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Perceptions of Professionals Who Serve Adults with Mental Illness and Criminal Backgrounds

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Perceptions of Professionals Who Serve Adults with Mental Illness and Criminal Backgrounds

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

This qualitative research paper is based on the responses of social service professionals that were individually interviewed about their perceptions serving people with mental illness that have a criminal background by asking a series of questions. The social service professionals acknowledged the increased number of clients they serve in their work that have both a mental illness and a criminal background. Common barriers were reported, most commonly was lack of housing and employment. These barriers were identified as contributing homelessness amongst this population. The need for social service professionals to receive training about this population and to work collaboratively with criminal justice personnel was also determined. More research was recommended to identify best practices for improved service delivery when serving this population.

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Acknowledgements

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Introduction and Research Question

The number of individuals living with a mental illness that also have a criminal background has grown in the past few decades according to previous research (Mann, 2011; Thompson, et. al, 2003; Lurigio, 2001; Steadman, et al., 1999). Despite this growing population, there are few coordinated services between the mental health system and the criminal justice system (Dooley, 2010). In the past ten years, there has been presidential action to address the growing number of individuals living with mental illness entering the criminal justice system (Pogorzelski, Wolff, et al., 2005). This effort attempts to reduce the number of those living with mental illness from entering the criminal justice system and reducing common barriers experienced by this population such as homelessness and lack of access to community mental health services (Draine & Herman, 2007; Mann, 2011).

Statistically, the number of adults with mental illness who have been identified in the criminal justice system has grown exponentially over the past 30 years (Ditton, 1999; Mann, 2011; Thompson, 2003; Lurigio, 2001; Steadman, 1999).

Research Question

This research study is based on previous research that addresses social service professionals that serve adults who live with a mental illness and have a criminal background. The research explores common barriers the identified population experiences; the level of training the professionals have when working with this population and best practices or interventions being used.

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What are the perceptions of professionals who work with adults with mental illness, involved in criminal justice system; and what are the best practices for service delivery?

Literature Review

From a historical perspective, previous research found the number of adults with mental illness involved in the criminal justice system has been growing. This growth stems from the deinstitutionalization of adults with mental illness from government ran facilities dating back to the 1950's (Mann, 2011; Thompson, 2003; Lurigio, 2001; Steadman, 1999).

Between 1955 and 1994, the population of adults with mental illness residing in state facilities decreased from 559,000 to less than 72,000 (Lurigio, 2001; Thompson, 2003; Mann, 2011; Lamb, et al 1999; Hatcher, 2007). According to Bureau of Justice, (1999), over 700,000 people were identified as having a mental illness in jail or prison or on probation. The resettlement of this population into the community has been described as a system failure due to a lack of community services, resources and supports. This failure is described as a lack of access to community mental health services and in-home mental health services (Draine & Herman, Lurigio, 2001). These services, which research has shown improves attendance of this population to mental health services but are not widely used (Hatcher, 2007). A lack of these practices has indirectly led to the increase in the number of adults living with mental illness involved with the criminal justice system (Lurigio, 2001; Steadman, et. al, 1999).

The American Psychiatric Association (2009) estimated that 16 percent of

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prisoners have been identified as having a serious mental illness. Of this number, almost a quarter of them had a history of mental health symptoms at various times. The 2002 National Commission on Correctional Health Care submitted a report to Congress revealing that 17.5 percent of offenders in state prisons were diagnosed with Axis I conditions such as Schizophrenia, Bi-Polar Disorder, and Major Depression (Torrey, Kennard, Eslinger, et al, 2010). This does not take into consideration Axis II disorders such as Antisocial Personality Disorder, Borderline Personality Disorder, and so on, as well as other mental health related disorders (Steffan & Morgan, 2005).

Adults with mental illness who have criminal backgrounds are being served by corrections professionals, law enforcement officials and social workers in various settings, e.g. criminal justice system, community non-profits and other government agencies that provide services to this population (Lamb, et al, 1999; Mann, 2011; Thompson, 2003). Both the mental health system and criminal justice system operate independently of one another. Considering the growing number of adults with mental illness in the criminal justice system, for example, arrests, jail and prison, nationwide attention was given to this problem (Hatcher, 2007, Rich, 2009).

In 2004, the Mental Health Offender Act was signed by President Bush to address the barriers to this growing population and allotted funds for alternative programming demonstrations that emerged throughout the country (Mann, 2011; Pogorzelski, 2005). The main objective for this Act was to improve recidivism rates and access to mental health services in the community for this population (Mann, 2011). According to the Bureau of Statistics (2007), over 1.25 million adults with mental illness have been identified within the criminal justice system, which includes probation, jail, and prison.

