as compared to those who are working in community mental health agencies. In many counties in California, community mental health agencies are implementing a Recovery and Wellness approach to people with mental disorders. This is in line with the President’s New Freedom Commission (2001), California’s Little Hoover Commission (2000) and many consumers of mental health services, whose voices have been raised since the era of deinstitutionalization.

Those who will be interviewed work in two rural counties in the foothills of Northern California where the researcher has interned the past two years. Some of those interviewed are social workers who are working in either non-profit agencies, or a county adult care mental health setting. Others who have consented to be interviewed are working in criminal justice, working in a mental health court setting, as judge, prosecutor, bailiff, or as a public defender. The researcher believes there is a wide gulf in understanding about mental disorders that exists between the two types of professionals, perhaps from differences in education, training or work experience. Since the Consensus Report (Bernstein & Seltzer, 2003) has discovered the need for collaboration between all
the members of the mental health court teams, it seems logical to question those who work with mental disorders in these settings to see if the gap in understanding could be diminished. The explorations of these areas are the focus of this study. This chapter will discuss the design, the focus, and data collection methods, the data analysis plan, the assumptions and delimitations, and the population sample as elements of the study. The chapter ends with a discussion of human subject protections, and concludes with a chapter summary.

Research Design

The design method chosen for this research is an exploratory qualitative study, conducted through purposeful snowball sampling, drawing from the contacts made through social work internships in two neighboring counties in the foothills of Northern California.

The exploratory design is utilized because it addresses a concern that is not addressed in the literature. The value of the study is that it may point to an area that needs to be addressed in literature, and in the education and training of those who work with mental disorders and those who are involved in the criminal justice system. The information explored may help generate new perceptions and interventions for forensic social workers and criminal justice personnel. A limitation of exploratory research is that it does not produce new outcomes.

The purpose of using the exploratory research design is that there may be widely different perspectives between those who work in community mental health agencies and those who work with the same, if not similar clients in the criminal justice system. Just as
the Council of State and Local Governments (CSG) formed the Consensus Project to create proposals for diverting people with mental disorders from incarceration when appropriate, social workers and criminal justice personnel can begin to talk about what works in their dealings with this group, but what is a barrier, or deterrent to their success. Studies seem to point to the necessity of services being available for success (Little Hoover Commission, 2000; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005, Boothroyd, Poythress, McGaha, & Petrila, 2003) but in these times of drastic budget cuts, especially to social services, combining creative minds might produce more solutions.

**Study Focus**

The focus of this research project is to ask questions of both groups of professionals to determine if further education or training may be indicated to inform those in Criminal Justice work about what mental disorders are and how to best work effectively in partnership with community mental health agencies, especially in the mental health populations involved with the Criminal Justice system.

**Assumptions**

The main assumptions of this study are that social workers and criminal justice personnel understand that diversion from prison or jail is appropriate for those who have serious mental disorders and have legal challenges, and that this approach also reduces recidivism. The other assumption is that people with serious mental disorders can get supportive services that will allow them to stabilize and live in the community.
Sample Population

The study populations are two groups of professionals working in two communities in Northern California. The first group is mental health professionals with a recovery model perspective working with those who have a mental disorder. The second group of professionals is working with the same individuals in the criminal justice system. Those interviewed are assured that participation is entirely voluntary and that the interview may be terminated at any time without any adverse consequences. The participants signed and received a copy of the consent form. There will be a total of five people interviewed from each professional group.

Instrumentation

Interviews will be held with each individual who signs an informed consent and agrees to participate. A standardized schedule of thirty-seven questions will be used. The questions asked are about general demographics, training, career focus, and education, attitudes about mental disorders, reducing stigma and changing attitudes. The questions are a mixture of short answer and open-ended questions. The general demographic questions were 13% of the total 37 questions. The questions about education and careers were similar in number, about 16% of the total. Questions about attitudes towards mental disorders comprised the biggest percentage of the total, 43%. The remaining questions were about shifting attitudes and reducing stigma. They were 32% of the total.

Data Collection Procedures

The researcher will be interviewing participants in a standardized open-ended interview based on the interview schedule of questions attached to this document in
Appendix A. The information will be noted on sheets, which will be open coded for concepts and themes that emerge. The concepts and themes will be analyzed from the patterns that surfaced in the interviews.

Data Analysis Plan

Drawing on the grounded theory method (Glaser and Strauss, 1967, as cited in Rubin & Babbie, 2008), the founders recommend using the constant comparative method to organize the data. The first phase of the method is comparing concepts arising from categories. The second section of the method is integrating the concepts and themes. The third phase is referred to as ‘delimiting’ the theory. This entails discarding concepts initially thought to be of use, which seem unimportant after patterns in the data appear. The final phase is putting it together. This is considered the most important part of the method, as the information clarifies understanding and adds to the concepts initially developed.

Protection of Human Subjects

Prior to beginning the collection of data, the Protection of Human Subjects application was submitted to the California State University, Sacramento, Division of Social Work Committee for the Protection of Human Subjects for review. This study was approved as a minimal risk study. The risks of harm anticipated by the questions were minimal to the participants. The researcher submitted it as low risk simply because it was an exploration of attitudes and beliefs held on the part of those interviewed. Those who are interviewed are all professionals in the fields of mental health and criminal justice. A
reference list where low cost help is available was attached to the copy of the signed consent form.
Chapter 4

FINDINGS

Introduction

This chapter presents the findings of the study under the nine themes emerging from the focus of the research topic. The goal of the project was to examine the differences in perceptions about mental disorders between those who work with the recovery model in community mental health agencies and those who work in criminal justice. The themes are organized around demographic characteristics; background education and training; attitudes about mental disorders, medication and the law; being around people with mental disorders; responses to critical incidences; stigma, accountability, recovery and how perceptions change; reducing stigma and shifting attitudes; and final thoughts about recovery. The researcher chose five social workers who worked in community mental health agencies and five people who worked in the criminal justice system, as judges, prosecutors and public defenders. This researcher is aware that this represents a very small sample, even for a qualitative project.

Demographic Characteristics

Sex and Age. There were ten participants interviewed in this study. Of those working in community mental health settings, all five were females and the mean age was 59.8. Of the respondents in the criminal justice system, two were male and three were female. Their mean age was 41. All ten of the respondents identify as Caucasian. The responses about socioeconomic background were mixed in both groups. The answers from the social workers in the community mental health agencies were working class (1),
middle class (1), middle-middle class (1), and upper-middle class (1). The criminal justice group identifies as middle class (2) and upper-middle class (3).

