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Mental Health Professionals Working in Prisons: Their Perspectives on the Quality and Availability of Treatment and Therapy for Mentally Ill Inmates

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This is to certify that the doctoral dissertation by

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Walden University
2022

Abstract

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by

Tara S. Harvey

MA, Walden University, 2020

MA, Kaplan University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Forensic Psychology

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Abstract

The perspectives of mental health professionals who work with inmates who have serious and persistent mental illnesses is largely unknown. Prisons, law enforcement, and the courts may all benefit from understanding these perspectives regarding how to treat the mentally ill in the criminal justice system (CJS). Many studies (mostly quantitative) have been conducted to address the increase of mentally ill inmates and have focuses on different areas of this phenomenon. However, to date, no qualitative studies have been located that depict the perceptions of mental health professionals working in prisons and their viewpoints regarding this population's access to quality and available treatment and therapy. In order to understand the perspectives, interviews were conducted to determine themes involving the professionals' perspectives. The theoretical framework for this study was based on the deprivation theory and the importation theory. Those providing mental health treatment/therapy in prison have provided their perceptions. The data were analyzed after hand-coding and theming transcripts with the use of Microsoft Excel spreadsheets. This qualitative research involved interviews of nine mental health professionals working in prisons. Results of this study were mixed; some seemed to be protective of their facilities initially, yet as questions continued, they suggested an ability to improve. Conclusions of the study are the best medications are not used due to either abuse or lack of resources. The primary recommendation is a great deal more research should be performed in order to create best practices. The implications for social change are congruent with current movements for criminal justice reform. Diverting mentally ill individuals out of the CJS will be more cost effective and a demonstration of humanity.

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Dedication

This dissertation is dedicated to my husband, Michael Harvey. His love and support have made the difference between attempting this journey and completing it. He is my rock. I will never be able to thank him enough for all he has endured during this ride in order to allow me to achieve my objective. It is also dedicated to my sons, David and Jordan Patterson. David has been so very supportive during all of the issues I faced during this process. I am extremely proud of him. Prior to his death in April of 2021, my 29-year-old son, Jordan, was equally supportive and proud of me. I will miss you forever.

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I would like to acknowledge Dr. Brown (Chairperson) and Dr. Kimberly McCann (Second Committee Member) for their guidance and encouragement throughout this process. The word “acknowledge” does not adequately express my appreciation. Their knowledge and experience were inspirational and made this journey much less arduous than it could have been. Dr. Brown’s empathy and vast intelligence is astounding.

I would also like to acknowledge my sisters, Denise Jenkins and Joycelyn Bennett as well as CMSgt (Ret) Ann “Debbie” Stocks. My sisters championed me through this endeavor and kept me on track throughout the process. Their collective belief in me kept me going through the hard times and their praise was instrumental in keeping me moving forward. More than two decades ago, Chief Stocks became my mentor and has continued to be my role model. Without her example, I would have never believed I could do this.

During this journey, my husband and I suffered several extreme losses, and I experienced several acute medical conditions. We lost my mother, his father, two of his uncles, his aunt, two of our dogs, and most devastating, our son. At times I was not sure I would be able to continue on with this program. I am very grateful to all the individuals who encouraged me and reminded me the people I lost would want me to finish.

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Chapter 1: Introduction to the Study

In this qualitative study, I examined the perspectives of mental health professionals working in prisons regarding the level of care, the availability of treatment, and the accessibility of therapy for mentally ill inmates. I used answers to interview questions regarding the experiences of mental health professionals working in prisons to investigate potential issues and/or subjective ideas for remedies. Using the data that I collected, I was able to determine guidance for the safety of prison staff, fellow inmates, and ostensibly the public at large, when mentally ill inmates are eventually released from prison.

Much of the literature on the subject are quantitative studies regarding the statistical increase in the number of mentally ill inmates and the inadequacy of care provided while incarcerated (Barrenger et al., 2017; Bebbington et al., 2017; Chow et al., 2019; Daquin & Daigle, 2018; DeHart & Iachini, 2019; Hutchison, 2017; Jüriloo et al., 2017; Martin et al., 2018; Nardi et al., 2017; Torrey et al., 2017; Velasquez et al., 2020). I designed this study to examine the perspectives of individuals who work in these institutions, as they may be more experienced and knowledgeable on the subject. I used a qualitative method for this study, to determine meaning of the information obtained (Dahlberg & Dahlberg, 2019).

I conducted interviews with mental health professionals working (or having worked) in prisons to determine their perspectives on prisoners with mental health issues. I used the narrative responses of the participants to highlight themes to discover an apparent consensus and the obvious diversions of perspectives. I noted, addressed, and

weighed deviating ideas against the consensus. I incorporated ideas from previous research regarding the care and treatment of mentally ill inmates; however, to date, no qualitative studies regarding the perspectives of mental health professionals working in prisons have been discovered.

Background

Public sentiment has always been and always will be a key component in determining legislation and developing policies. Historically, it was acceptable to place individuals who were not deemed to be normal in institutions and out of public view (Slate, 2017). As a consequence, state run and private psychiatric facilities became overcrowded and numerous horror stories arose regarding the facilities and their practices (Waldron & Waldron, 2020). As communities became aware of the inhumane conditions in some institutions, the public viewpoint changed to believing these facilities should be closed or significantly modified. The changing public mindsets have potentially created an unforeseen and unintentional domino effect leading to the incarceration of the mentally ill.

Slate (2017) provided a rich, comprehensive chronicle of the deinstitutionalization movement in America for individuals with mental illness being housed in inpatient mental health facilities. His narration of events indicated an extreme reduction (94%) of inpatient residents since 1955 and the subsequent criminalization of mental illness. He suggested an alternative to criminalization is therapeutic jurisprudence. According to Torrey et al. (2014), the number of mentally ill inmates substantially exceeds (by more than 10 times) the inpatient population of psychiatric facilities in the United States. A

follow-up article by Torrey et al. (2015) demonstrated the available beds for inpatient psychiatric stays, compared to 1955 (the beginning of the deinstitutionalization movement), are between 2.4% and 19.8% less among the respective states. The citation above is regarding Torrey et al. (2015) It should be noted E. Fuller Torrey's practices of forced, coerced, and deceptive mental health treatment has been rigorously debated and condemned by some (Szasz, 2004).

Moving on from mental health treatment in psychiatric institutions, the current research is focused on treatment within prison facilities. This focus is due to the much larger percentage of mentally ill inmates as opposed to psychiatric facility patients. Mulvey and Schubert (2017) espoused a great deal of progress needed to be made regarding how mentally ill individuals are treated and processed in the criminal justice system (CJS). They suggested programs need to be changed and/or added and a complete overhaul of the system is necessary. Revamping the system might be accomplished by ensuring availability of treatment, diversion of people with mental illness out of the CJS, proper training for criminal justice personnel, effective use of data, and revitalization of re-entry programs (Mulvey & Schubert, 2017).

Many professionals in the field concur with these ideals yet have differing perspectives and foci. For instance, Wester (2018) performed a quantitative inquiry via survey to determine the roadblocks to proper mental health treatment of mentally ill inmates. Wester (2018) concluded the barriers were consistent across the state of Tennessee regardless of the facility's population size. The obstacles included lack of funding, insufficiently trained personnel, and insufficient number of staff. Additionally,

inmates maintain the constitutional right to be free from cruel and unusual punishment (8th Amendment) and prisoners are entitled to medical care (*Estelle v. Gamble*, 1976). Part of medical care is mental health care and in *Estelle*, the Supreme Court stated the care should be "adequate." The word is highly subjective and immeasurable in terms of mental health treatment. Goldberg (2016) proclaimed the level of mental health treatment in prisons is "inadequate" and further suggested constitutional rights of the mentally ill in the CJS have not been addressed in a manner which might change policy.

The personal experience of Misra (2016) reinforced Goldberg's (2016) claim of inadequacy. Misra (2016) discussed his 6-month rotation of psychiatric residency in a county jail and stated the availability of services for mentally ill inmates was stark as compared to that in the community. He claimed the volume of mentally ill inmates compared to the number of mental health professionals is an extremely skewed ratio. While he acknowledged more mental health professionals should be employed by the incarceration facilities, he advocated for mentally ill individuals to be diverted out of the CJS. Capuzzi et al. (2019) discussed this idea in terms of referring these individuals to high security forensic services (HSFS). These facilities focus on the mental health of an individual while maintaining physical control much like that of a prison. The majority of state hospitals have that capability yet have been nearly or completely closed down.

While punishment is an obvious purpose of incarceration, rehabilitation is an alleged co-occurring purpose. It is reasonable to suggest an individual should not be punished for being mentally ill any more than a person should be punished for having leukemia. Additionally, if treatment and therapy are deemed to be substandard for those

with mental illness in prison, there is an extreme unlikelihood of any type of rehabilitation. The evident reason for rehabilitation is the individual's presumed and expected return to society. Following a study by Angell et al. (2014) declaring the imperative nature of accurate and effective re-entry programs for mentally ill inmates in the prevention of recidivism, Barrenger et al. (2017) claimed research has produced mixed results regarding the efficacy of re-entry programs. Kendall et al. (2018) echoed the sentiment of the 2014 study and suggested quality mental (and physical) health care during incarceration is vital to a successful re-entry into the community.

Gonzalez and Connell (2014) identified a lack of continuity in treatment and medications for inmates as a significant issue which results in the higher potential for recidivism and a potential danger to public safety. They urged prison administrators to ensure proper mental health screening procedures upon inmate intake and to treat mental and physical health issues inmates may have. The public safety sentiment discussed by Gonzalez and Connell (2014) was reiterated by Perera and Sisti (2019) in their linkage of deinstitutionalization and increased mass shootings. However, many experts suggest those with mental illness are more likely to be victimized rather than act as an aggressor (Daquin & Daigle, 2018; di Giacomo & Clerici, 2020).

Shaffer et al. (2019) discussed a range of proposed interventions that may decrease the number of mentally ill individuals in confinement settings. They discussed the lack of community-based treatment programs, the need for law enforcement training when responding to an incident with a mentally ill individual, the potential for pretrial diversion programs, re-entry programs for mentally ill people leaving prison, and the

need for unity amongst mental health systems and the criminal justice system. Their focus was on individuals with serious mental illness (SMI) and used the 2017 definition provided by the National Institute of Mental Health (i.e. – mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities).

While there is a heightened awareness regarding the increased number of mentally ill inmates, a viable solution for the problem has not been identified. Though the implementation of mental health courts (MHC) across the United States has been touted as a successful solution, the number of mentally ill inmates continues to increase (Scott, 2020). My research assisted me in identifying recommendations made by the professionals in this field who were working with mentally ill inmates. Those recommendations are largely suggestions for additional research.

Problem Statement

Although there are theories as to why the population of mentally ill inmates has significantly increased, it is unknown how the mental health professionals in prisons perceive the influx, the quality of treatment, and the availability of therapy. Since 1955, when the inpatient population in mental health institutions reached its peak, there have been several movements to deinstitutionalize mentally ill individuals in order to allow them to lead full lives in the community (Slate, 2017). Following the deinstitutionalization movements, the mentally ill population has been overrepresented in prisons (Mulvey & Schubert, 2017). Mulvey and Schubert (2017) claimed 56% of prison inmates and 64% of jail inmates suffer some form of mental illness; however, they

included all mental illness diagnoses in the majority of their study. They specifically suggested individuals with serious and persistent mental illness (SPMI) be diverted from the criminal justice system entirely (Mulvey & Schubert, 2017). AbuDagga et al. (2016) surveyed jails across the United States and stated 21.3% of the jails had a SPMI population greater than 16%. In this current study, I focused on the perceptions of the mental health professionals who treat the inmates with SPMI and the effect their disorders had regarding their respective crimes, arrests, and incarcerations.

A lack of community-based services can lead to the mental decompensation of those suffering from mental illness and create a greater likelihood of situations in which law enforcement officers are enlisted to respond to events in order to ensure public safety (Wood & Watson, 2016). The unavailability (or limited availability) of community-based treatment and attempts of psychiatric rehabilitation via community resources are cited as reasons for the United States Department of Justice (USDOJ) filing lawsuits against states. The lawsuits devolve into settlement agreements (SAs). They are potential reasons for increased incarceration rates of the mentally ill. The situation is likely to become critical in North Carolina with a proposed budget cut of $9M in 2019–2020 in mental health funding (Stone, 2019). However, that budget cut did not occur largely due to the 2020 pandemic (Hoban, 2021). The deinstitutionalization movements to release mentally ill individuals from psychiatric facilities when infringement on liberties is not warranted started a domino effect for this vulnerable population (Slate, 2017).

The movement for deinstitutionalization began in the United States when the inpatient population in psychiatric facilities reached roughly 559,000 people in 1955 and,

today that number is assessed to be approximately 35,000 people, a 94% reduction (Slate, 2017). In a confinement setting, mental health professionals who treat individuals with mental illness may have a different perspective on the necessity of incarceration of the mentally ill and on the treatment programs available (Misra, 2016). Because these professionals also treat inmates with substance abuse issues, brain trauma, and cognitive impairments, they are able to distinguish between different illnesses and disorders, thereby providing insight to their perceptions based on first-hand experience (Misra, 2016).

In this study, I focused on individuals who treat those with SPMI or severe mental illness (SMI), the treatment and therapy available in prison settings, and their perceptions regarding incarceration of this population. It is essential to research the content of the mental health programs from the viewpoint of the mental health professional working within prison settings in order to determine if they have adapted to the influx of those incarcerated and diagnosed with SPMI/SMI in confinement settings.