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Many of the programs started have made a concerted effort to work collaboratively between both mental health and criminal justice systems. Some examples of collaboration are the use of diversionary programs such as pre-trial diversion, mental health court and the use of mental health discharge planners for those in jail or prison (Draine & Herman, 2007; Steadman, 1999; Osher, 2003). Lamb (1999) concluded, that there is a significant need for corrections and mental health professionals to work collaboratively at interface with the shared client. It is imperative that there is involvement from both systems in order to effectively serve and treat this unique population (Draine & Herman, 2007; Lamb, 1999; Steadman, et al.1999; Osher, 2003).

Identified Barriers

Symptom management while incarcerated. The National Institute of Corrections (2010), revealed that a collateral consequence of incarceration for this population is the presence of active mental health symptoms, such as aggressiveness, irritability, impulse control and inability to control intense emotions. As a result of these behaviors many in this population find themselves receiving disciplinary action during their incarceration (Rich,2009). Many times this population is booked into jail goes for days without access to prescribed medications (Rich, 2009; Osher, 2003). Dennis and Abreu (2010) found that upon release from jail or prison, the recidivism rates are higher for those with diagnosed mental illness than those without a mental illness.

Data from previous research has found differences in symptom management for the population of those who are in jail versus prison (Osher, 2003; Davis, et al., 2008; Steffan & Morgan, 2005). In addition, this research found that prisons have the capacity to provide discharge and treatment planning because sentences are typically longer than

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jail. Assessments, treatments and discharge planning are difficult to complete due to the

shorter length of jail time (Osher, 2003; Davis, 2008; Steffan & Morgan, 2005). The

importance of the mental health discharge planners are to work inside the correctional

facility with these inmates to plan for discharge.

     Chemical dependency. Previous research finds that chemical dependency is a

significant issue among adults in the criminal justice system and finds that over eighty

percent of adults living with a mental illness in general have reported co-occurring

chemical dependency issues without the presence of a criminal background (Hartwell,

2004; Wheeler & Patterson, 2008; Swartz & Lurigio, 2007). Individuals who have been

diagnosed with both chemical dependency and a mental illness have been found to have a

significant relationship with the criminal justice system resulting in multiple contact and

involvement with the criminal justice system (Swartz & Lurigio, 2007; Luskin, 2001;

Steffan & Morgan, 2005). In Porgorzelski (2005), as many as two-thirds of this

population in jail or prison was intoxicated when the offense occurred. For many in this

population, chemical dependency treatment while incarcerated is mandatory; however,

this does not address the co-occurring mental illness (Seiter & Kadela, 2003).

     For this population, chemical dependency significantly increases the non-

compliance with taking prescribed medications (Lamb, 1999). As a result, this

aggravates mental health symptoms which produce additional barriers around mental

health treatment and recovery (Lamb, 1999; Mann, 2011; Swartz & Lurigio, 2007).

Many in this population are resistant to mental health and treatment services which

present that program restrictions due to their criminal background (Lurigio, 2001).

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The lack of community resources further contribute to lack of medication compliance with this population (Lamb, 1999; Thompson, 2003; Hartwell, 2004).

      Housing. For many adults living with a mental illness and a criminal background, housing options are severely limited. Participation in mental health targeted housing programs is often diminished as a result of the nature of the offender's crime. As a result, these barriers to housing contribute to a significant portion of this population experiencing homelessness (Porgorzelski, 2005). Much of this is due to the difficulties they experience in trying to find and maintain housing and is associated with recidivism rates on return to prison (Thompson, 2003). According to Rich (2009), many individuals with criminal backgrounds also face similar difficulties reentering society, such as homelessness for those who have criminal backgrounds without the presence of a mental illness. For the individual living with both a mental illness and a criminal background the likelihood of homelessness and difficulty obtaining and keeping housing occurs at a higher rate (Hartwell, 2004; Osher, 2003). The type of offense the individual has also affects the ability to secure housing, for example, a history of violence or a sex offense even more limited(Hartwell, 2004; Osher, 2003). Much of the available housing is located in high-crime and high drug use communities (Seiter & Kadela, 2003; Austin, et al., 2001).

      Access to health care and mental health services. According to Lamb (1999), many times this population is resistant to treatment services. Many do not access them voluntarily, which also contributes to the presence of adults with mental illness to rise dramatically in the criminal justice system. According to Hartwell (2004), the rate of those individuals identified with a mental illness while in jail is significantly higher than

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those who are living out in the community. The ability for this population to access

mental health services are not well funded which impacts the ability for one to obtain

mental health treatment and medication. Many find themselves getting mental health

treatment while in jail and do not have medical insurance or access to community mental

health services upon release from jail (Swartz & Lurigio, 2007; Dennis & Abreu, 2010;

Osher, 2003).