**Working and Living in the Community.** The social worker group tended to not live in the same community in which they worked (Sixty percent did not live in the same community, while 40 percent did), while the criminal justice group tended to work in the same community in which they worked (sixty percent did live in the same community, while forty percent did not). Most of the respondents did not appear to attach much importance to whether they lived in the same community as they worked. Both of these counties are rural and have many other living choices within commuting distance. One of the respondents did remark that after living in the same community for ten years, she felt that her sense of privacy, or anonymity when she was out in the community was affected.

**Background of Education and Training**

**Career Field and Education.** When the social work respondents were asked what their career field was, they answered social work, or mental health. Among the five social workers, eighty percent had Masters of Social Work degrees. One person had been certified as a psychiatric technician and had worked in the field for twenty-two years. She essentially performs the same duties as a case manager. All of the social workers held positions in community mental health. The range of degrees held by this group was wide. Four of the five social workers had four-year degrees, one was in psychology and the other three were in social work. Two of the social work respondents were licensed clinical social workers, and one of the group also had received a law degree. The mean number of years spent in this career was 14.8.
Among the criminal justice group, all five had completed a four-year degree. Three of the four-year degrees of this group were in political science. One respondent held a degree in business administration. The fifth respondent held a degree in sociology and liberal arts. All five respondents had received J.D.’s. The current positions they held in criminal justice ranged from judge, to deputy district attorney, and public defender. The responses to the question about their career was answered by indicating the law, legal/prosecution, attorney, and public defender. The length of time in the career field varied from three years to thirty-nine. The mean length of time was 14.4 years.

**Education in Diversity or Community Relations** When questioned whether any of the education they received focused on diversity or community relations, four of the social workers were able to describe classes in their graduate and undergraduate days that focused on some aspects of diversity. One of the social workers remembered a class on domestic violence that focused on a variety topics including gay and lesbian issues, and child sexual abuse. Another respondent discussed her anthropology and women’s studies classes, which she said were significant in having her look at individuals and race in our culture. She said how struck she was, in learning in anthropology about the physiological differences between people, and how the more physiological differences there were, the more discrimination increased.

The respondents in criminal justice positions answered these questions in various ways. One said that there had been no diversity or community relations education through law school, except to focus on due process as it related to bias, or prejudice. Another respondent answered that she had had diversity training in law school. Another explained
that he had not had any formal education, but that it was a topic covered in Minimum
Continuing Legal Education (MCLE). One of the attorneys replied that she had taken
several diversity classes during her time as an undergraduate. Another attorney said that
her degree program had combined a law degree with a social justice curriculum, and that
she had had a great deal of exposure to both.

*On the Job Training about Mental Disorders.* On the job training for social
workers regarding ways to work with people who have mental disorders was usually
provided. One respondent replied that she had many in-service trainings, and that “her
hands on experience has taught me a lot.” Another respondent said that her on the job
training began when she started her social work internship. One of the respondents stated
that her job was an on the job training. Another respondent explained that she
remembered beginning with “empathy” trainings many years ago. She described one
sensitivity exercise that required her to wear headphones with multiple tracks of voices,
and then being directed to continue with her normal activities. This was a simulation of
how a person with schizophrenia might experience hearing voices and be required to
perform a number of tasks. Another respondent answered that she had had a lot of on the
job training, beginning with her first internship. She described this as her first experience
working with identifiable mentally ill people, in a forensic setting. She said that at that
time, she would go to the county jail to evaluate an inmate and they would lock her in a
room with no communication with the central jail. The respondent said that she quickly
learned on the job to deescalate, to create safety, and to “join” with the inmate. “Above
all” she said, “was use of self. Use of self was everything in relationship.” Among the in-
services she remembered was one on risk management. This respondent also commented that conditions such as she described—of being locked in a room with no communication—changed as insurance companies and counties became more knowledgeable about issues such as risk management.

Two of the respondents from the criminal justice system replied that there was not anything offered formally from their employers about how to work with people who have mental disorders; one of these two respondents commented that she mostly learned from observing others and her own experiences. Two of the respondents answered that although nothing was offered at their employment officially, they took advantage of sections at conferences they attended and occasionally continuing education was offered. One of the respondents replied that related topics were covered in the MCLE (Minimum Continuing Legal Education) training seminars for prosecution of crimes against elder/dependent adults which included information on interviewing techniques used with disabled people, and information on the rates of victimization for people with mental disabilities.

**Attitudes about Mental Disorders**

*Stabilizing, integrating, and having meaningful roles.* To explore attitudes about mental disorders, the respondents were asked a series of questions about whether people with mental disorders should have additional assistance. Most respondents answered with a short “yes” or “absolutely” when asked if people with mental disorders should have extra help stabilizing in the community, integrating in the community and whether they believed that people with mental disorders can have meaningful roles in the community.
One social worker commented that “integrating into the community at their level of ability to do so...within the parameters of safety for the mentally ill person to do so, and with lots of support for them in place.” Another respondent stated that those who have a mental disorder should be funded to have extra support to stabilize their lives “both practically, and ethically we should provide the level of support needed.” The same respondent answered that people with mental disorders should have extra support to integrate into the community, but “with limitations. For some people living with a serious and persistent mental disorder, the realistic need for support is great.”

The respondents from the criminal justice sector also answered most of the questions in this area with “yes” or “absolutely.” One of the respondents stated that he believed people should have extra help to integrate into the community, but “what help depends on resources and the nature of the disability.” Another respondent said that she believed that extra resources should be available, and that she thought that people can have any type of role in the community.

Medication and the Law. There were three question that explored attitudes about people with serious mental disorders being required to take medications, and whether they should be given different treatment by the court when having legal difficulties. Social work respondents gave mixed responses. Two of the social workers answered that they did not believe that people with severe mental disorders should be required to take medication. One of these respondents said that she “won’t take away that right of choice…unless they are conserved under the Public Guardian’s care because of grave disability.” Another of the respondents reported “It’s not against the law to be mentally
ill. As long as it is not a case of danger to self, or danger to others, we have the right to make our own choices.” She felt that if it were not an issue of safety, or grave disability, we should not interfere. One of the social workers responded to the question of medication requirements by saying it depended on community safety. She talked about an incident that was covered extensively a few years ago when a man, whose family had notified the Behavioral Health Department for several weeks that the individual was not taking his medication, his behavior was deteriorating, and had guns in his possession. The man did act out violently and several people were killed at the Behavioral Health office. This incident scarred the community, and eventually resulted in a law that enforces outpatient commitment under certain circumstances. This social worker thought that if someone was hearing “command” voices to commit violence, then requiring medication would be warranted.

Two of the five social workers stated that they believed people with severe mental disorders should be required to take medication. One respondent reported that she believed it should be required when their safety and the public safety was at risk. All of the respondents paused to think before answering this question and several commented that it was a tough question.