I reviewed literature regarding evidence-based mental health treatment programs to identify the increased population rate (Thomas & Watson, 2017). Numerous articles included discussions regarding statistical data, literature reviews, and/or meta-analyses, and recommend additional research be performed on the topic (Daquin & Daigle, 2018; Hoffman et al., 2016; Hopkin et al., 2018; Nardi et al., 2017; Rukus & Kulkarni, 2019). Few qualitative studies have been performed regarding mentally ill inmates and to date, I have not discovered any qualitative studies based on the perspectives of the mental health professionals working with the inmates. However, there was a comprehensive

quantitative study performed in 2016 regarding a survey of staff members in jails across the United States by AbuDagga et al. (2016). The report indicated many responses to the open-ended questions contained "valuable [and] lengthy" feedback regarding staff interaction with inmates with SMI (AbuDagga et al., 2016, p. iii). The authors suggested a qualitative study could furnish rich detail and provide insight previously unknown in the field.

Purpose of the Study

The purpose of this qualitative descriptive study was to explore the perspectives of mental health professionals working in prisons and their descriptions of the treatment programs provided to mentally ill inmates. Specifically, I addressed the treatment for inmates with SPMI as described in the Diagnostic and Statistical Manual – 5 (DSM-5) (American Psychiatric Association, 2013). In responding to interview questions, participants were able to disclose their perspectives through a narrative response.

Given my goal for the study, a descriptive design was appropriate to code the perspectives of mental health professionals who work with mentally ill inmates. While previous studies have provided statistical data on the subject, the rich detail associated with qualitative research was appropriate for studying the perceptions of mental health professionals working with mentally ill inmates in order to broaden knowledge in the field. Dahlberg and Dahlberg (2019) recognized quantitative research as a dominant form of study yet claimed it may be insufficient when researching issues such as health and illness of human beings. They strongly advocated for the use of qualitative research in

this area. I used a descriptive design to examine new information and assist in filling the gap in the literature.

The nature of this study is qualitative using a descriptive approach, as explained by Dahlberg and Dahlberg (2019) in their defense of qualitative research. I used this approach to determine commonalities and differences in the descriptions provided by the mental health professionals working in prison settings. I explored the descriptions provided by mental health providers within the prison setting to understand if these professionals perceive current programs as adequate and if their descriptions highlight trends of information which depict the adequacy of care, as discussed by Hutchison (2017). Because the most recent deinstitutionalization movement of implementing USDOJ SAs has been a factor in ensuring mentally ill people are not placed in inpatient settings when not warranted, it is beneficial to understand how prison mental health professionals describe their patients' care and subsequent conduct in the prison setting. Experts in the field suggested the prison population in the United States is heretofore unprecedented and the number of inmates with mental illness has superseded that growth in percentages (Bowler et al., 2018; Bronson & Berzofsky, 2017; Hopkin et al., 2018). Although there are more individuals in prison overall, the rates of those with mental illness has increased at a higher rate than the general population. Hutchison (2017) indicated the United States comprises approximately 5% of the world's population yet incarcerates 25% of the world's inmates; Wagner and Bertram (2020) claim that percentage is 20%.

Framework

At the core of the current study is the population of mentally ill inmates as discussed and described by their mental health care providers in prisons. I used the deprivation theory, developed by Samuel Stouffer, and the importation theory, developed by Irwin and Cressey, as the theoretical framework for this study to develop insight regarding the inmates. Lahm (2016) suggested scholars in the field ascribe to one theory or the other; however, the two are not mutually exclusive and, according to Bumberry and Grisso (1981), both theories can be used to assist in explaining inmate behaviors. I used both of these theories to develop the interview questions for the participants in this study.

Moon and Tillinghast (2020) discussed the differences in the two theories as they apply to inmates and both theories were relevant for this study. The deprivation theory addresses the indigenous prison culture with inmates being deprived of autonomy, heterosexual relationships, freedom, security, and goods/services (Moon & Tillinghast, 2020). Those deprivations may contribute to adverse behaviors among mentally ill inmates as witnessed by the mental health professionals. The importation theory is particularly relevant to this study in that the inmates being discussed have likely been diagnosed with a mental illness prior to being sentenced to prison (DeLisi et al., 2011). Since the importation theory suggests inmates enter prison with their own beliefs and cultures, it would likely be true the prisoners also import their respective mental illnesses, whether or not they were diagnosed prior to entering prison.

I also used the therapeutic jurisprudence framework because the goal is for the criminal justice system to "address the overall well-being of the individual" (Arstein-Kerslake & Black, 2020, pg. 1). This framework specifically targets individuals with higher recidivism rates and mentally ill inmates frequently fit the category. The idea behind therapeutic jurisprudence is to enlist a multidisciplinary team to discuss all aspects of the offender which may have contributed to the alleged or actual criminal activity. I considered the mental health aspect of the therapeutic jurisprudence framework when developing the interview questions for respondents and understanding the descriptions provided by mental health professionals who participated in this study.

Because the study was qualitative in nature and the viable analysis method was interpretive phenomenological analysis (IPA), I audio recorded participants during semi structured interviews to enhance probing questions based on responses. I created the questions I asked based on a comprehensive literature review and the recommendations for further research provided in the literature. I did not note body language or tone during interviews because video recording participants was not permitted. I analyzed the transcripts of the interviews using IPA in order to ensure a detailed depiction of the interviews was provided (Smith & Osborn, 2015).

I designed the interview questions to elicit detailed responses from mental health professionals who work in the prisons about the interactions they have with mentally ill inmates and the programs/treatment available within the prisons. I paid special attention to the number of years of experience and types of experience the participants had in order to analyze their responses accordingly. For example, if the position an individual has had

was their current position, they have little to compare to their work experiences outside of a prison setting. That scenario is vastly different than an individual who had worked outside of a prison and in a different capacity or who had worked in the field with inmates for more than a decade. I differentiated the experience level in the research analysis.

Research Question

The research question for this study was: How do mental health professionals working in prisons describe their individual perceptions of the quality and availability of mental health care provided to inmates?

Nature of the Study

I conducted interviews with mental health professionals in prisons and themed and coded the collected data. Participants gave their personal perceptions based on personal observations and experiences. I encouraged the participants to share experiences with inmates (keeping confidentiality a priority) as a source of secondary data to fully explain their perceptions. I used IPA to analyze the personal accounts of the mental health professionals working in the prison setting. The volunteers participating in the study responded to my requests for volunteers via social media groups (e.g. – Black Mental Health Professionals, Mental Health Professionals, Prison Reform Movement, etc.). Some of those volunteers forwarded invitations to coworkers or others who fit the criteria for participation in the study. The snowball method was a valuable tool for locating participants.

The nature of this study was qualitative and I used a descriptive approach, as explained by Dahlberg and Dahlberg (2019) in their defense of qualitative research. I used this approach to determine commonalities and differences in the descriptions provided by the mental health providers in prison settings. I have discovered no qualitative studies regarding this group to determine how mental health professionals in the prison view the interventions, diagnoses, prognoses, and overall treatment in their respective facilities. I coded and themed the personal perspectives of these professionals regarding mental health programs and their descriptions of inmates and interactions with the inmates. The diverse experiences each participant had working in prisons, with juveniles, in communities, and in private practice was helpful for me to determine similarities and differences noted in the themes. I used a qualitative approach to determine the mental health professionals' perspectives of the level of care, quality of treatment, and availability of programs for mentally ill individuals in prison as seen and described by mental health providers.

Scope and Limitations

Working for the government can be political and if respondents in the study had been employed by a single prison sanctioned by and aware of the participation, they may have felt pressured to provide the "right answer" to avoid criticism from supervision. Additionally, due to many states currently undergoing a SA with the USDOJ, state prison officials were not inclined to grant this research request. Each mental health professionals' level of experience was determined in order to weigh the validity of each opinion. Some mental health care providers were unaware of the deprivation theory and

importation theory and did not supply enough information to fully answer the questions posed in the interview. This is a limitation because the structure of my study did not allow for creation of any criteria (aside from the criterion to have a minimum of one year of experience of working with SPMI inmates) to ensure the most knowledgeable individuals were included.

Although the study was inclusive of all volunteering mental health professionals responding to social media requests and subsequent snowball sampling, the varying levels of expertise caused the answers to some questions obtained to lack significant themes. However, the homogeneity of opinions regarding certain questions tended to be thematic. Respondents verbalized viewpoints which created a relatively synchronistic mentality among staff working in different jobs at different facilities. Coding the data proved to be challenging because it appeared to reach a saturation point prior to completing interviews of the number of intended participants.

Significance and Implications for Social Change

A great deal of the current literature focuses on the quantitative increase of mentally ill individuals who are incarcerated (Hutchison, 2017; Meyers et al., 2018; Mulvey & Schubert, 2017; Nardi et al., 2017). Mental health courts and other types of diversion programs are also the focus of many studies (Cheesman et al., 2016; Honegger, 2015; Landess & Holoyda, 2017; Scott, 2020). The literature gap is a lack of qualitative information regarding the descriptions from mental health professionals who work directly with this population and provide the mental health treatment they need. Misra (2016) claimed the mental health client intake procedure in jail was far from ideal in

terms of quality due to a heightened anxiety of the arrestee/patient. He revealed his disappointment in his ability to properly assess and treat individuals in jail during a six-month residency rotation. While Misra's (2016) article is valuable in terms of this study and provides qualitative information on the perspective of a mental health professional's opinion of mental health treatment in confinement facilities, it was not intended to be a peer-reviewed research study regarding other opinions on this matter; it was an article which simply stated the observations and the experiences of one mental health professional.

The current research examined the descriptions provided by mental health professionals in prisons in the United States and one participant in the United Kingdom. The type and number of years of professional experience may be noted when reviewing the background of each professional and their respective levels of experience in the field of mental health.

Results and recommendations of many qualitative studies demonstrate the deinstitutionalization movements were resultant of a severe lack in community-based treatment for mentally ill individuals (AbuDagga et al., 2016; Dempsey et al., 2020; Dinerstein, 2016). The absence of available care caused mentally ill individuals to have increased interactions with police when decompensation became an issue (Cummins & Edmondson, 2016; Hoffman et al., 2016; Kane et al., 2018). Identifying themes from mental health professionals working in prisons and coding the qualitative information from the participants' descriptions are reflective of previous studies; however, the

information provided detailed new data based on the perception of the mental health professionals who participated.

If research in the area of mental illness as it intersects with criminal justice is able to provide directive information to develop evidence-based procedures, there are numerous areas for the possibility of positive social change. Law enforcement will be able to respond more readily to criminal activity rather than mental health crises, the courts will not be inundated with mentally ill defendants who may benefit more from treatment and therapy, and mentally ill individuals will be treated instead of having their civil rights violated by being prosecuted for mental illness. An additional benefit would be fiscal; mentally ill individuals would receive treatment alone as a replacement for treatment *and* incarceration saving the U.S. public more than $1 billion annually (Delgado et al., 2020).

Operational Definitions

United States Department of Justice = USDOJ – This term is referenced only in regards to that portion of the USDOJ which files lawsuits against states for violations of civil rights of mentally ill individuals.

Settlement Agreements = SAs – This term is in reference to lawsuits filed by the USDOJ which devolve into agreements with the respective states. They depict the demands by the USDOJ in which the states are ordered to comply in order to avoid the lawsuit initially filed.

Olmstead – The court case of *Olmstead v. L.C.* 527 U.S. 581 (1999) which set case law in reference to the freedoms of disabled (mentally ill) individuals and integration into the community.

Serious and Persistent Mental Illness/Severe Mental Illness = SPMI/SMI – Refers to several mental illness diagnoses as defined in the Diagnostic and Statistical Manual for Mental Disorders 5 (*DSM-5*). These diagnoses include schizophrenia, severe Post Traumatic Stress Disorder (PTSD), major depressive disorders, bipolar disorders, and borderline personality disorders. These disorders are only relevant if the mental illness impairs functionality and substantially interferes with life activities (American Psychiatric Association, 2013).

Warehousing – A practice of mental health institutions in which patients require no new treatment or a reason to infringe on liberties, yet the mentally ill individuals are not discharged from the facility in a timely manner (Freudenreich, 2020).

Mental Health Court = MHC – A diversionary court created to funnel mentally ill offenders who fit MHC criteria into therapeutic court-ordered treatment programs in lieu of criminal prosecution (Dempsey et al., 2020; Mulay et al., 2017).

Therapeutic Jurisprudence – A concept in the criminal justice system which recognizes a need for treatment instead of punishment. A multidisciplinary team of professionals who address all aspects of the individual involved and each member of the team opines regarding meeting the individualized needs (Dempsey et al., 2020; Mulay et al., 2017).

Summary

The statistical information derived from previous studies indicates extreme increases in the mentally ill inmate population (Cohen, 2019; Jüriloo et al., 2017). While the information from those quantitative studies provides valuable information, qualitative research should be performed as well. In social sciences, it may not be enough to know "how many," it may be essential to discover the "how" and "why" answers as well in order to become proactive. This study fills in the gap in the literature to answer the questions by theming and coding descriptions provided in interview responses. The compilation of the history seems to indicate a sort of "backsliding" by the U.S. into the eras in which those with mental illness are isolated from society. The difference now is mentally ill inmates are trading psychiatric beds for incarceration. Mandates of deinstitutionalization intended to ensure liberties, have inadvertently exchanged facilities from those intended to treat mental illness to institutions which focus on punitive measures.

New procedures seem to be attempted frequently to ameliorate the problem. If the numerous studies are any indication, a great deal of focus is placed on the issue of incarcerating mentally ill individuals and changes in legislation and policy are needed. Delgado et al.'s (2020) assertion it will cost less to do the right thing should be motivation for stakeholders to reevaluate the current procedures and processing. Two measures to remedy the situation which are currently underway include the existence and increased numbers of MHCs and the creation of Crisis Intervention Teams (CITs). Other

measures include a focus on intake and assessment of potentially mentally ill individuals entering jail/prison and advancements in treatment and therapy within the facilities.