Compliance with corrections conditions and recidivism rates. Traditional

conditions of probation or parole within the criminal justice system requires the identified

population to find employment, obtain housing, and abstain from chemical use (Lurigio,

2001). As a result, clients who are typically non-voluntary are assigned to treatment

resistant programs (Davis, et al., 2008). The literature indicates homelessness,

unemployment, lack of income, health care, transportation, and social support as reasons

for higher recidivism rates with this population versus non-mentally ill individuals with a

criminal background (NIC, 2010; Lurigio, 2001; Thompson, 2003).

Interventions

The three interventions highlighted in this paper are mental health court, Assertive

Community Treatment (ACT) and dual diagnosis substance abuse treatment (Mann,

2011; Thompson, 2003; Reynolds, et al., 2004; Steadman, 1999). This research found a

number of programs throughout the U.S. that have emerged in the past ten years and are

being practiced throughout the country on various scales. The most common were

diversionary in nature and aimed to reduce contact with the criminal justice system.

Mental Health Court. Mental health court (MHC) emerged from Broward

County, Florida in 1997, in response to the growing number of people processed in

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criminal court which were identified as having a mental illness (Osher, 2003). The role

of mental health court is to serve adults with mental illness that are involved with judicial

system as an intervention. It deters one from going through the traditional criminal court

system and focuses on therapeutic interventions and stabilization instead of punitive

measures such as incarceration (Thompson, 2003; Luskin, 2001).

The target population in Broward County was limited to misdemeanor offenses

and there were strict guidelines for participation (Osher, 2003). Once accepted, the

individual is processed through court but the sanctions are mental health related instead

of punitive (Mann, 2011). Treatment of mental health symptoms to reduce recidivism

focuses on participation in therapy, group, psychiatric services and medication

management to treating the symptoms of mental illness to reduce recidivism (Thompson,

2003; Luskin, 2001). According to Mann (2011), in 2006, there were over one hundred

mental health courts running throughout the country.

Mental health court overall, is designed to identify and offer adults with mental

illness entering the criminal justice system an alternative or diversion to entering the

traditional criminal court system (Luskin, 2001; Mann, 2011; Thompson, 2003). Mental

health court addresses the crime secondary to the individual's mental illness instead of

criminal punishment. The individual is ordered to seek mental health services and is

offered support and stabilization services to reduce symptoms related to mental illness

which prevents a permanent record (Thompson, 2003; Mann, 2011; Luskin, 2001).

Saunders and Marchik (2007) indicated that there may be cost benefits to both the

criminal justice system and mental health system by coordination of services in areas

where both systems intersect.

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It should be noted, mental health courts do not run uniformly throughout the country and each municipality identifies participants differently.   Some courts only accept those with misdemeanors and gross misdemeanors while others process felony offenses such as property crimes, drug-dealing and crimes against persons (Mann, 2011, Luskin, 2001). The delivery of these services takes a multidisciplinary approach that consists of members from local police, attorneys, community mental health providers and criminal justice professionals such as probation officers (Thompson, 2003). These professionals exclusively manage a mental health caseload (Osher, 2003).

Assertive Community Treatment (ACT) Team. Assertive Community Treatment (ACT), is an evidence-based practice used when working with the Severely Persistent Mentally Ill (SPMI) population and has been around for over 30 years (Davis, 2008; Brown, 2004). This intervention was designed to reduce hospitalization and increase community stabilization for the SPMI population by using a multi-disciplinary approach that provides case management services to aid with housing, access to mental health services and obtaining financial assistance (Davis, 2008). Porgorzelski, (2005), discusses the use of a similar model to ACT as Crisis Intervention Teams (CITs) is being used to serve this population. It differs from ACT in that the criminal background is considered and probation, parole or law enforcement officers are a natural part of the multi-disciplinary team. Davis (2008) reported that the use of ACT with mentally ill offenders being released from prison was shown to reduce recidivism.

Co-occurring disorders. Hartwell (2004), individuals identified with SPMI as disproportionately involved in the criminal justice system versus those without the co-occurring substance abuse. In response to those with co-occurring disorder, there is

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Mental Illness and Chemically Dependent (MI/CD) treatment programs that address and

treat the mental illness and the chemical dependency concurrently (Thompson,2003).