When asked if they believed it was reasonable or coercive to require people to take medication for their mental disorder when they also had legal offenses, two social workers said reasonable, another said it was reasonable because it was part of the consequences of having legal offenses, and another replied that it was both reasonable and coercive. One of the five social work clients responded that it was reasonable and as
a forensic social worker, she was biased because she felt that “people do bad things and when they are ill, you prevent it when you can.”

When the discussion turned to whether people with serious mental disorders should receive different treatment when in trouble with the law, the answers were again varied and interesting. Two respondents gave a short answer of “yes.” One said that it depended on the degree of severity of their mental illness and the other respondent said “yes” but it depended on whether the crime was connected to their mental health issue. She used an example of jaywalking; “children know that they are not supposed to do it. If a client is so defective that they are not capable of following the rule, then they should have special treatment.”

The respondents who were working in criminal justice answered the question about people being required to take medication in the following way. One subject responded after a long pause and answered, “generally, no.” Another person answered that she did not believe that people should be forced to take medication, unless someone’s life is at stake and the proper due process is followed. She said she did think that not all choices should be taken away from mentally ill people. Another respondent replied that medication is useful when monitored, but not when forced. He still listed some circumstances under which he believed medication should be required; when violent and a danger to society, and when a danger to self. The last two respondents qualified their answers as “yes, under certain circumstances.” One relayed that he has seen people with bipolar disorder who were “non compliant” with their medication become more functional when on medication. The last respondent answered in a similar
way, he believed that under appropriate circumstances, medications are necessary to maintain functionality and reduce the risk of violence. He also commented, “If there were a medically sound basis, including a prior history of problems, I would support requiring medication.”

When discussing whether it was reasonable or coercive to require people with mental disorders to be on medication when they had legal offenses, all the respondents working in criminal justice replied that they believed it was reasonable to require people to be on medication. Two commented that it was really both reasonable and coercive, and depending on the nature of the illness, they did support it. One respondent went on to say that it is part of probation and one need not agree to be on probation. She said, “It is an incentive instead of going to jail, and incentives are by nature coercive.”

Four of the five respondents from the criminal justice area answered that they do think that people with mental disorders who get into trouble with the law should have some form of different treatment from the courts. One respondent said that they do receive different treatment in her county because of the law surrounding juvenile and adult mental health courts. A second respondent discussed the reasonable person standard, elaborating by saying that a broader understanding is needed, but not excusing the actions. Another respondent commented that he thought that perhaps mitigated sentences and special probation conditions would be needed. The fifth respondent gave an answer that said it depended on the circumstances. He went on to talk about people who were adjudicated NGI-not guilty by reason of insanity, as an example of someone who is not culpable for his actions. He went on to state that “chronic mental illness (in the
court) required additional vigilant supervision and care to assist them through the system and help avoid recidivism and increased risk.”

Having Contact with People with Mental Disorders. Each group of respondents were questioned about whether they had contact with people with mental disorders before their present career, about behaviors that made them feel uncomfortable, in what capacity they presently work with people who have mental disorders, and whether they are frightened by any behaviors of people who have mental disorders. One social worker countered “everybody has a mental disorder.” Another told of having neighbors she lived next door to for ten years who had schizophrenia, and that when she moved to another home where she also lived for ten years, she again had a neighbor who had schizophrenia. Three of the five said that they did not have any contact with anyone that they knew had a mental disorder before they began their career as social workers. One social worker stated that she did not think she knew anyone with a mental disorder, but added that she grew up in an alcoholic family where there was depression masking the symptoms of their illness.

All the social workers had direct contact in their jobs presently and encountered people with mental disorders in custodial settings, causally, in institutions such as state hospitals, as a public guardian, as consumer/employees, in case management, in home visits, and in court. Three of the five respondents from the social work area responded that they did not feel embarrassed or uncomfortable by any behaviors, but when asked later what behaviors make them feel uncomfortable, one answered that threatening behaviors, or behaviors escalating to violence make her uncomfortable. Another replied
that table manners were an issue with her. As a casemanager, she used to take clients out to dinner occasionally, and she was disturbed by some people who did not practice good table manners. Another spoke from her position as a forensic social worker and answered that her concerns were about the safety of her clients and others. She admitted that she sometimes was frightened of people with certain paranoid delusions. She acknowledged that mental health and substance abuse also led to an increased risk of violence.

When discussing whether they were frightened when they encountered behaviors that were extreme, they responded in a number of ways. One respondent defined her response as cautious, saying that she has worked for so long in this field, then laughing because what she wants to do is a mental status exam—that she is curious about such a “rich experience.” Another said that the behavior that disturbs her is encountering someone with threatening, hostile behavior that escalates into violence, especially if coupled with suicidal ideation and nervousness. Another respondent expressed uneasiness when encountering behavior that is threatening, or violent. “It reminds me of childhood, of my father.” When asked how she manages her uncomfortable feelings in this situation she responded that she had to “just sit with it.” Two of the social work respondents admitted to being frightened of men who were much larger. One of these two respondents remarked that the one person who she was frightened of was incarcerated, and she felt more secure knowing that he is locked up.

The five respondents were also asked how they dealt with extreme behaviors in their work. The responses were to sit nearest the door, take precautions of someone knowing where I am, know where the alarm is located (in the psychiatric hospital), be
aware of people looking in the window while I am in the interview room, know how to deescalate the situation, develop rapport and be as safe as possible, evaluate for a 5150 hold (for someone who is a danger to self, or others), and “have someone come with me if I think the situation may be unsafe (in a home visit).”

The respondents from the criminal justice group were questioned about contact in their lives with people who have mental disorders, in what capacity they encounter people in their jobs with mental disorders, and what behaviors might make them uncomfortable, or frightened. Four of these five respondents answered that they did not have contact with anyone with a mental disorder before working in their present career, although one said that some years ago he discovered that his son had a mental disorder, and that his son had needed assistance over the years. The respondent who replied affirmatively said that she had had friends who had mental disorders before working in this career.

Three of the respondents replied that they had direct contact in their jobs with people who had a mental disorder, one as a judge and two as public defenders, representing them as juveniles (about 70% of her caseload), or representing people in conservatorships. One respondent answered that he rarely had contact in his job as deputy district attorney with people who had mental disorders. The fifth respondent said that she had frequent contact as a public defender, usually with clients who had serious felonies.