The awareness of how effective evidence-based treatment may lead to a reduction in recidivism may be a key factor which would require additional research. The ability to adjust theories to reflect new discoveries and the development of assessment tools may assist in understanding if hospitalization versus incarceration is more appropriate. Finally, training for correctional staff teaching them to refrain from stigmatization of inmates with mental illness and understanding these inmates are more likely to be victims than aggressors may assist in the reduction of this inmate population.

Chapter 2: Literature Review

Introduction

Since the deinstitutionalization movement in the United States began around 1955, there has been a great deal of research performed on deinstitutionalization. More recently, much of the research has been quantitative and focused on the increased influx of mentally ill individuals being incarcerated (Dierenfeldt et al., 2020). Some of the statistical information suggests an extreme rise in percentages of inmate populations having a mental health diagnosis. Depending on the inclusive criteria of the studies, the range of mentally ill inmate populations range from 10% to 86%. However, many of the studies include diagnoses developed after the individual became incarcerated (Bebbington et al., 2017; Besney et al., 2018; Bronson & Berzofsky, 2017; Capuzzi et al., 2019). In this study, I did not address mental illness diagnoses of depression, anxiety, or other mental illnesses that may have developed due to being imprisoned. Instead, this study focuses on serious mental illness (SMI) or serious and persistent mental illness (SPMI) diagnoses prior to arrest or diagnosable during intake assessment performed following arrest.

The DSM-5 does not include a single definition that encompasses each aspect of all diagnoses, yet suggests “an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” is considered a mental illness diagnosis (American Psychiatric Association, 2013, p. 20). In essence, an individual’s diagnosis of SMI largely depends on the reason for the diagnosis; it may for be legal, clinical, or an

epidemiological explanation (Shaffer et al., 2019). For the purposes of this research, Shaffer et al.'s (2019) use of the National Institute of Mental Health's definition of SMI was most appropriate, as it explains serious functional impairment on a mental, behavioral, or emotional level. Perhaps the most important aspect of this definition is the inclusion of how the mental illness interferes with or limits significant life activities.

Many articles proclaim prisons as the new psychiatric facilities because the number of mentally ill inmates far outweighs the number of inpatients in psychiatric centers (AbuDagga et al., 2016; Bebbington et al., 2017; Nardi et al., 2017; Rukus & Kulkarni, 2019). This is likely due to the fact many psychiatric facilities have been closed or, at the demand of the USDOJ via SAs, have extreme limitations regarding the number of available beds. While Lamb and Weinberger (2019) believed there is a failure on the part of mental health providers, the actuality is those providers have been mandated by the USDOJ to minimize inpatient mental health care. With no alternative for placement when public safety is in peril or the individual poses a threat to self, police have no choice but to retain custody of an individual even when treatment and therapy would likely be most appropriate. Police at all levels are receiving training regarding the handling of situations that may be psychiatric emergencies rather than a criminal matter (Dempsey et al., 2020; Helfgott et al., 2016; Kane et al., 2018; Krameddine & Silverstone, 2015; Mulay et al., 2016; Shapiro et al., 2015). However, once police are involved, the issue most often evolves into a criminal justice issue.

An active response by the criminal justice community is the creation of MHCs; it began in the late 1990's and has been enacted in many jurisdictions. This diversionary

program allows for individuals who are diagnosed with a mental illness and whose crime(s) adhere to MHC criteria (e.g. – the crime cannot be a violent offense, the individual may not have a history of violent infractions, etc.) to seek treatment in lieu of being sentenced in criminal court. I designed this study to understand the perspective of the mental health professionals working in prisons regarding the overrepresentation of mentally ill inmates. Staton (2019) discussed some different aspects of this phenomenon by reviewing how criminal justice and mental health professionals interact and how both groups interact with mentally ill defendants. The concept is intriguing due to the differences in missions and perceptions. Good order and discipline are primary motivations in criminal justice while treatment and therapy are primary purposes with mental health professionals. To accomplish therapeutic jurisprudence, multidisciplinary teams are able to promote their individualized foci while understanding other purposes may be as crucial and central to achieving a collective objective. MHCs further the idea of therapeutic jurisprudence (Dempsey et al., 2020; Mulay et al., 2017).

Literature Search and Strategy

I searched databases for relevant and recent peer-reviewed journal articles on the topic of people with mental illness in prisons. Keywords used in searching databases: *Mental illness, inmates, deinstitutionalization, prison, mental health professionals, treatment programs, settlement agreement, mental health court, serious and persistent mental illness (SPMI), and serious mental illness (SMI).* The databases searched were Academic Search Complete, Criminal Justice Database, EBSCO ebooks, Federal Agency Participation, Sciencedirect, Semantic Scholar, NAMI, govInfo, PsycARTICLES,

PsychiatryOnline, SAGE Journals, ProQuest, and Walden Library Books. I located the articles and categorized them into specific topics, organized by content and focus, and will be discussed in detail.

History

Historically, individuals who pose a threat to self or others and diagnosed with a mental illness have been placed in psychiatric facilities. The idea behind such a placement is linked to the notion of refraining from criminalizing mental illness (Dempsey et al., 2020; Lamb & Weinberger, 2019). However, an additional concept of avoidance of warehousing patients is an equal and simultaneous yet contrasting notion. A combination of the two ideas is supported by the decision in *Olmstead* which demanded this population be afforded the opportunity to thrive, to the extent possible, in the community by the creation and use of community-based mental health resources (Dinerstein, 2016). The efforts of deinstitutionalization are fraught with competing expectations likely due to individualized perceptions and experiences of people in different areas of the field of criminal justice.

Basically, one group (USDOJ) demands for mentally ill individuals to be released from psychiatric facilities as soon as they are stable. Another group suggests that after stabilization, the individuals should be observed at the inpatient facility to ensure maintenance of stability (psychiatrists). Yet another group sees mentally ill individuals as a potential threat to self or others and advocates for adjudication of criminal activity, frequently ending in incarceration (law enforcement and the courts). A final group recognizes the lack of therapy and treatment for mentally ill individuals provided by

prisons and recommends inpatient treatment at a psychiatric facility. I see it as a cyclical conundrum with no group providing an adequate resolution.

There have been movements to ensure community placement since 1955 when the population of psychiatric facilities reached its peak (Slate, 2017). Currently, the movement is being led by the USDOJ. In an effort to make certain the *Olmstead* decision is followed by the states, the USDOJ has filed lawsuits against certain states for violation of civil rights of the mentally ill. The lawsuits ultimately devolve into SAs. The SAs demand each state must discharge individuals as inpatients in psychiatric facilities in order to comply with *Olmstead* if the individuals demonstrate a propensity to be able to live in the community. The purpose is to ensure states refrain from warehousing those with mental illness. There is a limitation of the number of inpatient available beds specified in the SAs and the literature illustrates an extreme drop in those numbers as well as a desire for those numbers to be increased (AbuDagga et al., 2016; Collins et al., 2017; Torrey et al., 2014, 2015, 2017). In addition to the limitations discussed in the SAs, the budgets of mental health programs are undergoing substantial cuts (Stone, 2019; Taylor, 2018).

The United States has the highest incarceration rate in the world housing 20% to 25% of the world inmate population (Segal et al., 2018; Wagner & Bertram, 2020). While Segal et al. (2018) claims 20 to 25% of the U.S. prison population have been diagnosed with SMI, those statistics were derived from material published in 2006 and are likely no longer accurate. However, AbuDagga et al. (2016) suggested prisons house 10 times more seriously mentally ill individuals than psychiatric facilities do in this country. The

statistics demonstrate the idea of deinstitutionalization is not a reality; instead, mentally ill individuals appear to have traded psychiatric institutions for penal institutions.

There is considerable proof regarding the need for medication and therapy in treating mental illness (Wang et al., 2020). Those individuals who experience mental illness decompensate, sometimes drastically and rapidly, without medication and treatment; the same is true for those who are undermedicated (Tiry et al., 2020). My primary motivating objective for conducting this research was to discover how mental health professionals working in the prisons perceive mentally ill inmates and if there is access to the appropriate types and levels of care for their respective mental health diagnoses. The responses from participants revealed insight regarding the adequacy of care provided in prisons and may assist professionals in the field may assist in deciding an alternate solution.

The initial interaction for mentally ill individuals with members of the criminal justice system has historically been when police respond to a scene. Most often the scenario may involve a mentally ill person who is experiencing a type of psychotic episode. In the past, officers had few alternatives than to arrest the individual and bring them to jail to await adjudication (Kane et al., 2018). In numerous extreme instances, the encounters proved to be fatal for those with mental illness (Krameddine & Silverstone, 2015). Such encounters may be a result of the stigmatization of mental illness by police officers (Stuart, 2017). An effective way of remedying the situation was presented by Wood and Watson (2016) which suggested law enforcement view themselves as “guardians” rather than “warriors” (p. 289). Mulay et al. (2016) addressed the bias and

the need for improved law enforcement relations in suggesting CITs be developed and used in responding to psychiatric crises. While CITs are becoming more plentiful and more training regarding mental health for police personnel has become a higher priority, there are still a large number of mentally ill individuals incarcerated.

Mental Health Courts

In more recent history, MHCs have been established in response to the growing population of individuals arrested who are or may be mentally ill. Since the establishment of MHCs began in the late 1990's (Fisler, 2015), this judiciary also appears to be a response to the *Olmstead* decision which was decided in 1999. A third justification for the creation of MHCs is a public outcry for therapeutic jurisprudence and a communal desire for mental illness to be decriminalized (Dempsey et al., 2020; Mulay et al., 2017). The interviews I conducted with mental health professionals working in prisons illuminated observations from individuals on the "front line" of the issue and may be vital regarding recommendations for future research and policy/legislation changes.

The idea behind MHC is akin to involuntary outpatient civil commitment. The significant difference is civil commitment is adjudicated in a civil court, while MHC is handled in criminal court which. If demands are not met in civil court, the individual is returned to a psychiatric facility. If demands are not met in criminal court, the mentally ill individual faces punitive repercussions (Fisler, 2015; Scott, 2020; Staton, 2019). MHC mandates court supervision of treatment and employs individuals to assist in discovering resources for an offender (Fisler, 2015). If the *Olmstead* decision and the USDOJ claim it is a violation of civil rights to warehouse the mentally ill in psychiatric facilities, it is

reasonable to suggest it is as much, if not more of a violation to warehouse this population in corrective institutions. Indeed, Harki (2019) relayed an “astonishing” number of deaths in the United States of mentally ill inmates in custody largely due to the lack of appropriate psychiatric care. The MHCs may be able to divert individuals who fit the MHC criteria out of the criminal justice system and guide them toward community-based resources. Treatment may be more beneficial to the community as a method in the prevention of recidivism and as a cost saving measure. (Harki, 2019) This diversionary program has fiscal advantages by saving the United States more than $1 billion by redirecting individuals into treatment alone instead of incarcerating and treating them (Delgado et al., 2020). It is also beneficial to the mentally ill individual in aiding in the prevention of disorganized thoughts, confusion, and unwanted behaviors.

Van Deinse et al. (2019) suggested 4.65 million individuals with mental illness experience court supervision, which indicates the MHC program can be considered successful in preventing those individuals from being incarcerated. A criterion for a mentally ill individual qualifying for MHC is the offense cannot be violent. It is unclear why this factor is part of the criteria if the offense occurs substantially due to mental illness. Additionally, Costopoulos and Wellman (2017) discuss the obstacle of overcoming an accused’s criminal history. Regarding mental illness, of all courts, MHCs should be well aware of decompensation factors and relapse and cause them to refrain from incorporating the criterion regarding criminal history.

Intake and Assessment

During the interviews I performed, intake assessment procedures were specifically addressed at each facility and with each participant. The goal was to know the thoughts and perspectives of the mental health professionals regarding the process each uses and the different procedures at different facilities. It should be noted the intake assessment for determining mental illness is a separate process from the risk assessment that may be performed at numerous points during incarceration. At intake, personnel performing the evaluation should focus on existing or potential SPMI diagnoses when an individual enters a facility. While many of the assessments incorporate questions regarding substance abuse, this study is not intended to delve into the aspect of dual diagnoses for mental illness combined with substance abuse issues. Diagnoses of anxiety or depression may arise following incarceration due to the nature of the prison environment. This study was not designed to research these topics.

The Misra (2016) article depicts an extremely limited ability to evaluate arrestees in a local jail. The number of resources allotted to ensuring the procedure was done adequately was, in Misra's experience, woefully lacking. Additionally, the availability of psychotropic medication in the jail was wholly inadequate (Misra, 2016). This thought was echoed in Gottfried and Christopher's (2017) literature review of mentally ill inmates. The Misra (2016) article went on to explain the comparable quality of community-based treatments and the number of mental health professionals available in the community are decisively more plentiful per capita.

Warburton et al. (2020) performed quantitative research in order to discover trends regarding competency to stand trial. Referrals to “restore” competency are made following intake and initial assessment. The study determined many participants in the study stated there was an increase in such referrals and reasons for the referrals were limited community-based mental health services, insufficient crisis services, and limitations on psychiatric beds available. These problems seem to permeate all communities. While Warburton et al. (2020) performed a nationwide study, Zdanowicz (2015) discussed many of the same issues in numerous areas around the country. In-depth and thorough intake analysis is absolutely necessary to prevent unnecessary incarceration when mental health treatment may provide the optimal desired outcome (Zdanowicz, 2015).