This design is shown to be effective in treating many offenders who have self medicated

their mental health symptoms by use of alcohol and street drugs (Ditton, 1999;

Thompson, 2003; Osher, 2003). An additional finding was that structured residential

living settings are a key component to stabilization after incarceration for the adult with

mental illness and a criminal background. These structured housing facilities provide

skills for independent living, accountability, medication management, daily routine and

MI/CD treatment (Lamb, 1999).

Collaborative between law enforcement and mental health professionals.

Thompson (2003), discussed community intervention teams being used throughout the

country between law enforcement and community mental health professionals and are

designed for the individual's access to mental health and corrections services

concurrently. The desired outcomes reduce encounters with law enforcement and

improve access to community mental health services to stabilize the individual's mental

health (Osher, 2003). Traditionally, many of the relationships between these two systems

are informal. Successful outcome measurements are different between these systems.

The system goal in mental health focuses on stabilizing the individual by managing their

mental health symptoms whereas, the criminal justice system solely measures recidivism

rates. Hatcher (2007, p.47) states "the need to improve collaboration… has been

identified as critical to improve service delivery" where he recommends this as an area

for further research.

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The research found both social work and criminal justice systems could benefit from cross-training are best implemented collaboratively and cooperatively (Thompson, 2003). Some examples were intensive mental health training for law enforcement officials to best manage adults with mental illness while detained in jail (Dooley, 2010). The use of direct service professionals in formalized roundtables comprised of those who serve adults with mental illness and the use of mutual aid. For example, social worker responding with law enforcement officer to the scene of an event involving a person with a mental illness and intake and assessment tools available in jail settings to identify mental illness. Symptom management and discharge planning were all used collaboratively throughout the research as well (Saunders & Marchik,2007; Osher, 2003; Draine & Herman, 2007; Steadman, 1999).

Summary of Literature Review

In summary, the research revealed that adults with living with a mental illness and a criminal background have been identified within the criminal justice system in large and growing numbers. The barriers this identified population encounters are numerous and difficult to overcome. Barriers such as homelessness due to lack of adequate housing, lack of employment, chemical dependency and difficulty with medication compliance. The members of this identified population must learn to navigate both systems as the systems themselves operate independently of one another creating significant gaps in the continuity of care. A key reason for this is attributed to the criminal justice system and the mental health system differences in measurements of success. Recommendations for future research was developing more formalized and reciprocal relationships between the criminal justice system and the mental health system

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to improve service delivery to this population (Mann, 2011; Saunders & Marchik, 2007;

Osher, 2003; Draine & Herman, 2007; Steadman, 1999).

Interventions have been implemented to assess and identify the presence of a

mental illness upon initial entry to the criminal justice system, e.g., law enforcement or

jail deputies for diversion and referral to mental health resources to reduce symptoms

while in jail without access to medication or mental health providers. Additionally,

diversionary programs to the criminal justice system, e.g., mental health court, is used as

a diversion to traditional sanctions and order mental health services and compliance to

reduce systems that further reduces contact with the criminal justice system for this

population. Finally, mental health responses to this population e.g. ACT team and CIP

(community intervention professionals) is to provide intensive, community based services

to monitor stabilization, med compliance and access to health related resources.

As we face unprecedented and significant cuts to the budget for health care and

mental health services, evaluating the costs and benefits of a collaborative may allow

professionals to adequately meet the need of this population by providing more

structured, holistic community services and may prove to be cost effective.

Conceptual Framework

Theoretical Framework

This research project is based on the medical model and criminal justice system

model because this population is involved in both systems and must navigate both

systems. The medical model is currently used as the foundation for the mental health

system (Vergare, et al., 2006). The model is deficit based and focuses on a cure or

management of illness or disease. The DSM-IV is used within the model to identify and

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diagnose psychiatric illnesses and the use of medication is heavily used for treatment (Vergare, 2006).

Within the medical model is the mental health system that incorporates the use of diagnostic tools and medication. In addition, several therapeutic interventions from the bio-psycho-social model are used and are evidence based, e.g., cognitive-behavioral therapy, dialectical behavioral therapy in an attempt to reduce mental health symptoms, increase community stabilization and move the person toward recovery.

Similar to the medical model, the criminal justice system is also deficit based as it provides protection of public safety through response, arrest, jail, judicial and corrections sanctions in an effort to reduce crime (Alexander, et al., 2006). The use of sanctions to deter further criminal activity many times includes jail and/or prison time, supervision in the community by a corrections professional and behavior expectations as indicators of successful reentry such as employment, housing, and abstinence from substances (Alexander, 2006).

Conversely there is a lack of preventative resources and services available within this system regarding skills and knowledge of serving the adult mentally ill population. Inmates who have mental illness are considered a sub-population to the greater population served within the corrections system.