In discussing behaviors that embarrassed or made them feel uncomfortable, one respondent replied that he rarely felt uncomfortable by behaviors of those he works with who have mental disorders, but said he did feel uncomfortable with excessive emotional
displays, such as affection or crying. Another respondent answered that she sometimes is uncomfortable with other’s behaviors. She said the behaviors that made her uncomfortable or embarrassed were sexual behaviors or excessively hostile behaviors. One of the criminal justice respondents replied that there was not much that made her uncomfortable or embarrassed, but that when there was some “uncertainty of how other people were reacting” she was uncomfortable. She described an incident in court when a man wore a big blonde wig to the proceedings and she was unsure of what it meant. One of the respondents answered that she did not usually feel uncomfortable or embarrassed unless the behaviors were threatening. The fifth respondent said that he could not say any particular behaviors made him uncomfortable, but that in situations as a judge where he cannot assess the safety risk for public safety makes him uneasy.

When the respondents in the criminal justice field were questioned about how they dealt with extreme behaviors in their jobs, one responded by saying that it had never happened on the job, only in private. Another respondent answered that it is difficult to talk down someone who is agitated, so she usually told them she would talk to them later when they were calmer. She says if she waits a few hours, she is usually able to start over and have a more rational discussion. Another of the criminal justice respondents replied that she had bailiffs in court to handle any problem behaviors. The judge replied that he took a collaborative approach with all the professionals involved.

In examining the responses from both groups of workers about how they experience behaviors of those who had mental disorders in their jobs, and how they dealt with those behaviors, it seems that the social workers had more direct contact in a variety
of settings, and they were more prepared to respond to behaviors that were angry or threatening. The criminal justice group were aware of behaviors that made them uncomfortable, but responded with less direct interventions than the social workers. The behaviors described as uncomfortable were hostile and threatening on the side of the social workers and embarrassing and agitated on the side of the criminal justice group, but the two groups often worked with people with mental disorders in different settings.

**Responses to Critical Incidences.** The social work group was asked if there had been a time when there was a “critical incident” with someone who had a mental disorder and what their response was to it. One social worker could not recall any incidents. One of the respondents told me of a time when she had disarmed someone who had a knife at a day treatment program. She described how she and another worker walked the woman outside and then calmly took the knife from her. By this time, the staff had been alerted to call the police and the incident ended with their arrival. One of the respondents told of visiting a state hospital with a patient who had been “cheeking” his medications and was agitated and manic because of his decreased levels. She said he broke a chair and then destroyed the whole unit, breaking out lights with one of the chair legs, swinging at everyone as they were evacuating the unit, breaking soap dispensers and fixtures in the restrooms. The respondent said that “the staff all practiced duck and cover as he rampaged through the unit.” She said a team of police was needed to tackle and subdue him. One of social work respondents recalled a time she was visiting a client who was a sex offender in a state hospital. He was a large man and when he threatened her she decided to stop going. She was pregnant at the time with her third child and did not want
to expose herself to more risk. She said rather wistfully that she lost the opportunity to publish an article that she had been working on. The last respondent described a particularly frightening incident. She was the on-call crisis worker and received a crisis call from another facility that a client who might have a gun, was angry and out of control. She was told he was only five minutes away. Her first thought was to lock down the clinic and she did this, while instructing someone to call the police. As soon as she locked the front glass doors, the client arrived just behind a temporary worker who did not see the social worker signaling, and unlocked the door to let him enter. The social worker tried to engage him, and in a minute or so, the SWAT team arrived and shot him through he glass doors with a beanbag gun. The client did not have a gun, but had a pocketknife. She said the incident was very frightening.

In discussing this with the criminal justice respondents, one said that there were no incidents that she could remember. Another spoke of a time when she had a conserved client who was suicidal. She said that she worked in a collaborative effort with the client’s family and the police to resolve the problem. One of the respondents answered simply that he had called the friends and family to assist him. Another of the criminal justice group spoke of a time when she had a client in the PFH (Psychiatric Health Facility) and the client “was very verbally aggressive. I finally had to leave and communicate in writing since she had a difficult time listening when we were face-to-face.” The last respondent in the criminal justice group could not recall any incidents in the courtroom, but recalled incidents about clients reported to him and the appropriate sanctions he took. He went on to say he had had a felony molest case that was referred
out, and the client committed suicide. He also spoke of his experiences with his son and said there have been times when they have had to 5150 him (Involuntary commitment for 72 hours to a psychiatric facility because of a danger to self or others, or grave disability).

In describing critical incidences, the two groups reported somewhat different experiences. Four of the social workers related incidences when it seemed clear that someone might actually harm them. Four criminal justice workers recalled incidences when someone might become threatening. Given that the social workers had more direct contact with people who have serious mental disorders and work in a variety of settings, it is not surprising that they encounter more threatening behaviors.

**Stigma, Accountability, Recovery and How Perceptions Change.** In exploring with each of the social workers, the questions asked were about whether the stigma about mental disorders really exists, whether people with serious mental disorders should be held accountable for their actions, whether they believe that people with serious and persistent mental disorders can recover, and whether they believe that changes in how mental disorders are viewed come about through direct contact with those who have a mental disorder, through education, or through social movements. There was agreement among all the social workers that stigma does indeed exist, and that people with serious mental disorders should be held accountable for their actions. One respondent commented, “If you think that there isn’t stigma surrounding mental health, just tell someone that you work in mental illness. You can also detect quickly who has a family member with mental illness.” In discussing whether recovery is possible for people who have a severe and persistent mental disorder, three of the social workers said “yes.” One
of the respondents first replied “It depends,” and then when the researcher defined recovery as reaching the goals and roles wanted in a person’s life, rather than absence of symptoms, the respondent agreed that with this definition she would agree that recovery is possible. One of the social work respondents answered “no, she thought that people with severe and persistent mental disorders could stabilize their lives with medication and support systems, but that she did not believe that they could be “all well again.” Even after exploring the definition of recovery she still responded that she did not believe they could recover.

In exploring the topic of whether changes in how mental disorders are perceived happen because of direct contact with someone who has a mental disorder, through education, or through social movements, two of the social workers responded that they believed it came about through all three mechanisms. One of the respondents answered that she thought it happened through direct contact. Another thought it came about through education and social movements. One of the respondents replied that she believed that it came about through direct contact “more than anything.” The fifth respondent said that each of the three had a role and that we need all three. “Contact alone doesn’t give enough…education and social movements by themselves don’t do enough to teach.” She believed strongly that you have to have conversations and relationship to bring about this change.

The same questions regarding stigma, accountability, recovery, and how perceptions change about mental illness were explored with the five respondents from the criminal justice group. In answering questions about whether they believed that stigma
exists for people with mental disorders, and whether people should be accountable for their actions, all the respondents replied affirmatively to both questions. One respondent added a comment with her answer that she believed many people see it (the mental disorder) as an excuse for bad behavior. Another respondent commented that people should be held accountable for their behavior, unless it is beyond their control.