A potential problem with mental health screening during intake is the notion the screening does little (or nothing) to ensure appropriate treatment is provided (Martin et al., 2018). It would be a complete waste of a mental health professional’s time to be tasked with performing the intakes and then fail to follow-up on the findings provided by the professional. In fact, following an assessment and finding of at least one mental illness diagnosis, a large portion of inmates received no treatment for the diagnosis (Jakobowitz et al., 2017). In the companion paper of Jakobowitz (2017), Bebbington et al. (2017) details much of the same information and claims recidivism as a consequence of failure to treat appropriately following an intake assessment.

Treatment and Mental Health Programs in Prisons

Once an individual is sentenced to a prison term, the availability of medication, treatment, and therapy for mental illness is a much-debated issue. Many of the individuals treating this population are psychiatric nurses who relay significant challenges in incorporating best practices with available treatment in penal facilities (Kucirka & Ramirez, 2019). Additionally, failure to properly care for inmates with mental illness is a violation of their 8th Amendment rights of protection against "cruel and unusual punishment" (Collins et al., 2017, p. 34).

The availability and quality of medications for inmates in correctional facilities is a primary issue in much of the literature. While all pharmaceuticals are known to be expensive in the U.S., it is especially true for psychotropic medications. Budgetary constraints frequently determine the kind, the amount, and the quality of medications correctional facilities are able to purchase. Collins et al. (2017) suggests such constraints should not prevent a mental health professional from providing the same type of care which would be administered in the community. While Collins et al. (2017) is indubitably correct in theory, what *should* occur and what *does* occur are quite different in practice. The mission of a penal institution is far different from the mission of a psychiatrist or psychologist. The correctional facility focuses on containing offenders, maintaining order, and ensuring safety for all; the mission for the mental health care provider is focused on minimizing symptoms of mental illness diagnoses thereby creating a safer environment (Collins et al., 2017). The two missions are not mutually exclusive. If a mentally ill inmate is properly medicated, it is likely they will be less of a safety threat

or potential victim. In fact, mentally ill inmates tend to experience more adverse results during incarceration than the general population inmate (Meyers et al., 2018) and violence and criminal activity are not necessarily linked to mental illness (Mulvey & Schubert, 2017).

While Nardi et al. (2017) point out a lack of coordination between mental health agencies and correctional facilities to ensure appropriate treatment, Moore et al. (2018) suggested regulating inmate behavior through dialectical behavioral therapy (DBT) as a key requirement during incarceration. DBT was developed by Linehan (1987) in an attempt to curtail parasuicide attempts of patients with borderline personality disorder. While DBT was initially created with this particular population in mind, it is a method which may allow mentally ill individuals to "cope with or ameliorate psychic distress brought on by negative environmental events" (Linehan, 1987, p. 328). Although their study appeared to be fraught with logistical challenges, the research specifically addressed a systemic failure to utilize DBT with inmates in short term incarceration (jail) as opposed to those in long term incarceration (prison) (Moore et al., 2018). The results of the Moore et al. (2018) study suggested an abbreviated version of DBT in jail settings could be as effective (or nearly) as the full program utilized in prisons.

The Shaffer et al. (2019) quantitative study and subsequent report on findings thoroughly discussed numerous aspects of SMI in association with the CJS. A large part of the study focused on prevention and intervention with mental health care needs prior to an individual being involved in the CJS. In addition to prevention efforts, Shaffer et al. (2019) discuss the need for increased resources for inmates with SMI. Their theory is that

a cost analysis could demonstrate a fiscal benefit to ensuring treatment is available and provided prior to a need for incarceration and the benefit continues when there is no need for incarceration combined with mental health treatment. The significant benefits would naturally extend to the mentally ill individual as well when his/her liberties are not jeopardized, and they receive treatment from community-based resources.

In an attempt to highlight the rights of individuals with mental illness, de Souza et al. (2020) discussed the attitudes and perceptions of institutional staff. While de Souza et al.'s (2020) focus is on mental health institutions and not prisons, the findings and recommendations may be transferrable to penal institutions. Although inmates lose some of the rights most individuals eNew Jerseyoy, they maintain certain civil rights under the Constitution; indeed, they gain the right of the 8th Amendment. The study performed by de Souza et al. (2020) indicated barriers to appropriate treatment derived from the staff in regards to stigmatization, discrimination, marginalization, and exclusion. If individuals whose job it is to treat mentally ill individuals have such perceptions, it is reasonable to believe prison staff may feel similarly.

DeHart and Iachini (2019) developed a program to assist prison staff in aiding in the appropriate treatment for mentally ill inmates. The program is available online and advocated for use in prisons. The idea is to utilize evidence-based training to correctional officers who tend to have the most frequent interaction with mentally ill inmates (DeHart & Iachini, 2019). This concept is particularly intriguing after review of Segal et al.'s (2018) qualitative research with focus groups which indicated correctional officers do not feel they are adequately trained in this area. MacKain and Baucom (2008) approached the

issue of appropriate treatment in a different way. They placed the onus on the inmate and claimed the inmates with SPMI should be provided training regarding their own medication management and suggested more rigorous training be made available to inmates (MacKain & Baucom, 2008). This equates to therapy.

In addition to the training of correctional personnel discussed by DeHart and Iachini (2019) as well as the training of inmates regarding self-managed medication (MacKain & Baucom, 2008), Van Horn et al. (2019) advocated for the use of a manual for mental health treatment for justice involved individuals. The manual is entitled *Changing Lives and Changing Outcomes* (CLCO) and is believed to provide assistance in effective treatment with mentally ill offenders (Van Horn et al., 2019). Ellis and Alexander (2017) focused their study on the care provided by psychiatric mental health (PMH) nurses working in prisons. They claim incarceration tends to exacerbate existing SMI and may instigate new diagnoses. The study suggested the PMH nurses have unique advantages (education, experience, leadership roles, etc.) which allow them to be able to treat individuals as well as locate community-based treatment upon release.

Some professionals in the field promote the use of therapy in lieu or in addition to medication for treatment of mental illness in a prison setting. Byrne and Ní Ghráda (2019) discussed four specific therapies and their respective effectiveness: 1) Acceptance and Commitment Therapy (ACT), 2) Compassion Focused Therapy (CFT), 3) Metacognitive Therapy (MCT), and 4) Functional Analytic Psychotherapy (FAP). There were significant issues with the study as the sample sizes were admittedly small with only one participant for CFT and eight participants for ACT. The research conducted for FAP

and MCT had were zero participants. While this study is better categorized as research of the treatment programs and less of an actual study, future research may prove all four programs to be effective for treatment of mentally ill inmates (Byrne & Ní Ghráda, 2019).

Effectiveness/Recidivism

One aspect of understanding the perspectives of mental health professionals working in prisons is recognizing their insight regarding the effectiveness of the treatment and therapy in order to determine the potential for recidivism. In short, a mentally ill individual who is left untreated or has been ineffectively treated for his/her mental illness while incarcerated has proven to be more likely to recidivate (Rukus & Kulkarni, 2019). Wilson et al. (2018) refers to the issues of arrest and incarceration as "pervasive" in reference to individuals with mental illness and claims those with mental illness are more likely to be re-arrested and imprisoned (p. 1839).

Matejkowski et al. (2017) seemed to be splitting hairs in claiming the *conduct* of a mentally ill individual is a *direct* reason why this population is involved in the criminal justice system, yet their diagnosis is an *indirect* reason. The conduct is an obvious and inevitable result of the diagnosis and the two cannot be placed in different categories in explaining recidivism. In such a discussion, medication and treatment must be part of the dialogue in order to differentiate. Nardi et al. (2017) suggest the use of evidence-based programs whereby mental health facilities cooperate and work with the criminal justice community is the answer to recidivism prevention and increased public safety.

Theories

The importation theory and the deprivation theory provide some insight regarding behaviors mental health professionals observe within their respective prisons. The experiences and observations allow them to develop their perspectives which they might relay during the interview for the current research. While the theories are discussed in more detail in Chapter 3, some of the information is pertinent this chapter.

DeLisi et al.'s (2011) research, albeit somewhat dated, contributed to the importation model after a 50-year stagnation on the concept by incorporating the life-long effects of childhood events and/or traumas. Bowler et al. (2018) suggested imported characteristics, behaviors, childhood traumas, and all pre-prison experiences significantly contribute to mental health issues and inmate conduct/misconduct. Previously, the importation theory focused mainly on inmate misconduct; DeLisi et al. (2011) suggested the theory can be attributable to pre- and post-prison behavior. In more recent research performed by Butler (2020), use of specialized prison units (SPU) was discussed in reference to punishment for inmate misconduct. Butler (2020) discussed the concept of the importation theory as first by Irwin and Cressey which suggests inmates import their personal beliefs, behaviors, attitudes, and personalities into prison when they enter a facility (Moon & Tillinghast, 2020). Some of those behaviors and personality traits are a direct result or symptomology of a mental illness in which the individual has been diagnosed. Therefore, it is reasonable to suggest importing the mental illness into the prison is or may be a strong factor to consider in understanding an inmate’s behavior or misconduct.

A review of the deprivation theory is helpful in illuminating potential decompensation causes for already mentally ill inmates during incarceration. The mental health professionals are aware of the diagnoses, medications, and therapy inmates receive. They are the individuals who might be able to describe improvement or decompensation. Their close proximity will assist in determining if deprivation may be a causal factor regarding inmate behavior and misconduct.

Frequently, the importation model and deprivation (socialization) model are compared and contrasted in research (Bumberry & Grisso, 1981; Lahm, 2016). They are the quintessential argument of nature versus nurture. Both theories address prisoner misconduct, yet one suggests individuals are who they are when entering the institution (importation; nature) and the other claims the relative deprivation a person experiences from the prison environment (deprivation; nurture) is the cause of behavioral issues (Bumberry & Grisso, 1981). Both theories can be true when considering the individuals in the current study are struggling with SPMI.

The seminal works of Bumberry and Grisso (1981) provide a thorough analysis of inmate behavior and pose reasonings for misconduct. Bumberry and Grisso (1981), DeLisi et al. (2011), and Moon and Tillinghast (2020) agree it is possible an individual's personal experiences in addition to being deprived of liberties, relationships, the food and comforts they are used to, security, and general autonomy to aberrant or undesirable behaviors. Lahm (2016) echoes the sentiment in the discussion regarding only female inmates.

Risk Assessment

In order to determine if the individuals with mental illness pose a potential risk to society or themselves, a risk assessment should be accomplished. Shaffer et al.'s (2019) viewpoint may be accomplished using the Risk Needs Responsivity (RNR) model discussed by Velasquez et al. (2020) which focused on unit design of forensic psychiatric settings. The RNR model was developed out of Canada by Andrews and Bonta (2010) in response to an austere criminal justice system which advocated harsh punishments for crimes. Andrews and Bonta (2010) pointed out the strict stance on punishment did nothing to alleviate recidivism and crime prevention. Velasquez et al. (2020) researched forensic patients placed in the forensic side of a psychiatric hospital due to the system being over-burdened with mentally ill individuals. They claim some mentally ill inmates/patients with behavioral issues pose a physical threat to other inmates/patients and staff. The RNR model used suggested a restructuring of the environment for the prevention of violence (Velasquez et al., 2020).

A criminogenic needs assessment is vital in recidivism prevention. Wilson et al. (2018) explained the delivery of five specific interventions for individuals with SMI is crucial to this idea and may be able to significantly increase the benefit to these individuals. While diversion programs, specialty supervision, MHCs, and re-entry services have been vital to determine the risk an individual may pose, they are considered to be "first-generation services" (Wilson et al., 2018, p. 1839). The five service delivery strategies addressed by Wilson et al. (2018) are 1) repetition and summarizing, 2) amplification, 3) active coaching, 4) low-demand practice, and 5) maximizing

participation. The study explained how and when to use the strategies in order to assess and intervene regarding criminogenic needs.

Tools

There are numerous tools experts use to assess a risk level of an inmate. However, special consideration should be used in such a determination when dealing with a mentally ill inmate. In order to provide accurate and timely treatment for mentally ill inmates, it is prudent to perform an assessment early on in the process (Leidenfrost et al., 2018). However, Leidenfrost et al. (2018) claim credible and reliable assessment tools are lacking in confinement settings. While the Leidenfrost et al. (2018) study incorporates all mental illness diagnoses made at varying times throughout incarceration, they claim the level of care index (LOCI) tool utilized is potentially appropriate to utilize for intake and subsequent assessment.

In contrast, Jones et al. (2019) performed a study in Ontario, Canada. They used a five-point scale to determine inmate needs in order to determine if the mentally ill inmate should be transferred to a psychiatric facility. The study showed a different perspective from another country which allows for individuals to be treated for mental illness instead of the imposition of punitive measures. Price (2019) advocated for the use of the Millon Clinical Multiaxial Inventory – IV (MCMI-IV) for assessment of mental illness specifically for inmates. However, the study focused on inmates already receiving mental health treatment and not individuals suspected of having mental illness who were not yet evaluated.

Baird (2017) advocated the use of the Level of Service Inventory – Revised (LSI-R) to assess needs. The LSI-R is a 54-item assessment tool which not only assesses criminogenic needs, it also identifies a risk level. Matlasz et al. (2017) utilized the Personality Assessment Inventory (PAI) with SMI inmates. The PAI may be a beneficial tool for mental health professionals to use in consideration of the importation theory.

Offender/Victim

A common myth among the American public is that mentally ill individuals are dangerous to the public. However, studies have shown mentally ill people are more likely to be victims of violence and not the perpetrators of such acts (Daquin & Daigle, 2018; di Giacomo & Clerici, 2020; Jachimowski, 2018). Additionally, this population is more likely to harm themselves or act erratically which may inadvertently cause self-harm (Bursac et al., 2018; Kennedy & Savard, 2018; Winters et al., 2017).