Professional Framework

The researcher of this study has worked in corrections and in a community service setting that serves ex-offenders released from prison with a mental or physical diagnosis that presents barriers to successful reentry back into the community. By working collaboratively with outside agencies that focus on mental health and available

resources, the participant's served received enhanced or wraparound services that take on a holistic approach to the continuum of care for this population. In this work, it became evident that the majority of the population that participated in the demonstration project had an SPMI as well as chemical-dependency issues that heavily impacted the participant's adjustment to life back in the community. Housing, treatment and programs were limited for this population due to the nature of the offense and poor adjustment while incarcerated. As the demonstration project came to an end the need to serve this population was so evident that the social service agency continued to fund the program as a part of their mission to serve those with barriers to independence, education and employment.

In summary, the medical model focuses on the diagnosis and symptom management of the adult with mental illness whereas the criminal justice model considers public safety and recidivism rates to measure effectiveness.   The question becomes "what" is being done to close the gap between systems appears to be critical when addressing this population and established best practices?

Methods

The study was qualitative in nature and comprised of five respondents who work as social service professionals and have a multi-person perspective serving the identified population. Individual interviews were conducted at a variety of settings at a convenient location made by the respondents.

The purpose of this study was to identify barriers this population commonly experiences and best practices based on the perceptions of professionals who serve individuals concurrently involved in both the mental health and criminal justice systems.

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The perspectives of the professionals were examined in areas of skills and knowledge of

the mental health system and the criminal justice system and the impact training plays in

effective service delivery.

Sample

The researcher contacted the St. Paul chapter of NAMI (National Alliance on

Mental Illness) Criminal Justice Committee Chair and obtained the names and email

addresses of members that may be interested in participating in the study. A snowball

technique was used to further recruit the participants for the study (Berg, 2008). As a

result, five individual interviews were conducted at various locations in the Twin Cities

metro area. All respondents were social service professionals, each from different

agencies serving the identified population from a variety of perspectives. An

introduction letter and an attached consent form were attached in an email and phone

contact made with respondents to arrange logistical details and answer further questions.

A description of the study was attached to the emails as well.

Protecting Human Participants

Recruitment. Informed consent was given that included protection and

confidentiality. The consent assured the respondents that the interview was confidential

and the audio recording and transcriptions would be destroyed upon completion of this

research project.

Confidentiality. The interviews were confidential and there were no

confidentiality concerns expressed by any of the respondents. Agreement to

confidentiality of the respondents was sought, clarified and signed by both the respondent

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and the researcher. No one but the researcher had access to the raw data gathered in the

interviews and the audio recording and transcribed interviews were destroyed.

Informed consent. The participant received written informed consent at the

beginning of the interview. Signed consent was given by each respondent and all

questions were answered before beginning the interview (See Appendix A).

Data collection and instrument. The data was collected from individual

interviews of five participants who responded and were asked a series of eight qualitative

questions based on prior research. An example, how important is training and knowledge

of both mental health and criminal justice perspectives? (See Appendix B for a full list of

the individual interview questions). The interviews were held in private locations to

ensure confidentiality.

Data analysis. Content analysis of the data collected was used to identify themes

within the participants' responses. The individual interviews were transcribed and ideas

were examined and grouped into codes and themes. The researcher analyzed the data by

interpreting the transcribed interviews; identified themes by coding specific words as

well as examining the data line by line for similarities and then differences. Specific

words were used for coding and findings consisted of three or more with similarities

equaled a theme (Berg, 2008).

Findings

The sample was comprised of five respondents that are social service professionals, each

from different agencies serving the identified population from a variety of perspectives. The

level of experience the professionals had working in social services ranged from two years to

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thirty plus years. The gender make-up of the respondents was three male and two female.

Additionally, three respondents were Caucasian and two African-American.

There were five themes identified in this research project; the growing number of this

population; common barriers; role and impact of chemical dependency; lack of sufficient

training; and need for more collaboration.

Growing Number of Population

All five respondents acknowledged an increase in the number of clients they serve who

have criminal backgrounds. The growing number of clients being served by social service

professionals who live with a mental illness and have a criminal background is based on the

frequency of response to their knowledge of the identified population. According to one

respondent, "I think people with disabilities don't all have criminal backgrounds but a lot of

people with criminal backgrounds have disabilities."

This explains the perspective the professional is coming from and the nature of

their relationship with the identified population. Two of the five respondents have

worked directly with the identified population in programs that specialize in ex-offender

reentry services. All five of the respondents worked for non-profit, community based

agencies and primarily serve those with mental health and/or physical barriers from a

variety of perspectives.