In discussing whether recovery is possible for someone with a severe and persistent mental disorder, only one respondent answered affirmatively. The four remaining respondents qualified their answers by saying “not recovery” (alleviation of all symptoms), but that they believed it possible that many people with the help of medication and support could live normal lives. In considering whether changes in attitude about mental disorders come about through direct contact, education, or social movements, three of the respondents replied that they did not know the answer to the question. Two of the respondents said that it was a combination of all three factors.

In discussing the existence of stigma and accountability, both groups agreed that stigma does exist and that people should be held accountable for their actions, unless the severity of their disorder made them not culpable. In exploring how they believed recovery results, the social workers generally believed that someone with a serious mental disorder could recover, if not to their original functioning level, to a satisfactory one. The criminal justice workers tended to believe that recovery was not possible, but in examining their remarks, one finds that they qualified their answers to say that they thought it was possible to recover to lead a normal life. The researcher finds that the two groups had responded in a similar way to the process of recovery from a mental disorder.
Reducing Stigma and Shifting Attitudes. The group of social workers were asked a series of questions that further explored what would help change attitudes about mental disorders, how their jobs might change if attitudes about mental disorders and stigma were reduced, and whether they believed that reduced stigma would change how our society views “supporting” those who cannot work because of their disorder. The first respondent thought that working alongside of people who had mental disorders (and were able to be open about the fact that they had a disorder) would help change attitudes. She said, “It would not change my job if stigma were reduced-still…” She thought that reducing stigma would make it easier for people with mental disorders to be more comfortable, and thought it would change how our society viewed financially supporting people who could not work. Over the years, she said, she had developed more compassion and a deeper sense of understanding for people with mental disorders through her work.

The second respondent expressed a belief that younger, more idealistic people involved in a social movement would change attitudes about mental disorders. She thought that jobs, housing, and credit-things we take for granted might change for people with serious mental disorders if stigma were reduced. She replied that she hoped that increased willingness to support those who could not work would come with the reduction of stigma. She said her job has completely changed how she views people with mental disorders from “not knowing to knowing pretty intimately” about the obstacles and what clients with mental disorders face.
The third respondent said that she believed that having much more public exposure to mental disorders would change attitudes about mental disorders. She referred to an documentary made by a Hollywood director, Ron Howard, she thought, that had people wearing T-shirts saying things like “I am schizophrenic” or “I am the sister of a Bipolar” or “I am married to someone with Chronic Depression” and filmed the reactions they encountered. She thought that was an effective social action. She believed that her job would be less stressful as a Public Guardian, if stigma and attitudes were reduced, and client’s stress levels and perhaps symptoms would decrease. She said her job has changed how she views people with mental disorders by reducing her fear and bringing her a greater understanding for people who struggle with addictions like smoking.

The fourth respondent initially said that she did not know what would change attitudes about mental disorders, and then exclaimed that if they could “come out” to others, as gays and lesbians have done, then attitudes might change. She said, “It is like a bell curve, with norms at either end for those who have it.” In discussing how reducing stigma might change her job, she said, smiling, “It is interesting. At one time, you could have a mental problem, but not be gay. Now you can be open about being gay, but do not tell anyone you work with, even here, that you have a mental problem.” She did think that reducing stigma would make it easier for society to support those who could not work, but added “it might not.” She declared that she thought there would be less discrimination about mental disorders if stigma were reduced.

The last social worker responded that she believed that “personal experiences with those who are mentally ill are what allows for changes in attitudes. We buy the
stereotypes.” She thought that the more people with mental disorders are integrated, the less stigma would exist. She thought it all starts with relationship, which leads us to be open to education. She also believed that if stigma surrounding mental disorders were reduced there would be more social supports in the community, rather than professionals, and that support would be given to those who could not work because of their disorder. It would enable people to get housing and employment. She thought the community would then take care of them, rather than the clinic. Her job has changed how she views mental disorders, she said. “I have gained respect and appreciation for what they face daily, day in and day out…to be living with active symptoms of schizophrenia and to be moved from house to house…”

The group of criminal justice workers responded in the following ways. The first respondent answered that he thought that education about mental disorders, as part of the school curriculum, would help change attitudes about mental disorders. He said that if changes occurred it would probably not affect his job, as deputy district attorney, at all. He did agree that reducing stigma would probably increase support for those who could not work because of their disorder. This respondent replied that if stigma were reduced it might lead to higher employment.

The second respondent answered that more training and understanding would help change attitudes about mental disorders, not publicized accounts of “crazy people”, but education about the disorders and early interventions. She did not think that a reduction in stigma or changes in attitudes would change her job as public defender, but added that there might be a ripple effect, with reduced budget costs and less people sent to prison, or
perhaps increased services available. She thought that even if there were a reduction of stigma there would always be a segment of society unwilling to support those with mental disorders, feeling that there are always two ends of the spectrum. She thought that there would continue to be those who believe “you must pull yourself up by your bootstraps.” This respondent believed that her job had changed how she viewed mental disorders by “giving me a perspective of people with mental disorders—just broadening my view, in a good way.”

The third respondent said that she thought education of law enforcement would help change attitudes about serious mental disorders. She responded that reduction of stigma would make her job more treatment oriented, rather than punishment oriented. She did not think that a reduction in stigma would allow for more support of those whose disorder did not allow them to work. She said, “Not in these times—social support is too unpopular now,” but she believed that if stigma were reduced that people would be less reluctant to get help—if it were treated like any other disease. She did agree that her job had changed how she views mental disorders.

The fourth respondent of the criminal justice cohort responded that she believed more visibility would bring improvement to attitudes about people with mental disorders. She thought improving attitudes and reducing stigma would make her job easier, as a public defender, but could make it worse. She said there might be more alternatives available for the court. She thought that there might be more housing opportunities, education, and jobs. There might be less fear. She expressed a belief that reducing stigma would change how people view supporting those with mental disorders who cannot work.
Her job has changed how she views mental disorders by giving her a broader knowledge of forms of symptoms, and how they might be managed.

The fifth respondent replied that he believed that public education was most important to change attitudes about mental disorders. He said that if attitudes and stigma were reduced it would affect his job by providing more resources to work with treatment, and less people in the criminal court because they would be diverted to mental health treatment. He thought that if attitudes changed, there might be more willingness to be a support system for those with mental health issues, better success in employment if employers were ‘tuned in’, and perhaps a shift in funding for mental health service, including chronic and acute facilities. When thinking about whether changed attitudes would alter the way society supports people who cannot work, he replied, “To a degree. It depends on the severity of the disorder. Many do work, and many are viewed as lazy and not deserving of sympathy. It is hard to tell if they can work.” He said that his job, as a judge, has not changed how he views those with mental disorders.