Daquin and Daigle (2018) and Jachimowski (2018) highlighted how specific mental illness diagnoses can increase the risk of victimization. Individuals with personality disorders or those who experience hallucinations, depression, and paranoia were more likely to be victimized while others experiencing psychosis were less likely (Daquin & Daigle, 2018). di Giacomo and Clerici (2020) differentiate between victimized and victimizer in the assertion mentally ill individuals are also more prone to act aggressively. However, Jachimowski (2018) claims those with mental illness are more inclined to be victimized even prior to incarceration.

There are evidence-based programs which assist in prevention of the cyclical psychiatric hospitalization of inmates and significantly deter the need for “suicide watch”

of mentally ill inmates (Bursac et al., 2018). Winters et al. (2017) discussed the issue of self-harm amongst mentally disordered inmates and declared suicide as a leading cause of death in penal institutions. The authors advised implementing intervention efforts and recommended further research in the development of assessment tools in order to gauge risk levels. If assessments are not performed or inadequately performed, successful suicide is the likely outcome. Kennedy and Savard (2018) discuss a bizarre death of a mentally ill inmate in relation to a symptom associated with excited delirium (ExD). While ExD can be an attributable symptom of drug use (specifically cocaine) and drug withdrawal, a similar reaction called Bell's mania is a symptom of SMI. The case discussed was of a mentally ill inmate who died due to Bell's mania. The extreme agitation brought on by the mental illness can cause an individual's body to overheat or overly cool; death is natural consequence to hyperthermia or hypothermia. Correctional officers are not trained in recognizing symptoms or equipped to react to the condition (Kennedy & Savard, 2018).

Literature Gap

Misra's (2016) personal account of his experiences and his perspective of lack of mental health resources in the jail in which he worked during a residency rotation was valuable information to consider. However, the recitation was a single account of a single mental health professional and, to date, no qualitative research has been performed in this area from the perspective of mental health professionals. A qualitative study performed by Segal et al. (2018) included the perspective of all prison staff: administrators, sergeants, nurses, and clinicians. The conclusions of the Segal et al. (2018) study

informed how jail personnel believe many individuals who suffer from SMI, would benefit from psychiatric treatment in lieu of incarceration. AbuDagga et al. (2016) performed a qualitative study across the U.S. regarding the increase in the mentally ill population in jails. The questionnaire provided to participants primarily collected quantitative data; however, a few questions were open-ended allowing participants to provide detailed information. The findings in the report suggested the rich, detailed information received from the open-ended (qualitative) questions was highly beneficial to research.

Summary

The statistical information derived from numerous studies indicates extreme increases in the mentally ill inmate population (Cohen, 2019; Jüriloo et al., 2017). Those quantitative studies provide valuable information as to why the current qualitative study is able to fill in the gap in the literature by theming and coding the descriptions provided in interview responses. The compilation of the history seems to indicate a sort of "backsliding" by the U.S. into the eras in which those with mental illness are isolated from society. Mandates of deinstitutionalization intended to ensure liberties are not deprived, *Olmstead* is recognized, and the ADA is adhered to, have inadvertently traded facilities intended to treat mental illness for penal institutions which focus on punitive measures.

New measures seem to be attempted frequently to ameliorate the problem and if the numerous studies are any indication, a great deal of focus is placed on the issue. Two such measures include the existence and increased numbers of MHCs and the creation of

CITs. Other measures include a focus on intake and assessment of potentially mentally ill individuals entering prison and changes in treatment and therapy in the facilities. The awareness of how effective evidence-based treatment may lead to a reduction in recidivism may be a key factor which would require additional research. The ability to adjust theories to reflect new discoveries and the development of assessment tools may assist in understanding if incarceration or hospitalization is more appropriate. Finally, correctional staff refraining from stigmatization may improve the ability to recognize individuals with mental illness are more likely to be victims than aggressors.

Chapter 3: Research Method

Introduction

The purpose of the qualitative descriptive study I performed of the perspectives of mental health professionals who work in prisons is to describe the viewpoints of individuals who treat mentally ill inmates. In previous chapters, the issues involving mentally ill inmates highlighted qualitative and quantitative studies which focus on several different aspects of the phenomenon. Some of the various topics I discussed were the statistical increase of this population since the latest surge of deinstitutionalization, the likelihood of recidivism based on current practices, and potential evidence-based remedies. Abbott et al. (2018) discussed qualitative research methods specifically used in prison settings and the inherent potential barriers to research conducted in correctional settings as well as ethical considerations and was based on qualitative studies over a 12-year period (2005-2017). The purpose of this chapter is to elaborate on those ideas as well as provide (a) the research design, (b) the role of the researcher, (c) the methodology, (d) issues of trustworthiness, (e) ethical considerations, and (f) limitations of the study.

Research Design and Rationale

In an effort to ensure the study did not contain irrelevant information, there was only one research question. I used the answers to the interview questions in the interview protocol that I developed to provide a deeper understanding of the topic and answer the research question.

The research question I used to guide this study was: How do mental health professionals working in prisons describe their individual perceptions of the quality and availability of mental health care provided to inmates?

For the purposes of this study, the term *mental health care* includes psychotropic (and other) medications, different types of therapy (individual, group, etc.), housing, and all programs within the prisons designed to alleviate symptoms of diagnosed SPMI.

In order to discover answers to the research question, I asked the interview questions listed in Appendix A. I used the interpretivist paradigm in this study as it provides an analysis of positivism in the social sciences by assigning a relativist ontology and subjectivist epistemology as discussed by Robert Wood Johnson Foundation (2006). Through investigation and dialogue on the subject with the professionals who volunteered, findings emerged offering new knowledge to the field. The interpretivist paradigm is appropriate in this type of qualitative research due to the study's obvious subjectivity regarding reality determined by the professionals and an interpretation of the information. However, I paid strict attention to assigning meaning to the information by delineating the concepts of the phenomenological (descriptive) approach and the hermeneutical (interpretive) approach (Dahlberg & Dahlberg, 2019).

Two theories emerge regarding inmate conduct and behavior: the deprivation theory and the importation theory. The deprivation and importation theories can be considered as opposing theories regarding inmate behavior; however, they are basically an example of the *nature versus nurture* argument scholars have debated for decades, possibly centuries. Professionals in different fields are potentially able to use any case

study and decide if behavior is environmentally induced or if it is a result of genetics or predisposition. However, regarding inmate behavior, the deprivation and importation theories can be explanatory of inmate behavior simultaneously by discussing several inmates. After I conducted interviews with mental health professionals working in the incarceration facilities the information demonstrated the existence of either or both theories. Analyzing the data I collected from interview responses will advance the field in this area of knowledge.

The deprivation theory, developed by Samuel Stouffer, and importation theory, developed by Irwin and Cressey, framework provided insight regarding the behavior and conduct of inmates in the respective prisons. Lahm (2016) suggested scholars in the field ascribe to one theory or the other; however, the two are not mutually exclusive and according to Bumberry and Grisso (1981). Both theories can simultaneously be used to assist in explaining inmate behaviors. The theories aided me in the development of interview questions for the participants in this study.

Moon and Tillinghast (2020) discussed the differences in the two theories as they apply to inmates and both theories are relevant regarding my study. The deprivation theory addresses the indigenous prison culture with inmates being deprived of autonomy, heterosexual relationships, freedom, security, and goods/services (Moon & Tillinghast, 2020). Those deprivations contributed to adverse behaviors among mentally ill inmates as witnessed by the mental health professionals. The importation theory is particularly relevant to my study in that the inmates discussed had mental illness prior to being sentenced to prison (DeLisi et al., 2011). Since the importation theory suggests inmates

enter prison with their own beliefs and cultures, it would likely be true prisoners also import their respective mental illnesses, whether or not they were diagnosed prior to entering prison. Erratic behavior and psychotic episodes can demonstrate mental illness even when a diagnosis has not been established.

Additionally, therapeutic jurisprudence is a framework I used since the goal is for the criminal justice system to "address the overall well-being of the individual" (Arstein-Kerslake & Black, 2020, pg. 1). This framework specifically targets individuals with higher recidivism rates and mentally ill inmates frequently fit the category. The idea behind therapeutic jurisprudence is to enlist a multidisciplinary team to discuss all aspects of the offender which may have contributed to the alleged or actual criminal activity. The mental health facet of the therapeutic jurisprudence framework was a valuable aspect to consider while I was developing interview questions for participants and understanding the descriptions provided by mental health professionals in the prisons.

While the phenomenological and case study approaches were considered for my study, the nature and goal of the research supports the use of the narrative approach utilizing the interpretivist paradigm. It allows for a descriptive depiction of the data and assisted me in developing a consensus (or lack thereof) of the information gathered. The narrative approach permitted my incorporation of the deprivation and importation theories as well as the concept of therapeutic jurisprudence.

Role of the Researcher

Frequently, there is interaction between the researcher and the participants in qualitative research and the researcher's role may be significant. The information

retrieved from participants in my study is subjective in nature because it is the personal perspective of the participant and my subjectivity of deriving meaning from the participants' responses. My own subjective lens was not a factor in interpreting answers provided in the interview protocol. Therefore, using an interpretivist paradigm is preferable due to the subjectivity of the data gathered and my viewpoint in relaying the content and assigning meaning to the data (Dahlberg & Dahlberg, 2019). Since no video recording was permitted, it was important to listen to tone as it allowed me to understand if a participant was adding emphasis to an issue or if the feeling is more apathetic; however, apathy may be a result of a lack of knowledge, being uninformed, or from having a feeling of having no control.

Dahlberg and Dahlberg (2019) discussed the term *sense* regarding the interpretation of information and the assignation of meaning. One may get a sense of the information being relayed which is relative to their personal perception of the idea (Dahlberg & Dahlberg, 2019). This concept is why the role of the researcher in my study is vital. In essence, for the current study, the analysis and findings were my perceptions of the participant's perceptions. In all research, it is vital to behave ethically by understanding how and to what extent the research has the potential to cause harm to participants. However, qualitative research frequently has the added element of personal contact (e.g. – face-to-face, telephone, Zoom/Skype/Facebook interviews, personal observation of focus groups, etc.).

It is, therefore, essential to ensure the participants are not offended or put-off by the demeanor of or comments made by the researcher. Morris-MacLean et al. (2019)

suggested the use of a practice of *reflexive openness*; the concept brings the researcher's attention to the ethics of research practice and calls for an awareness of the practice throughout the study. Openness allows the researcher to utilize active listening skills while displaying respect for the participant regardless of agreeance of ideas. Jacobs et al. (2020) report combined the discussions amongst numerous scholars regarding qualitative research and recommended researchers maintain complete transparency while performing the research and relaying the findings. The concepts of openness, active listening, maintenance of ethics, and transparency are all parts of the role of the researcher (Jacobs et al., 2020). Strong adherence builds the level of trust necessary in research and ensures participants are afforded the deserved respect and appreciation.

I had no concern regarding permission to enter the prisons personally or via electronic means (Skype/Zoom/telephone/etc.). The participants identified the type of facility in which they are employed. It was necessary to discover job titles to identify who performs some type of counseling or treatment. Acceptance of incentives is always a sensitive subject when dealing with research. Although incentives are permissible to give for research, my study refrained from using incentives for participants. I believe there should not be even an appearance of impropriety to protect the integrity of the study.

I have not worked in or around correctional facilities or mental health facilities in more than 5 years and had no associations with mental health professionals who responded to recruitment requests. Since I have no personal or professional relationships with any participants (even the participant who also worked in Delaware), their supervisors, or inmates in the prisons in which they are employed, there was no power

differential and no reason for participants to feel a need to answer appropriately. There was no conflict of interest and there was no attempt at coercion regarding the questions and subsequent answers during the data collection process. No person had any rank or supervisory role and there was no expectation regarding responses during data collection.

I have had many years of experience in military law, criminal prosecution, criminal defense, and civil rights protection of mentally ill individuals. My background suggests a possibility of bias. However, I have learned through the various experiences to expect nothing. In the mental health arena, a thing may be true regarding one person and false with another; it may be true in one state and false in another. My experiences have been cautionary regarding expectations and/or forming an opinion prior to gathering data. In my work in Delaware protecting the civil rights of individuals in the state hospital, I frequently encountered patients who had been off their medication because they were incarcerated, and state/local officials claimed their budget did not allow for the expensive psychotropic medications or therapy programs. Those encounters do not suggest participants from another state will indicate the same practice or similar procedures. Indeed, issues of budgets may be significantly different in different states. For instance, in the state of Delaware, if the state wanted an individual involuntarily committed, the individual was committed. It was akin to a conveyor belt of commitment hearings. However, other individual accounts have shown that not to be the case in numerous other states. Each state has its own practices and/or policies and assumptions should be avoided. For the current study, participants did not perceive any bias by the researcher

during the interviews and data collection process. If such a belief were to be held by a participant, the findings of the study would be skewed and unreliable.

Methodology

The conceptual framework grounding this study is guided by the work of Cho and Lee (2014) regarding qualitative content analysis . My idea for the study was due to a great deal of quantitative information having been published regarding the increase in the mentally ill population; however, less is known about the perceptions of mental health professionals working in the prison system following the deinstitutionalization movements. Therefore, I performed interviews with open-ended questions combined with qualitative content analysis is appropriate as the conceptual framework for this study.