Common Barriers

All five respondents agreed that there several barriers this population experiences to

community stabilization that differs from those living with a mental illness and do not have

criminal backgrounds. The two barriers identified as most commonly experienced are housing

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and employment. One participant said, "Working with people who are chronically homeless, I

have a few who are their lives on the street are a direct result of having been in prison".

The frequency of response from the participants regarding barriers was identified

as housing and employment barriers. The impact these barriers have on the individual

and the natural tendency to get basic needs met such as housing over priority to

medication management or finding employment to avoid returning to jail or prison.

Additional barriers regarding housing is the inability to sustain the housing to due lack of

income or chemical dependency resulting in the loss of housing.

Chemical Dependency

All five respondents acknowledged that chemical dependency was a significant problem

with this identified population and expanded on how chemical dependency interferes with

stabilization of the individual due to an increase in non-medication compliance and the role

chemical dependency plays in criminal behavior. One respondent stated "Chemical dependency

is a big problem with the clients I see".

The respondents reported that chemical dependency spills into all areas of the client's life

and it adds to the housing and employment barriers even for those without a criminal

background. Three of the respondents felt that drug addiction does lead to committing crime

such as property crimes to get access to money.

Lack of Sufficient Training

The need for formal training was identified by frequency of response regarding serving

this population as necessary and was noted unanimously by all respondents. The need for more

formalized training opportunities is desired when serving this population. The process of

learning about best practices and interventions are mostly gained due to the professionals' level

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of on the job experience by demand or personal interest to respond to the needs of clients. All

respondents expressed a need for more available training opportunities to obtain a basic

understanding of the criminal justice system and how to navigate it to best serve their clients.

Three of the five respondents reported attending trainings at government agencies in the past,

such as county mental health centers and police departments and corrections agencies about this

population from a variety of perspectives but all respondents sought the trainings on their own.

The following quote is an example of this theme. "I don't have professional training per say, I

have over 30 years of experiential training and as a result find myself offering trainings about

this population as a result."

Need for More Collaboration

All respondents reported that due to the growing number of clients being served by social

service professionals that collaboration with probation or parole officers at a micro level would

be helpful but also the need for the systems to collaborate more in areas where the identified

population is being served by both systems. An example of the responses was summarized by

one respondent who said

"Collaboration, between both systems would be so helpful."

All respondents reported a lack of collaboration with criminal justice professionals and

would like to work more collaboratively around shared clients. Difficulty coordinating

schedules and large caseloads were cited as barriers to collaboration.

Discussion

There were five themes identified in this research paper, the number of this population;

housing and employment as most common barrier; lack of sufficient training; and formal

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collaboration. The following includes a discussion on the findings and implications for further study and relationship to social work.

Increased Number Identified Population

All participants acknowledged an increased number of clients who have both a mental illness and criminal background being served in mental health or rehabilitative as mental health practitioner, case manager, employment counselor and program manager all in community based agencies. Previous literature finds that since the deinstitutionalization of state run mental health facilities the number the offender population has risen. Systemic failures were identified as contributing to the lack of community resources available that contribute to the increase in this population.   (Mann, 2011; Thompson, 2003; Lurigio, 2001; Steadman, 1999). More recently, this identified population has gained recognition on a macro-level as a result of the large prison and jail populations throughout the U.S. and identifying those with a mental health diagnosis while incarcerated (Torrey, Kennard, Eslinger, et al, 2010).

Barriers

According to Rich (2009) the many individuals with criminal backgrounds also face similar reentry difficulties. For the individual living with a mental illness and criminal background the likelihood of homelessness and difficulty obtaining and keeping housing occurs at a higher rate. All respondent's identified housing the criminal background itself as a barrier to accessing resources primarily employment and housing this population experiences. Rich (2009), compared difficulty in obtaining housing being similar to those with criminal backgrounds alone. All respondents reported that the majority of the client's that have a criminal background are living in homeless or substandard living e.g., couch-hopping, living in shelters and outdoors as well as the increasing level of difficulty with them finding housing even in what

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used to be considered "bad neighborhoods" due the frequent use of criminal background and credit checks performed in routine housing applications. Thompson (1999) found that due to criminal backgrounds there is a significant number of the identified population that experiences homelessness. One of the respondents noted that housing resources known to rent to people with criminal backgrounds are cleaning up the properties and no longer accepting criminal backgrounds in future tenants thus further limiting housing options. Three of the five respondents discussed hierarchy of needs to explain how this client population is essentially "set up to fail by design" such as landlord and employer reliance of criminal background checks to making housing and employment decisions.