In summarizing what the respondents felt was effective in reducing stigma about mental disorders and how reducing stigma would change their work or change our society’s willingness to support those with serious disorders who could not work, several of the social workers felt that if people with mental disorders were more integrated, visible and known for who they are, the stigma might be reduced and resources such as jobs and housing might be more readily available. The criminal justice workers believed that more education, both in our schools and of law enforcement would help change the stigma experienced by people with mental disorders. They also thought that by reducing
stigma, more resources might become available in several areas. The groups were not widely divergent on this set of responses. The criminal justice group used different language than the social workers, but the main themes they both mentioned were education and resources.

*Final Thoughts about Recovery* The respondents were given two quotes to comment on from two individuals who have been involved in writing and speaking about recovery over the years. The first quote was from Dr. Mark Ragins, who says that to create a recovery culture people with mental disorders need to “have hope, personal power, responsibility, and meaningful roles.” The first respondent replied that was exactly what she had come to believe…”hope and purpose are vitally important”. Another respondent said that the statement means a lot of what you want for the client-a codependency inverse. The next respondent replied that she had heard the quote before and agreed with it. The fourth respondent commented that people with serious mental disorders want to be treated like everyone else. They want normal stuff; just like anyone else. They want to be treated as if they can do it (recover). The final respondent discussed the fact that people with disorders should be held to the same rights and responsibilities. “We all have hope for the future. They must have more responsibilities of giving and receiving which leads to personal power.”

The next quote was from Patricia Deegan, who refers to herself as a psychiatric survivor. She says, “the label of mental illness comes as a ‘package’ plan that too often includes poverty, trauma, hopelessness, dehumanization, degradation, being disenfranchised, being unemployed, receiving inferior health care, ect.” Three of the
respondents simply answered “yes” to Deegan’s statement. One of the respondents commented that she thought that the statement was true, not just for mentally ill people, but for very poor people, as well. Another commented “we run the risk through benign neglect, or maybe not so benign.”

The last question posed to the social work respondents was how they would change the system in which they work to allow more recovery based approaches. One simply said she did not know. Another said she thought her agency did a good job, but that she would like to see more community clubhouses, with peer support and more resources. She wants to include employers, not to replicate the clinic, but to broaden the roles of the person with mental disorders. Another respondent answered that she also thought they did a pretty good job at her community agency. She said “We’re right here (the clinic). Some dodge, refuse to participate. That’s about them, but given the population…I feel satisfied with my job.” The last respondent said that she tries to do it (use the recovery approach) every day. It is the supportive nature of relationship, she said. “We hold the hope, lay out the encouragement and eventually, the clients will adopt it (recovery).”

In discussing the quotation from Dr. Mark Ragins with the group of criminal justice workers, they commented as follows. One of the respondents explained her view of the quote by remarking that it means we need to treat people supportively, because they do have value. Another said it means that we cannot take their freedoms away. Another respondent interpreted it to mean that people must have hope—just like any of us. “They must have a role beyond their mental disorder—such as being in the workforce, and
responsibility to manage their medication and mental disorder.” One of the respondents replied that all of these remarks seem to be principally that self-esteem makes people higher functioning. The fifth respondent reflected that Mental Health court was on the right track, in regard to the quotation.

Deegan’s statement about the label of mental disorders “being a ‘package plan’ that too often includes poverty trauma, hopelessness, dehumanization…” brought varied reactions from the five criminal justice workers. Two of the respondents simply agreed with the quotation. One respondent answered that mental illness often become the controlling factor in one’s life, and that the daily tasks and responsibilities associated with daily living becomes impossible if the illness is not treated. Another responded that he mostly agreed with the statement, but that he felt it was generally too broad. He said that he believed in a more moderate view. The last respondent answered that he “did not agree with the statement. It seems excessively dramatic and a gross generalization.”

In discussing how each of the respondents in the criminal justice system might change the system in which they work to bring more recovery based approaches, one of the respondents answered that he was not sure. Another reflected that they had a good community, and had improved their Mental Health court system. She indicated that she wants to see more serious offenses dealt with in their system. One of the other respondents also mentioned that he thought he worked in a pretty good system, but would want more providers and more services. The third respondent thought the system she worked in was on the right track with the Mental Health court system. She said that some punishment should not apply to both –meaning those with serious mental disorders and
those without. She wanted there to be more flexibility in the measures they could use. The
last respondent replied that in her “ideal world” the DAs (district attorneys) would
understand that controlling the symptoms of mental illness reduces crime.
Chapter 5

DISCUSSION

Introduction

The objective of this project was to examine the differences in perceptions about mental disorders between those who work in community mental health agencies, using a recovery model, and those who work in the criminal justice field. The researcher used an interview schedule of thirty-seven questions (attached as Appendix A) to explore themes relating to the research question. In this chapter, the finding will be discussed further to compare and contrast whether the perceptions between the two groups of professional differ in working with individuals who have a serious and persistent mental disorder.

Background of Education and Training

The backgrounds of the two groups of respondent were not dissimilar. All but one of the respondents had graduated from college and all had graduate degrees in their field. Several of the social workers were licensed as clinical social workers, as well. The social worker group had more training and exposure to courses about diversity than did the people who worked in criminal justice, but this is something expected by the researcher because of the nature of social work. Social work education deliberately focuses on issues of diversity including race, class, sexual orientation, physical and psychiatric disabilities, and the effect of poverty on marginalized people. The researcher found that forty percent of the workers in criminal justice had some coverage of diversity issues and on the job training about working with people with mental disorders, and twenty percent chose to explore some of these issues through continuing education and conferences.
The social workers had a higher median age. This was likely because they all were women who had returned to college and entered social work at a later age, as the researcher discovered in interviews. The criminal justice workers had one person who was in her late twenties, several in there thirties, and one who had been practicing law for forty years, so the mean number of years was comparable to the length of time that the social workers had been in their career, although the criminal justice workers tended to be younger in age.

**Attitudes about Mental Disorders**

The social workers were in agreement one hundred percent of the time when responding to questions about whether they believed people with mental disorders should have additional resources to stabilize, integrate, and having meaningful roles in the community.

The criminal justice group also were one hundred percent in agreement about these three areas of support and having roles in the community that are beyond being a “patient.” One of this group did remark that the extra assistance would depend on the nature, or extent of the disability.

**Medication and the Law**

As was discussed in the literature review, people with serious mental disorders do not always want to take medications for their disorder, sometimes because of the serious side effects of the medications, or because they begin to feel better in the stabilization process and determine that they no longer need the medication. Social workers hold a principle of self-determination as important and so are reluctant to say that someone
should be required to take medication for a mental disorder. They also see the role psychiatric medication plays in stabilizing people when they are a danger to them self or other people, or cannot take care of themselves because they are gravely disabled when not taking it.