Qualitative content analysis is similar to grounded theory but has six significant differences: a) philosophical base, b) characteristics of the methods, c) goals, d) analysis process, e) outcomes, and f) evaluation of trustworthiness (Cho & Lee, 2014). For my study, the differences are what makes content analysis most appropriate. Interviews were conducted to understand the viewpoints of the mental health professionals who are required to follow protocol. The data was then themed and coded to understand if there are meaningful opinions and experiences expressed by participants in order to accomplish the objectives of the study. According to Grant and Osanloo (2014), a qualitative content analysis approach was an appropriate method to support my study. This type of analysis describes the approach needed to obtain information regarding the similarities and differences mental health professionals perceive in reference to inmate mental health treatment programs.

With permission from the administrator of the aforementioned groups involved in the study, I posted a request for participants who fit the criterion (1 year of experience in providing mental health treatment and/or therapy to inmates). I was aware of job descriptions as well as titles of the participants. For instance, an individual listed as a nurse may actually be a psychiatric nurse or act in that capacity when situations arise.

Participants of the Study

Wheeldon and Faubert (2009) discussed participants in qualitative studies and highlighted the importance of the perspectives of those participants in social science research. For my study, nine mental health providers working in the prisons were interviewed even though there appeared to be data saturation at the fourth interview. The remaining five interviews proved useful. The participants were required to have acted in the capacity of providing mental health support for prisoners for a minimum of 1 year to be included in the study. Due to the limited number of mental health providers at each facility, I recruited participants who met the criteria from different locations until a minimum of eight participants were identified. Nine participants were interviewed.

Once participants who meet the inclusion criterion of a minimum of one year of work with mentally ill inmates were identified and agreed to participate in the study, interviews began. The Prison Professors (2020) identified three potential job titles (case worker, counselor, and psychologist) which were not be exactly the same titles as those of the volunteers. The job titles differed even when the roles and tasks were the same or similar. Although an individual may not be classified as mental health professionals by virtue of job title, the selected participants did provide mental health treatment and

provided rich, detailed information regarding treatment and therapy for the specified population (Ellis & Alexander, 2017). In addition to case workers, counselors and psychiatrists or forensic psychologists volunteered to participate due to their roles and purposes regarding treatment and therapy of mentally ill inmates.

However, it is possible the selected sample have the same or similar perceptions regarding the availability of treatment and therapy within their respective facilities. If data saturation is achieved after interviewing eight participants, recruitment and interviews will cease. Guest et al. (2006) demonstrate a review of selected studies indicates data saturation after 12 interviews and no further themes were identifiable among the responses from participants. They also claim no significant thematic evidence was detected after only six interviews identifying the subsequent information as "*metathemes*" (Guest et al., 2006, p. 59).

The interviews will be immediately (as nearly as possible) personally transcribed or transcribed by a transcription service following the completion of the interview. After completing all interviews, hand coding and theming will take place. At that time, transcripts will be entered into Quirkos for a computer assisted analysis of the data. If, at that time, no new information is evident, it will be apparent data saturation has been achieved. However, if there are new themes developed from data collected at the second site, it will be necessary to continue with interviews at a third (and possibly fourth) facility.

As part of the preparation process, I coordinated with and failed to receive permission from the external IRBs with the states of North Carolina and the state of

Delaware. The research was being conducted during the COVID-19 pandemic and their committee members and staff were inundated with research requests regarding the pandemic.

Strengths and Weaknesses of the Selected Sample

There is frequently a great deal of politics involved with state/local government and a potential the selected sample will answer questions to the liking of their superiors. Since this research was conducted by recruiting volunteers via social media, the political arena was avoided. It was necessary to note tone and body language of the respondent to determine if it appears as though the answers being provided are "the right answer" instead of a thorough factual answer. However, since the respondents in the research did not participate during work hours and their employers were not made aware of their participation, it is possibly more likely there was a stronger sense of trust between the researcher and the participant and the responses may be more accurate (Lambert et al., 2020).

The participants were not subjected to briefings by supervision to ensure it does not appear as though the facilities are not adequately treating/medicating mentally ill inmates. In truth, the lack of adequate treatment does not reflect poorly on the facility if the budget does not allow for it. The costs for medication and therapy programs could be evaluated at the legislation level in order to ensure prison personnel work in the safest environment possible. Additionally, with a demonstrated inability to adequately care for mentally ill individuals, it may be possible to encourage legislators to divert mentally ill people to facilities with the appropriate resources.

Instrumentation

The interview protocol in Appendix A was used as the instrument to obtain answers to the research question. While all questions are listed, the interviews were semi-structured due to the nature of the questions being asked. Differing answers may require additional probes or explanations throughout an interview in order to maintain clarification of meaning and accuracy of acquired data. Each participant had to understand the same question in the same way.

Since job titles, job tasks, experience levels, and education levels differed among the participants, it was important to ensure all participants understood the meaning of the questions in the same way. For instance, the clinical supervisors fully understood the importation and deprivation theories; however, LCSW with a bachelor's degree was less knowledgeable on the subject. The questions were asked to all participants in the same manner, and additional information was provided when requested.

The interview protocol was able to illuminate a systemic reasoning regarding treatment of mentally ill inmates. The lack of adequate treatment and/or medication available to inmates from the perspectives of the nine participants is able to inform regarding insufficient funding and lack of trained personnel. Generally, it is not the responsibility of correctional officers to administer treatment or therapy and it is not typically in their job descriptions. However, the ability to maintain safety during a psychotic break or other episode of psychosis has become an essential job duty due to the increased number of mentally ill inmates (Chow et al., 2019).

The researcher-developed instrument used in this study was created in stages. Personal experience in mental health raised awareness of deficiencies in Delaware correctional facilities regarding the availability of medications and a lack of programs and therapy for mentally ill inmates. Several questions were developed at that time. Additionally, a review of the literature and recommendations for future research produced ideas for questions. One of the articles discussed in the literature review was a survey performed by AbuDagga et al. (2016) which included open-ended questions in the survey. The researchers in that study indicated they acquired rich and detailed information from the open-ended questions. While no questions from that study were used in the current instrument (because the subject of study in that research was based solely on jails and was a quantitative study,) their survey questions aided in ideas for the development of questions for a qualitative study. Additionally, my committee chairperson informed me not all participants will understand the questions in the same way and explanation of meaning should be included in the question (e.g. – questions regarding importation and deprivation theories). My methodologist provided guidance regarding the research question and assisted in making the purpose of the study a single and direct focus. In doing so, the finalized research question resulted in the development of more detailed and relevant questions on the instrument. The creation of the instrument was an iterative process which required a great deal of thought and many changes.

The theories regarding inmate behavior and the research question were vital in directing the content of the questions contained in the instrument. The perceptions of the individuals working in the mental health profession and working in confinement settings

regarding the availability of treatment and therapy was accurately obtained and recorded via the instrument and those perceptions were correctly relayed. The deprivation theory and importation theory are aspects of the phenomenon which, when correlated with mental illness, can explain the perceptions of the mental health professionals and it allowed participants to elaborate on their perceptions. This unique research will provide a deeper understanding for scholars in the field and further knowledge through "front line" perspectives.

Data Collection

The interviews with participants were the sole source of data collection. The interviews were transcribed by Otter ® (Otter, 2022). This transcription service is very fast. There is limited waiting time; however, it lacks accuracy. I went back through each transcript with the audio recording and made the necessary corrections. The Zoom meeting interviews took less than 45 minutes for each. The transcription reveals verbatim answers and the semi-structured interviews only differed to ensure the meaning of the question was understood or to encourage elaboration of an answer when the offered information was minimal or unclear. The transcriptions were personally hand-coded using highlighting and a Microsoft Excel spreadsheet.

COVID-19 dramatically affected the data collection process. Participants were unable to discuss therapy programs due to the inability to hold group sessions and because transfer of inmates was halted. Therefore, current information was lacking. While the initial intent was to perform face-to-face interviews at the prisons, the prisons did not approve the research requests due to the pandemic. This turned out to be a benefit

in many ways: 1) there was no travel required, 2) there was no delay in proceeding due to a background check and processing issues in order to be allowed in the facilities, 3) participants who agreed to participate in the study were able to do so at their convenience from their homes, and 4) the interviews were recorded with ease in a Zoom meeting interview. When participants were able to engage in the interview process at their leisure, they seemed to feel more comfortable and provided the rich detail needed in qualitative research.

Data Treatment and Storage

The participants were informed the interviews would be recorded. Each interviewee was assigned a code (e.g. – P1, P2, P3, etc.) in order to describe responses in Chapter 4 and Chapter 5. After hand-coding the interviews, the information was re-analyzed to ensure accuracy. The acquired information is being securely stored per Walden research protocol for five years. Since interviews were performed via Zoom, the audio recording have been password protected in a secure location on my computer accessible only to me.

Analysis of Data

Though not the most current source, Mills et al. (2012) provides a thorough explanation to the iterative methodology: A "systematic, repetitive, and recursive process in qualitative data analysis" and is useful guidance for the research at hand (p. 2). Each interview followed the same protocol and answers were analyzed using a hand-coding analysis. Initially, I assumed I would use Quirkos as a back-up for analysis. Upon further review, it appears the software does not actually analyze; it relies on the researcher to

identify the themes and codes and load them into the software. Therefore, there was no need for me to use the software simply to develop figures or tables. After coding, themes, were identified and anomalies were recognized. The data analysis was used to answer the research question regarding the availability of treatment and therapy for prison inmates as perceived by mental health professionals working in those facilities.

As a novice to research protocol, it was important to adhere to suggestions by professionals in the field. Lester et al. (2020) discussed the nature and intent of qualitative research and suggest learning how to do this type of research is a challenging venture. Although they specifically refer to Human Resource Development (HRD), their suggestions are relevant to the current study. They suggested using a thematic analysis and provide the basic steps in performing the tasks (Lester et al., 2020). For the research at hand, I followed the guidance to 1) prepare and organize the data for analysis, 2) transcribe the data, 3) become familiar with the data, 4) memo the data, 5) code the data, 6) categorize and theme the data, and 7) analyze the data (Lester et al., 2020). At each phase of the data analysis, it was a primary objective to ensure each step highlights the research question posed as the reason for the study.

Preparation and organization of the data was accomplished by utilizing the researcher-designed instrument and individually reviewing answers to interview questions to determine the perspective of each participant. In creating memos, I was able to memorialize initial reflections of the acquired information (Lester et al., 2020). Since I was familiar with the collected data, hand-coding and theming was accomplished more

quickly. The analysis of the data was authenticated by the redundancy of hand-coding and a final review of each transcript.

Quirkos is widely used to organize data and develop themes and connections within a data set and between different data sets (Harvey & Powell, 2020). However, it is not a necessary tool. It claims that after inputting the data, "bubbles" with recognized themes appear and draw attention to similarities in the data. The "recognized themes" it discussed are the themes recognized by me already. The software does not identify tone or nonverbal cues and does not interpret.

Trustworthiness

Trustworthiness is essential in all research. However, since qualitative research has historically been criticized as being subjective and less likely to be replicable, it is possibly more important to determine trustworthiness in qualitative studies. Although human beings are subject to bias or opinions on any matter, the information must be presented with a lack of personal bias and subjectivity in order to be considered trustworthy. Essentially, there are four aspects to consider in order to demonstrate trustworthiness of the research: credibility, transferability, dependability, and confirmability.

Credibility

Another term for credibility may be "believability" (Yourdictionary.com, n.d.) The current research reflects only themes identified through answers to interview questions relayed by participants in the study and supposition by the researcher developed from information obtained while researching the topic for Chapter 2. The

wording of the answers was quoted in many instances in order to allow for readers to interpret for themselves.

Transferability

Careful attention was paid to and memorialized by documentation of the process of data collection. In doing so, a like study may be completed in different states or in a single facility to determine transferability. Since budgets and resources differ from facility to facility and state to state, transferability was not an issue for the current study. This is discussed further in the "dependability" section.

Dependability

In order to determine if the information is, in fact, trustworthy, it is important to ensure the identified themes are replicable. Replicability is often not easily achieved in qualitative research (Anchundia & Fonseca, 2020). However, the current research was performed in several states and in the UK. Much of the information obtained was similar enough to demonstrate dependability and transferability. Regarding replicability, mental health professionals in different incarceration facilities in the same state would likely answer similarly and, when coding, similar themes would likely be apparent. In this research, this was true from state to state. In order to demonstrate the themes are transferable, it would be necessary to complete a similar research project in other states. Since no such research has been located, it is difficult to suggest the findings of the current research are transferable.

Confirmability

The responses to the questions on the interview protocol were transcribed verbatim. While the transcription service made *several* errors, a review of the transcripts while listening to the audio recording rectified them. Upon completion of the transcription, the typed interview was reviewed a second and third time. The transcripts were verbatim.

Ethical Considerations

Both mentally ill individuals and individuals having the status of "inmate" are protected groups and considered to be vulnerable populations. This fact assisted in refocusing on the mental health professionals working within prisons in lieu of interviewing the mentally ill inmates. Since the topic of this study focuses on mentally ill inmates, it is essential to act ethically and ensure privacy and confidentiality of all acquired data. In Tiidenberg's (2018) research, she suggested trust and empathy are vital parts of the ethical considerations one must contemplate. The open-ended questions posed to participants provoked a response from one participant and she named specific inmates. The names of the inmates were redacted and replaced with, "InmateA, InmateB, etc.) In order to maintain trust, the respondents were assured of the confidentiality of their information. Participants were also assured their responses will not be attributed to them by name in order to ensure anonymity. The assurance may have assisted in evoking factual and relevant responses to interview questions. Respondents were provided an informed consent contract which indicated their agreement to being recorded (audio only), the confidentiality of their answers, and an explanation as to how the information

they give will be utilized. These issues were addressed in Appendix A and advise participants of confidentiality, expectations, and their authority during the data collection process.