Of the five respondents, four reported that substandard housing in high crime and high drug use communities are typically where many of their client's were forced to live as a direct result of their criminal background and the impact that has on the individual stabilizing.

The second most commonly identified barrier cited by respondents identified employment to be another primary barrier this population experiences. The respondents attribute employment as a barrier primarily due to criminal background checks, lack of skills and training and homelessness as the barriers to employment.   Previous research in this study was not exhaustive and did not address the issue of employment as a resounding common barrier this identified population experiences.

Additional barriers reported by the respondents were the terms of probation or parole are separate from mental health treatment goals such as the lack of planning and building routine from a and expects that an individual be available for impromptu meetings or having to show up at a random UA sites for drug testing.

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Chemical Dependency

All five respondents reported chemical dependency as a significant barrier to community stabilization and successful outcomes. Chemical dependency was identified as contributing to non-compliance with medication as well as the inability to obtain and maintain housing and employment. Lamb, et al (1999), reported that over 80% of those diagnosed with mental illness are chemically dependent independent of a criminal background and those with criminal backgrounds without a mental illness are also disproportionately chemically dependent. The respondents did link chemical dependency and a criminal background for crimes that are result of the intoxicated behaviors, such as arrests for public intoxication or disorderly conduct, disturbing the peace. Additionally, three respondents reported more serious offenses such as theft, robbery and drug-dealing to make money to support the habit.

Training

The need for training was unanimously indicated by the respondents as really important in order to better serve their clients and gain more knowledge of the identified populations overall.   Some of the participants suggested possible on-site trainings by the employer to satisfy mandatory training needs. Additionally, offering CEU's may also be of benefit to encourage participation for larger local trainings. The respondents reported little to no training on this population specifically and upon encounter and some do not currently feel sufficiently trained when serving this population. All five respondents reported having gained most of their experience either through need to learn in order to serve a client or by personal interest in the population. Previous literature regarding practice trends is the training of both mental health and criminal justice professionals that includes specialized services, e.g., roundtable or multi-agency team approach.

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Lurigio (2001), reports a duty for social workers to be trained serving this population due

to the multitude and significance of the barriers and finds the same for corrections

professionals. Findings of this research project reveal a need for a more formalized

training experience for social workers that include training around basic corrections,

access to resources navigating systems and more shared information to better serve

clients. The reported training needs have been identified in previous research (Saunders

& Marchik, 2007; Osher, et. al, 2003; Draine & Herman, 2007; Steadman, 1999) as

needed to better serve clients and improve community stabilization outcomes. Finally, as

a result of the demand for this training two of the five respondents provide training on

this population to mental health and corrections professionals in a variety of community

and government settings.

Collaboration

The desire to work more collaboratively with law enforcement, corrections and judicial

personnel was also indicated as very important. Collaborative efforts starting on a micro level

was considered more realistic than a full merging of the systems. This shared responsibility of

the individual's stabilization and compliance with probation or parole requirements was

identified in the literature and more informal and required a mutual respect and understanding

between the service providers (Lurigio, 2001). Three of the respondents reported a desire to

learn more about navigating the corrections and judicial systems and coordinated care meetings

such as, attending treatment planning or case management meetings between the client's mental

health and criminal justice system professionals. One respondent reported the level of

involvement was to provide progress information to the probation officer over the phone without

mutual sharing of information. Conversely, one respondent that worked on an ACT team

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reported a working relationship with local police regarding well-being calls for assistance as the

primary interaction with criminal justice professionals.

Implications for Social Work Practice

The implication for social work practice recommends the use of more assessment tools to

gain a better understanding of the client's overall level of functioning and consideration of the

criminal background be made in treatment planning and other mental health oriented

interventions. Also, improving communication with the criminal justice professionals by having

coordinated meetings with the shared client to clarify and streamline goals and expectations has

been identified as helpful when serving this population. Additionally, social work practice

recommendations was to develop a list of resources available to the social service professional to

provide to clients that address barriers such as housing, employment and other basic resources

and referrals. The use of mental health discharge planning while the client is still incarcerated

should continue to be used and with greater frequency.

Implications for Social Work Policy

Implications for social work policy revealed a need to utilize more "in-house" trainings at

the professionals' workplace and offer continuing education credits for licensure standards.

Training that focuses primarily on this population has also been identified and learning how to

navigate systems where the client meets the two systems. This could be accomplished by

offering it social work students in both the classroom and more internship opportunities outside

of traditional social work settings, e.g. corrections or judicial system education about this

population.