Criminal justice workers look to the law as their guiding principle and tend to believe that people with a serious mental disorder should be required to take medication because it enhances the public safety and the safety of the person who had a mental disorder. Both groups tend to believe that if someone with a serious mental disorder was also facing legal challenges they should be required to take medication. In the literature review, one can see the changes in philosophy over the past fifty years. In the 1960’s, people with mental disorders did not have a voice in their treatment. Since the late sixties and seventies legislation began to reflect a trend toward more patient rights. The Supreme Court decided in 1972 (DiNitto, 2005), that people with mental disorders should live in the least restrictive settings possible. In interviews with criminal justice workers, the discussion on attitudes about mental disorders focused on diversion for people who had serious mental disorders, who would not have committed a crime had they not had a mental disorder and if they had had adequate community resources in place before the offense. This echoed the literature from the Consensus Report (Bernstein & Seltzer, 2003) and other commission (Little Hoover Commission, 2000; President’s New Freedom Commission, 2003; Markowitz, 2006). The social workers responded to this with concerns for the individual’s rights and their concern for the safety of the client and others. This reflects what was found in the literature about client choosing to define their

Having Contact with People with Mental Disorders

One hundred percent of the social of the social workers had had some contact in their lives with people who had mental disorders prior to entering into their careers. One hundred percent presently have direct contact with people with mental disorders in their work now and most could identify behaviors that made them feel frightened, embarrassed or uncomfortable. Most of these behaviors centered on hostility or anger, especially of someone much larger.

The literature discusses how one study found that high stress loads in childhood and prepuberty suggested a result in negative symptoms of affect in adulthood (Weber, et al., 2008). Herman (1997) and the WHO report (2001) touch on the effect of childhood trauma affecting the development of the brain and the increased possibility of depression later in life. The difficulty in emotional regulation leads to poor coping skills and inadequate social skills for many people with a serious and persistent mental disorder.

The proportion of those who had previous exposure to someone with a mental disorder before starting their present career was very different in comparing the two groups. Most of the social workers were aware of knowing someone with a mental disorder and most of the criminal justice people were not aware of knowing someone with a mental disorder before this present career. All could point to a behavior that they knew made them feel uncomfortable, mostly concerning safety. The group as a whole
believed that increased exposure to people with serious mental disorders brought about more understanding and acceptance.

**Responses to Critical Incidences.** The responses to critical incidences were mainly anecdotal and not easily grouped into categories. Eighty percent of the social workers could identify an incident that they defined as critical. Eighty percent of the criminal justice workers could identify a critical incident from their jobs, although the person who could not remember an incident on the job was able to describe an incident in his personal life.

The researcher would like to point out that this does not necessarily mean that people with serious mental disorders are violent. The literature did not support this, although it does support the increased risk for violence when a person with a mental disorder had a co-occurring substance abuse disorder. The researcher wants to acknowledge that this was found frequently in working with mental health and in criminal justice. This was a correlation pointed out in the literature, especially in connections with prison populations (Markowitz, 2006).

**Stigma, Recovery and how Perceptions Change**

One hundred percent of the social workers were in agreement that stigma about mental disorders does exist and that people should be held accountable for their actions. One hundred percent of the criminal justice workers were able to agree that stigma did exist for people with mental disorders and that everyone should be held accountable for their actions, although one respondent qualified his statement unless the person was not in control of his behavior.
In the discussion about the possibility of recovery with both groups, once recovery was defined as being attainment of the client goals rather than complete reduction of symptoms, there was a bigger gap between the social workers and the criminal justice workers than on any other question. The social worker respondents felt that recovery from a serious mental disorder was possible in most situations. Eighty percent of the respondents said they believed that people with a serious mental disorder can recover and twenty percent of the respondents felt that it was not possible.

Of the criminal justice workers, twenty percent of the respondents said that he believed recovery was possible and eighty percent said they did not believe it was possible. The researcher believes that the lens of the criminal justice personnel may have worked to limit their ability to see recovery as a process rather than a destination (Ragins, n.d.; Jacobson & Greenley, 2001). Exploring the opinions of the social workers about whether they felt perceptions about mental disorders changed because of direct contact with those who have a disorder, through education, or through social change, sixty percent indicated that they believed the change came about through all three mechanisms. Forty percent thought it happened because of direct contact.

In the group made up of criminal justice workers, the sixty percent replied that they did not know how changes in perceptions about mental disorders come about. Forty percent believed that changes come about because of a combination of all three factors. The Recovery Model continues to evolve through the writings of those who live the model in terms of their disorder and those who work with them to support their growth (Anthony, 1993; Adame & Knudson, 2008)
Reducing Stigma and Shifting Attitudes

The social workers and criminal justice workers were in agreement with the literature about how attitudes change when people integrated in their work and community along with being able to be open about their mental disorders. This supports the literature, especially from those who are writing from personal experience (Chamberlin, 1998; Deegan, 1997; Carpenter, & Cohen, 2005). The idea that people with mental disorders needs more resources to live successfully in the community is supported in the literature and the sentiments disclosed by both groups of workers. With reduction of the stigma and discrimination, the social workers and the criminal justice workers agreed that there might be more resources available for basic human needs like jobs and employment. The literature discusses these points in establishing what a recovery oriented model of mental health care would look like (Anthony, Cohen, Farkas, & Cohen, 2000).

Implications for Future Research

There is a pressing need to analyze what diversions are successful in reducing recidivism and rehabilitating people with serious mental disorders and legal offense. It is clear that many are spending time in prison which could have been averted with proper treatment and resources. There are many in jails in counties across the United States that have struggled with their disorder, a co-occurring substance abuse history and inadequate housing and employment because of both. Mental Health courts need to studied to see whether the scrutiny of the court and the resources of community mental health agencies really are effective.
More research about pre-release treatment for reintegration into communities is effective. Research into what resources are most effective in keeping people from recycling back into prison is needed. Research is needed to develop effective measures of the Recovery model as it is practiced in community mental health agencies. More research might produce best practice interventions into how to implement a recovery oriented model in the mental health agencies.

*Implications for Social Work Policy*

The research on the recovery model has been largely narrative rather than evidence based. This is an area that future social workers will investigate as they work to collaboratively explore how to implement it with their clients and in agency settings. As the social workers understand the principles of the recovery model, they will need to have evidence-based research to support their application of the methods. Many social workers and agencies have begun this process of changing attitudes about mental disorders. This shift to the Recovery model will necessitate social workers to educate themselves about the methods and present the reasons why the medical model of disease and deficits can be infused with healthier ways of interacting with those people who have a mental disorder.