The increased risk of coercion is an ethical consideration when performing research in a prison setting (Abbott et al., 2018). While Abbott et al. (2018) described this concept regarding research studies involving inmates, the same can be true with participants who work at the facilities. In the state of North Carolina, the participants will be government or contract employees. They cannot be made to feel as though they are required (coerced) to participate or that their answers should reflect an opinion of their supervision.

Limitations

A significant limitation with this research was the inability to gain access by the prisons. However, the facilities had valid reasoning, the timing was not good. Social media recruiting turned out to be quicker than the "red tape of the DOC." A second limitation is the admission there is little in the way of fact checking the self-reporting provided by the participants in the study. Thirdly, a personal perspective of an event is inherently subjective, and it must be recognized not all individuals would necessarily perceive an instance in the same manner. A final limitation may be the fact that respondents in the study will largely be relying on memory. The memory may be intensified or diminished depending on the amount of elapsed time since an episode or event.

Summary

The deprivation and importation theories may be proven or disproven in any study as catalysts regarding inmate conduct. The mental health professionals working in their respective confinement settings were able to elucidate regarding specific interactions and describe details. The data were analyzed and coded in order to inform the field on the perspective of mental health professionals working within the prisons. Conducting interviews with mental health professionals working in the incarceration facilities demonstrated an insufficiency or inadequacy of mental health treatment, medication, and programs and assisted in identifying the need for additional therapy and treatment for inmates suffering mental illness. The analyzed data from interview responses will further the field in this area of knowledge.

Chapter 4: Results

Introduction

In this study, I interviewed nine mental health professionals working in prisons to understand their perspectives regarding the quality and availability of treatment and therapy for inmates. The only inclusive criterion for participants was to have a minimum of 1 year of experience in providing mental health care to inmates. I designed the criterion to ensure the amount of time of service at the current location of employment can be combined with other similar amounts of time in the type of job performed at any prison facility. Seven participants fit the criterion with their current employment. The participants who were not currently employed in that manner were as follows: a) P6 – This participant had 32 years of experience in corrections and mental health. His experience and education resulted in numerous promotions in order to effect change and create appropriate policy regarding mentally ill inmates in New York, and b) P4 – This participant was enrolled in school in order to focus on the medical side of caring for inmates. I performed coding of the interview transcripts by hand to determine if, in the perspectives of these professionals, there was adequate mental health care provided to inmates suffering with SPMI/SMI prior to and/or at the time of incarceration.

Participants

The required criterion was to have a minimum of 1 year experience treating mentally ill inmates. The participants had a combined total of (approximately) 95.5 years of experience in treating mentally ill inmates. Aside from data required to determine inclusion, the only demographic data were genders and locations. My study was not

designed to incorporate the perspectives of ethnicities, religions, races, or any other identifying information regarding participants. Some participants divulged education levels while others did not. I interviewed nine participants, eight women and one man. There was one participant from Texas (P1 with 10 years of experience), two from Idaho (P2 with 8 years of experience and P7 with 14 years of experience), one from Colorado (P3 with 5 years of experience), one from the United Kingdom P4 with 3.5 years of experience), one from Delaware/New Jersey (P5 with 13 years of experience), one from New York (P6 with 32 years of experience), one from North Carolina (P8 with 18 years of experience), and one from Missouri (P9 with 2 years of experience).

The participant who works in Delaware/New Jersey began working in New Jersey approximately 18 months ago. Prior to that, she worked in Delaware for over 11 years. Her ability to compare and contrast the availability and quality of treatment and therapy between the two states was invaluable regarding informing on best practices. The stark differences between the two states depicts images of the substandard type of treatment in Delaware and evidence-based practices in action in New Jersey. However, since that participant left Delaware, the state claims (through publications) to have made drastic changes regarding the care of mentally ill inmates. In the findings section, the participants will be discussed as P1, P2, P3… and so on. I assigned each participant a number to them indicate the order in which they were interviewed.

Methods

Personal interviews were the sole method of data collection for this research. The open-ended questions I asked were researcher developed and are located in Appendix A.

The answers to the questions provided a thicker, richer source of data than surveys or questionnaires might. The data were hand themed and coded utilizing transcripts which were highlighted and entering an abbreviated answer onto a Microsoft Excel spreadsheet. The data depicted on the spreadsheet showed similarities and differences in the answers provided, as well as some quantitative information.

Presentation of Findings

Since there is only one research question in my study, presenting the findings goes in order of the questions asked. During data collection, I asked numerous questions which were answered similarly. However, I noted the participants with the least experience diverged from the majority on some responses. While five participants did not mention COVID-19, the other four mentioned the pandemic 36 times. Those four participants described the pandemic as having had a significant impact on their jobs and the lives of the inmates.

The research question for this study was: How do mental health professionals working in prisons describe their individual perceptions of the quality and availability of mental health care provided to inmates? To answer the research question, I asked 21 questions to participants during Zoom meeting interviews. The theoretical framework, review of the literature, and recommendations made in that literature, were vital in assisting to develop the questions asked.

Question 1

Question 1 was: Please describe the type of facility in which you work. Include the number of inmates and the number of staff if known. Most participants omitted the number of staff who were not mental health professionals at each facility. As seen in Table 1, the stark differences in ratios of mental health professional to mentally ill inmates from facility to facility is astounding. It should be noted the number of inmates is not the number of mentally ill inmates. That will be discussed in section on Question 4.

The initials following the identification of the participant identify the type of facility in which each person works; SA stands for substance abuse, MAX is a maximum-security prison, MED is a medium-security prison, and P stands for prison when no level of security was identified by the participant. The others are self-explanatory.

While some participants did not know the number of mental health staff and P8 included all staff members, it is apparent that, between different states (and the United Kingdom), there is no consistency regarding ratio of mental health provider and inmates. In fact, P5 demonstrated the concept very succinctly. She stated she was responsible for treating and seeing 32 mentally ill inmates per day while working in Delaware prisons and is currently responsible for seeing five mentally ill inmates per day in New Jersey. She claimed her level of care has increased and her “guys” feel as though their concerns have been met.

Question 2

Question 2 was: Please discuss your title and the number of years in your current position and any relevant previous experience. The titles and years of experience of each

participant varied greatly. These numbers are crucial to demonstrate inclusion criterion, however, they are also beneficial in identifying the weight which one may want to give to subsequent answers to interview questions.

Table 1

Participants, Their Experience, and Their Job Titles

Participant	Experience (in years)	Job Title
P1	10	LPC
P2	5	Clinical Supervisor
P3	5	LCSW
P4	3.5	Mental Health Trust (U.K.)
P5	13	Psychiatric Nurse Practitioner
P6	32	Forensic Psychologist
P7	14	Clinical Supervisor
P8	18	Psychologist
P9	2	Psychometrist

Question 3

Question 3 was: Please describe how inmates are assessed at this facility during intake. Include types of questions as well as who administers the intake in regard to mental health assessment. All participants described a comprehensive examination given upon intake. All medical health, mental health, and substance abuse issues are addressed, and internal referrals are accomplished. Only P6 provided the number of questions asked regarding mental health (25). When probed regarding the types of questions, all participants stated inmates are asked questions regarding suicidal and/or homicidal feelings. The answers to Question 4 were congruent with identifying immediate needs yet did not suggest a full mental health evaluation is conducted upon intake. Such an exam would require a great deal of resources. Although expressing the intake is a

comprehensive evaluation, P3 claimed she would change the questions asked and had additional questions she would ask during intake.

Question 4

Question 4 was: Please discuss the number of inmates with serious mental illness at the facility and relevant diagnoses. In your response to this question, please include what you believe to be or what you know to be the percentage of mentally ill inmates with SPMI at the facility. It was emphasized to participants the question only pertained to inmates with SPMI. This study is not designed to include all inmates with every mental health diagnoses. Some participants had separate units at their facility for SPMI inmates. In those units, there was a 100% rate of SPMI mentally ill individuals. Those units were also filled to capacity at all times. Most suggested they did not know an exact percentage of mentally ill inmates and did not include their acute or separate units in their estimation of percentage of SPMI. The most common answer (P1, P3, and P8) was 50% of SPMI inmates in the general population. P2 estimated 35% to 40%, P5 estimated 25%, P6 estimated 40%, and P7 estimated 33%. The individuals with the least years of experience suggested the percentage to be 5% (P4) and 15% (P9).

Question 5

Question 5 was: What are your thoughts regarding SPMI inmate's behaviors evolving from being deprived freedom, goods and services, and heterosexual relationships? I derived this question from the deprivation theory where inmates behave in an unwanted fashion due to being deprived of freedoms, goods and services, and heterosexual relationships. Many participants suggested deprivation instigates unwanted

behavior of SPMI inmates. P7 stated it “100% plays a role.” However, she went on to suggest some SPMI inmates are more deprived of such necessities outside of prison. Some examples of violent behavior due to deprivation were provided by P2 and P4. Although P1 did not answer the question, other participants agreed deprivation “exacerbates” (P3), “creates problems” (P5), and creates an “absence of connection” (P6). Responses to this question from P8 and P9 were the same: deprivation is a factor in undesirable behavior with SPMI inmates.

Question 6

Question 6 was: What are your thoughts regarding SPMI inmate’s behaviors stemming from the diagnosis, beliefs, and experiences they may have had prior to entering prison? This question is in reference to the importation theory of inmate behavior where inmates import their own experiences, beliefs, experiences, and potentially, mental illnesses, into prison with them and that is the cause of misbehavior. The participants responded to this question with a unanimous decision and agreed the importation theory has more to do with the behavior. Two participants (P2 and P4) suggested trauma had a tremendous impact on the inmate behavior. Misdiagnosis or underdiagnosis was discussed by P6, suggesting the inaccuracy of diagnosis is what the inmate imports into prison. While P7 indicated 100% of the SPMI inmates import mental illness into prison, she was reminded of one inmate who did not. She discussed an individual who appeared to have no mental health issues on intake and within a year, experienced extreme psychotic episodes. Upon review of Matrone's et al.'s (2022) article, and due to the age of the individual, it is not unusual for men in their late teens and early

twenties to experience the onset of schizophrenia. Matrone et al. (2022) suggested adult onset of schizophrenia is any time over the age of 18. However, whether apparent and/or diagnosed prior to entering prison, the individual would have likely experienced the onset of schizophrenia regardless of their environment. That follows the importation theory as well. Interestingly, P9 suggested labeling has a great deal to do with inmate behavior and those labels tend to be a self-fulfilling prophecy.

Question 7

Question 7 was: Please explain the types of therapy (i.e. – group, individual, counseling, psychiatrist, psychologist, etc.) available to inmates. Three participants discussed how COVID-19 has significantly changed or completely canceled the occurrence and/or frequency of group therapy. When asked about therapy programs as they existed prior to the pandemic, some had not been working there at the time and only discussed programs as they are currently, and others provided information from before the COVID-19 pandemic.

Table 2
Therapy Availability and Frequency

Participant	Therapy – Availability and Frequency
P1	G/Daily-Ind/Mo or BiMo-On Request-Family 1xWk
P2	G/Wk-I/Wk-BiWk or Mo
P3	G/2 or 3 Wk/I-1Wk
P4	G/Daily preCOVID
P5	Watch-Daily SPMI-1xWk for 60 days on request 2x-mo norm G-6x Mo preCOVID
P6	Only stated there are I & G therapy
P7	BHU-Acute MHUs-CBT-G&I
P8	2xWk-psych 1xWk-G 1xWk-I
P9	Seg-Suicide watch-Protective custody-All monitored. Ind-1xor 2xWk or as needed. G-COVID delayed.

G=Group I=Individual BHU/MHU/CBT=Acute Units Wk=Weekly Mo=Monthly

During the interview, P5 expressed extreme disappointment by her "guys" as well as herself when discussing the lack of group therapy sessions due to the pandemic. P5's answer indicates "Watch." She stated she had "10 guys" on watch and those SPMI inmates are seen on a daily basis in order to prevent self harm and to assess their mental status for improvement or decompensation. She also stated she feels she has made a difference because, since she arrived at the facility 18 months ago, no new individuals have been placed on watch.

Similarly, P9 had individuals on segregation (also called protective custody) as well as those on suicide watch. She said those individuals are monitored hourly and seen for individual therapy daily. The remaining general population of SPMI receives individual therapy once or twice per week. P9 also asserted group therapy is non-existent due to the pandemic.

Question 8

Question 8 was: Please explain why you believe the therapy is or is not effective. The answers provided was a resounding "Yes" by all nine participants. However, eight added caveats in their responses. Those qualifications are as follows:

- P1: "As long as it's not forced."
- P2: "If they have the cognitive capability."
- P3: "It's effective for shorter sentenced inmates."
- P4: "If they're engaged [participating]."
- P5: "*Very* effective, except with schizophrenia."
- P6: "If it's combined with medication."

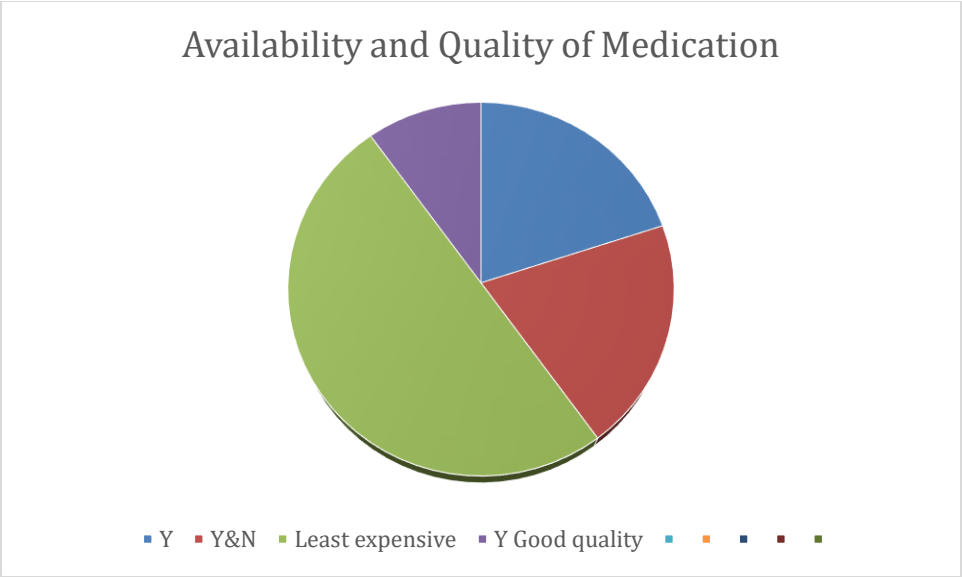
- P7: “But it can’t be more therapy than they receive in the community.”
- P8: Did not have a caveat. She provided a success story regarding effective therapy.
- P9: “It’s only effective for people who want it.”