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Implications for Future Research

Recommendations for future research with this population might include the use of a survey to gain a larger response from a variety of professionals including law enforcement and corrections professionals regarding the perceptions of those in other disciplines compared to those in social services. Another recommendation is to research implications this research has on communities of color, primarily African-American, regarding access to community mental health services and the availability of culturally specific mental health services. The final recommendation is to research the outcomes of clients of this identified population and community stabilization when served by non-specialized social service providers vs. specialized social service providers, e.g., mental health court. Previous research suggests that outcomes are improved when there is system collaboration and representation from all providers involved in client's life.

Strengths and Limitations

A strength of this research was the use of individual interviews that allowed for a more in-depth interview of the respondents without concern of a dominate focus group member preventing full participation of members. These social service professionals had a multi-person perspective working with adults living with a mental illness and involved in the criminal justice system. The respondents came from a variety of social service settings and had varying degrees of experience ranging from two to thirty plus year's experience in the mental health field.

Limitations of this research were that the identified population did not participate in this research due to time constraints and complexities beyond the scope of this paper. There was not a cross section of professionals such as law enforcement and corrections

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professionals that who also serve this population. Finally, due to brief amount of time allowed for this research and lack of money a larger sample was not available.

In summary, this ever growing population is emerging in various social service settings and requires special considerations. Training and collaborative efforts were identified at both a micro and macro level as needed to improve service delivery. Common barriers such as, lack of housing and employment opportunities pose significant risk factors for homelessness with this population and results in increased contact with the criminal justice system and return to jail or prison. The costs associated with one individual receiving separate service from both systems should be assessed to identify areas to improved service delivery as well as cost reduction.

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APPENDIX A

CONSENT
FORM
UNIVERSITY OF ST. THOMAS

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What are the perceptions of professionals who work with adults with mental illness who are involved in the criminal justice system?

I am conducting a qualitative study about the perceptions of professionals who work with adults with mental illness who are involved in the criminal justice system. You were selected as a possible participant because you have experience working with this population and have the knowledge and skills about perceptions of barriers and best practices when serving this population. This subject is important as we further examine the statistics and treatment and recidivism and whether or not there are known best practices. Please read this form and ask any questions you may have before agreeing to be interviewed.

This study is being conducted by: *Researcher; Committee Chair; University of St. Thomas, School of Social Work Department.*

Background Information:

The purpose of this study is to identify perceptions of barriers and best practices when serving adults with mental illness who are involved in the criminal justice system and examining skills and knowledge of both the mental health system and criminal justice system from differing perspectives.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participant in the qualitative focus group facilitated by this researcher.

Risks and Benefits of Being in the Study:

The study has minimal risks which means that the likelihood of harm or discomfort to you in the research are no greater than risks ordinarily encountered in daily life or during the performance of routine interview questions.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create will be an audio recording of the focus group that will be destroyed upon completion of my project, May, 19, 2012.

Voluntary Nature of the Study:

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Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas.

If you decide to participate, you are free to withdraw at any time up to completing the focus group. Should you decide to withdraw after that time; data collected about you will still be used for data collection purposes. You are also free to skip any questions I may ask at the time of the focus group.

Contacts and Questions

My name is XXX. You may ask any questions you have now and prior to the beginning of the interview. You may also contact my Committee Chair, XXX via email at XXX. Additionally, you may also contact the University of St. Thomas Institutional Review Board at XXX with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

By completing the interview, you are consenting to participate with this research.

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Appendix B

Qualitative Questions for Focus Group and/or Individual Interviews:

The overall research question asks "What are professionals' perceptions about serving adults with mental illness who are involved in the criminal justice system?" My hypothesis will be that previous research will be supported and that the professionals will identify similar barriers and best practices as found in the literature review. This researcher will use partner reliability check upon transcription of the raw data to develop and code focus group response themes.

Qualitative Questions for Focus Group and/or Individual Interviews:

1.   In what ways do you feel adequately trained as mental health professional/as criminal justice professional working with adults with mental illness who have criminal backgrounds?

        a.   How did you get the training?

        b.   Is the training ongoing?

2.   How important is training and knowledge of both mental health and criminal justice perspectives?

3.   What role does chemical dependency play in successful outcomes?

4.   What are the barriers that prevent adults with mental illness from being successful in the community?

5.   What needs to change to improve successful outcomes from both mental health and criminal justice perspectives?

6.   How do you define successful outcomes?

7.   Give an example of how you have worked collaboratively?

        a.   What barriers prevent working collaboratively more often?

        b.   What recommendations do you have to improve collaboration efforts?

8.   What other factors do you think contribute to best practices that we haven't touched on?