*Implications for Criminal Justice Policy*

This exploratory study with criminal justice workers showed that although they did not have the same education in diversity and the recovery model in their practices, those who have direct contact in their work with people who have a mental disorder in the criminal system do see the need for diversion from jail and prison for many who have serious mental disorders.
The criminal justice workers recognize that treatment and support are needed to allow people with serious mental disorders to live stable and productive lives in the community. Projects like the Consensus Project, which utilized a collaborative approach to developing recommendations for criminal justice diversions and the establishment of Mental Health courts, can make a difference in the lives of communities. This study showed that those who work in criminal justice are interested in the issues surrounding serious mental disorders, and who benefit from more education about the issues identified.

Conclusions

This study was begun to explore the differences in perceptions about mental disorders in social workers in community mental health agencies and those who work in the criminal justice system with an intention that a future intervention might be necessary to bring the two groups closer together in how they understood serious mental disorders. Instead, the researcher believes that the levels of understanding are closer together than anticipated. Those who work with people who have serious mental disorders developed some understanding of the difficulties and need for resources for this population. The criminal justice system has been exploring different interventions for people who have serious mental disorders and have involvement with the law. As one example, a bill (SB151) was proposed in the California legislature this year (as it has been for several years) to form ten pilot programs for parolees who have either a mental disorder or a substance abuse problem. The bill did not pass through the appropriations committee because of the severe financial economic crisis in California. The pilot program would
create courts which would operate in a manner similar to the drug courts, or the mental health courts, with supervision and supports to enable re-entry to the community and reduce recidivism. This would be a positive example of diversion from returning to prison. Presently, about 70% of return to prison are parole violations.

The study has demonstrated to the researcher that direct contact with those who have a serious mental disorder is often an effective learning intervention in the work place. Based on answers received in this study, it is clear to the researcher that more education and interventions to integrate people with mental disorders in the community changes attitudes and perceptions about serious mental disorders.
APPENDIX A

Interview Guide

Demographic Questions:

1. What is your name?
2. What is your age?
3. What is your ethnicity?
4. How would you define your socio-economic background? Working class? Lower middle class? Middle class?
5. Do you live in the same community that you work in?

Background of education and training:

6. What is your career field?
7. How long have you been in this career?
8. Was it a deliberate choice, or an accidental choice that led you to this work?
9. Describe the type of education you have had
10. Did any of your education focus on diversity or community relations?
11. Describe any on the job training you have had about how to treat people with a mental disorders.

Attitudes about Mental Disorders

12. Do you think those with a mental disorder should have extra help to stabilize their lives?
13. Do you think people with a mental disorder should be given extra help to integrate into the community?
14. Do you believe that people with severe mental illnesses should be required to take medications?

15. In your opinion, is it coercive, or reasonable, to require people with mental disorders to be on medication when they have legal offenses?

16. Do you believe that people with mental disorders can have meaningful roles in the community?

17. Does it seem that changes in how mental disorders come about through having direct contact with people who have a mental disorder, education, or social movements?

18. Did you have contact with people who have mental disorders before you began this career?

19. In what capacity do you presently encounter people with mental disorders in your career?

20. Do you have direct or indirect contact with people who have chronic mental disorders in your job?

21. In your opinion, should people with a mental disorder who get into trouble with the law receive different treatment?

22. Do you feel embarrassed or uncomfortable by behaviors some people with mental disorders have?

23. What types of behaviors make you feel uncomfortable?

24. Do you think people who have a severe and persistent mental disorder can recover?

25. Are you frightened when you encounter behaviors by people with mental disorders that seem extreme?
26. How do you deal with this type of situation in your job?

27. Can you recall a time when there was a “critical incident” with someone who had a mental disorder and what your response was to it?

Reducing Stigma and Sifting Attitudes:

28. Mark Ragins says that to create a recovery culture that people with mental disorders need to “have hope, personal power, responsibility, and meaningful roles”. What does that mean to you?

29. Do you think that stigma about mental health problems really exists?

30. Patricia Deegan, a psychiatric survivor, says that “the label of mental illness comes as a ‘package’ plan that too often includes poverty, trauma, hopelessness, dehumanization, institutionalization, degradation, being disenfranchised, being unemployed, receiving inferior health care, etc.”. Do you agree with this statement?

31. What do you think would help change attitudes about serious mental disorders?

32. In your opinion, how would improving attitudes about mental disorders and reducing the stigma associated with it change your job?

33. Do you believe that reducing the stigma surrounding mental disorders would change how our society views “supporting” those who can’t work because of their disorder?

34. What other things might change if the stigma surrounding mental disorders were reduced?

35. Do you believe that people should be held accountable for their behaviors?

36. How would you change the system you work in to allow for more recovery based approaches?
37. Has your job changed how you view those with mental disorders?
APPENDIX B
Consent to Participate in Research

Application of the Recovery Model
in Community Mental Health and Criminal Justice

You are being invited to participate in research which will be conducted by Carol Grant, a Master’s level student in Social Work at California State University, Sacramento.

This study will investigate levels of awareness of the Recovery Model in community mental health settings and criminal justice settings. The interviews will consist of thirty-five questions and will take up to an hour of your time. There are no incentives offered. The information gathered in this study will be used to examine the gap in understanding between professionals who work with those who have a serious and persistent mental illness and work in mental health agencies and the criminal justice system.

The information from this exploratory study will be kept confidential and your name and work setting will not be used. The information gathered through these interviews will be kept securely in a locked file drawer in the researcher’s office. All information gathered will be destroyed upon completion of the study in May, 2010.

The information from this study will be examined to develop interventions that may make it possible to bridge the understanding of those who work with mental illness in these described settings.

It is not expected that the interview questions will result in any harm, but attached are several references where you might find assistance. You may decline to answer any of the interview questions, or end the interview without any consequences. If you have further questions about this research, you may contact D. T. Bankhead at (916) 278 7177, or by email at bankhead@csus.edu. Your signature below indicates that you have read this page and agree to participate in the research. Thank you for your assistance.

Sincerely,

Carol Grant
Deercrzy2@earthlink.net
(530) 274 7974

__________________________  ________
Signature of Participant     Date
REFERENCES


Ashcraft, L., & Anthony, W.A. (2008). Wellness must be part of our mission; we can help people in recovery live to their full potential. *Behavioral Healthcare. 28*(9),


http://bazelon.org/issues/criminalization/publications/mentalhealth courts/


CSUS Course Catalog. Retrieved on March 26, 2010 from [http://aaweb.csus.edu/catalog/current/Programs/CRJ.html](http://aaweb.csus.edu/catalog/current/Programs/CRJ.html)