Question 9

Question 9 was: Please discuss your perception of medication available to inmates at your facility. Although Q9 only discussed the availability of medication, many participants discussed the medications and the lack of quality. Two participants simply stated SPMI inmates do receive medications. Two participants stated some inmates receive medications while others do not. Five of the nine participants indicated the medication available was substandard and inadequate. However, P5’s answer was counted twice to accommodate the comparison between two states. Her first answer encompassed her experience in the State of Delaware and suggested the only medication she was able to receive was the least expensive. Her second answer was regarding the State of New Jersey where she stated she is able to get any medication she requests, regardless of the price.

Figure 1

Availability and Quality of Medication



Question 10

Question 10 was: Please explain why you believe the medication is or is not effective. Much like Q8 regarding the effectiveness of therapy, participants all agreed medication is effective. However, following their initial answer of "Yes," most qualified their answers as follows:

- P1: "If it's the right diagnosis."
- P2: No qualification.
- P3: "If it's crushed." (This information is regarding inmates "cheaking" meds and selling them.
- P4: "If it's combined with therapy."
- P5: "…And should be combined with therapy." (This answer is for NEW JERSEY.)

- P5: “Not as effective as it could be. We’re not allowed to use the best meds.” (This answer is for DE.)
- P6: “If it’s combined with therapy.”
- P7: “However, they always try lesser expensive meds.”
- P8: “Relatively.”
- P9: “It can be. Some mental illness is too far gone. Some would rather deal with mental illness than the side effects of the medication.”

Question 11

Question 11 was: Discuss your thoughts on the inmates with SPMI and if you believe the illness was pre-existing prior to incarceration. Again, all nine participants asserted the individuals with SPMI had the condition, if not the diagnosis, prior to entering prison. P9 again discussed the one and only case of schizophrenia she witnessed develop in prison. P7 alluded to that same issue by stating inmates are at the “ripe age of 21-25 for developing schizophrenia.” The issue regarding misdiagnosis and underdiagnosis was addressed again by P6. He believed the inmates did come into prison with mental illness and suggested the diagnosis they had received prior to entering should be reevaluated. P3 vehemently suggested prison is “not the right place” for SPMI inmates and suggested an alternative should be made available.

Question 12

Question 12 was: Discuss your thoughts regarding the prison/jail environment and if you believe inmates experiencing deprivation has a negative effect on the diagnosis. All participants except P3 agreed prison does have a negative effect on inmates with

SPMI. P3 focused on solitary confinement and suggested it had no negative effect because “prison is a noisy place” and many SPMI inmates need peace and quiet. She claimed isolation provides such a respite. P5 suggested prison, in general, has a negative effect on this population, however, “not in NEW JERSEY.” P6 asserted security establishment was a priority to attempt to alleviate the negative effect. P9’s answer was, “Absolutely!”

Question 13

Question 13 was: If there are programs at your facility which cater to mentally ill inmates, please discuss them with as much detail as possible. For a third time, the diversity in answers to Q13 requires a separation of information to address the different discussion topics in order to understand the perspectives of each mental health professional. Additionally, the differences between the different states (and the UK) are highlighted in Q13.

P1: Discussed mostly medical and educational programs.

P2: Discussed the different group and individual therapy programs and emphasized the lack of programs due to the pandemic.

P3: Discussed the acute unit only.

P4: Discussed the jobs given to inmates in the facility, mental health rehabilitation, and therapy.

P5: Discussed the facility in NEW JERSEY as being a farm and the innumerable types of jobs there are on the farm. She was effusive in explaining how those programs keep the “guys” busy and provides a sense of self-worth and accomplishment. She went on to

explain the facility had AA and NA programs as well as educational and reentry programs.

P5: She stated no or little of such programs were available in the DE facilities when she worked there.

P6: Discussed CBT, "Thinking for Change," and the restraining cages built to virtually immobilize aggressive and assaultive inmates.

P7: Focused mostly on a companionship program. The program tries to match inmates who would likely be able to live well together without incidents.

P8: Discussed work programs (highlighting a license plate program which seems to add to the inmates' self-esteem) and group programs.

P9: Discussed the issue of the pandemic and how it has virtually shut down all programs except the reentry program.

Question 14

Question 14 was: Please explain if you believe the programs are or are not effective. The participants decisively stated the programs, when available, are indeed effective. However, there were some dissenters. P1 stated the programs are not as effective as they could be. P2 said some programs are not effective. P6 stated he believed they were but had no research available to support his belief. P7 claimed a lack of funding made programs effective "in their own way." The participants who believed strongly the programs did make a difference, made comments such as, "Yes. Massively," "Yes. Very," and "Yes. It gives them a sense of accomplishment."

Question 15

Question 15 was: Please describe interactions, treatments, and therapy sessions with mentally ill inmates you have had or witnessed. Upon review of the transcript, P4 did not technically answer Q15. Three participants (P1, P7, and P9) provided examples of interactions with inmates:

Early onset schizophrenia was addressed. P1 was deeply affected by the trauma the young man experienced during his "whole life." She stated she wished she had more time with him. Her care and concern were evident while recalling the experience with the inmate.

P7 discussed an inmate who had been doing well while incarcerated and quit taking his medications just prior to being released. Her recitation of the ensuing events regarding prison officials attempting to retain custody of him and her perseverance in finding appropriate disposition was a testament to her dedication. She was able to get him the psychological help outside of prison even though he was involuntarily committed.

P9 provided two examples of schizophrenic inmates. She claimed she was performing an assessment of a young man who consulted the "guy on his shoulder" each time he was going to provide an answer to a question. She claimed he was happy and very funny, and she thoroughly eNew Jerseyoyed the experience. The second example was regarding another individual with a schizophrenic diagnosis. He did much the same as the first example in consulting with a "guy on his shoulder." However, she heard the inmate tell this invisible being, "We don't need to handicap her." She was very frightened.

The remaining participants stated:

P2 – Tended to focus on risk, safety, and ADLs

P3 – Many SPMI inmates have a hypersexual psychosis and tend to be manipulative and deceptive.

P5 – She spends a minimum of one hour per week with each SPMI diagnosed inmate and cited she was able to do so due to the requirement to see only five inmates per day (NEW JERSEY) as opposed to 32 inmates per day (DE).

P6 – Discussed performing group therapy and training sessions for inmates. He described how many in the women's prison he worked at, were resentful the sessions were mandatory and only showed up because the court would look favorably on their attendance. He stated the inmates who did not want to attend would not participate.

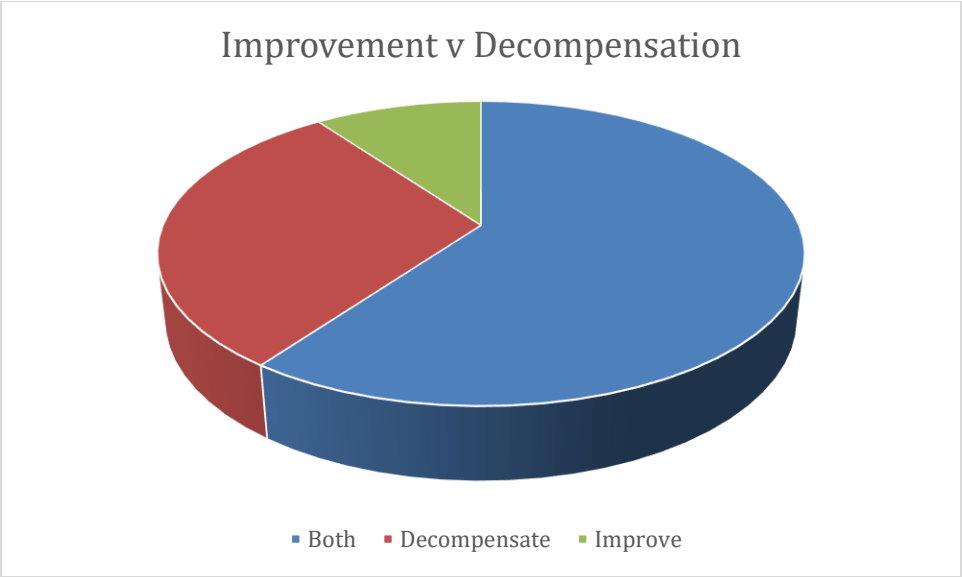
P8 – Discussed the SPMI inmates which felt as though they were largely ignored because the psychologist failed to spend the allotted time with them. She explained they felt as though they needed to say more to the psychologist when they were dismissed.

Question 16

Question 16 was: Please explain if you believe mentally ill inmates tend to improve in their mental health status or if you believe they tend to decompensate while incarcerated at your facility. Again, P5's answer was counted twice to accommodate the comparison between the states in which she worked. Therefore, 10 answers are provided from the nine participants.

Figure 2

Improvement versus Decompensation



Six participants believe SPMI inmates both improve in their mental health status and decompensate. The myriad of reasons given for this are the diagnosis, consistency of medications, the availability of the appropriate medications, and the inmates engagement in therapy and treatment. P5 claims the inmates in NEW JERSEY improve and the inmates in DE decompensate. P7 suggested whether an inmate improves or decompensates is largely dependent upon the length of the inmate's sentence: Short sentenced individuals tend to improve while lengthy sentenced individuals decompensate. P8 claimed 60% of SPMI inmates decompensate due to lack of funding and resources. P6 discussed decompensation in terms of humanity. He believes the treatment and attitudes of the correctional officers (COs) has an effect on mental health improvement or lack thereof and suggested the COs need mental health training.

Question 17

Question 17 was: Please discuss your beliefs regarding the increase or decrease of the mentally ill individuals at your facility and how the increase or decrease affects your job. Aside from P6's answer which claimed his state is undergoing a criminal justice reform and, therefore, fewer inmates are entering the system, all other participants suggested mentally ill inmates are increasing at their respective facilities. Additionally, P5 stated there is a "pause" in receiving inmates due to the pandemic. However, the percentage of mentally ill inmates had been steadily increasing prior to March of 2020. P3 stated mental illness among inmates is increasing partially due to the aging population in prison developing dementia and other mental illnesses. P7 claims her facility sees "sicker and sicker" inmates partially due to the lack of community-based treatment, lack of funding, and the nonavailability of group homes. She discussed the states recent mandate for an RN to be at every group home and the inability to comply with the mandate. P8 stated the increase of mentally ill inmates has created instability in her workload and decreases the amount of time she is able to spend with each SPMI inmate. P9 reiterated that same sentiment regarding time spent with inmates.

Question 18

Question 18 was: Please discuss the inmates you have treated or had contact with who were adjudicated in Mental Health Court. Most of the participants were unfamiliar with Mental Health Court (MHC) or had limited knowledge of it. However, P1 worked at a prison for substance abusers/mentally ill inmates. She stated 100% of her "clients" had been adjudicated in MHC or "drug court." P2 stated she only knew MHC was designed to

keep people out of prison. P5 was familiar with MHC and provided an example of a success story she was involved in years ago.

Question 19

Question 19 was: Please discuss your viewpoint regarding mentally ill inmates and their propensity to be violent in the prison. The variety of answers (yet mostly similar) to Q19 is as follows:

- P1: “They’re not the violent ones.”
- P2: “There’s a staff assault at least once a week.”
- P3: “I don’t usually see them being violent, they’re more confused.”
- P4: “They’re more at risk.”
- P5: “I have a lot of examples of violence when I was in Delaware.”
- P5: “There hasn’t been one instance of violence in my 18 months in New Jersey.”
- P6: “When they’re actively psychotic, they’re a challenge.”
- P7: “I think violent mentally ill people are a stereotype. There is occasional violence.”
- P8: “I’ve only had two episodes in eight years.”
- P9: “When they’re scared, they hallucinate and create violent acts.”

According to the participants, the prevalence of violence committed by mentally ill inmates seems to reflect what much of the literature discusses. Although it occurs, it is not as pervasive as many might believe.

Question 20

Question 20 was: Please discuss your viewpoint regarding mentally ill inmates and their propensity to be victimized in the prison. The answer to Q20 was alike for 100% of the participants. All claimed mentally ill inmates are more likely to be victimized by “devious” and “mean” inmates. P5 stated she witnessed it several times while in DE but has not witnessed it in NEW JERSEY. P6 claimed it is a “big problem.” P9 stated her facility keeps victimized SPMI inmates in segregation for their protection.

Question 21

Question 21 was: Please provide any additional thoughts you may have on this topic which were not addressed in the questions you answered. Although the participants’ initial impulses seemed to be to represent their facilities in a positive light, as questions persisted, they became more comfortable and discussed the facilities with honesty and cited shortcomings. For example, the final question asks the participants if they would like to add anything not covered in their answers to the previous questions The majority of the answers focused on resources. Aside from the “physical health” answer, and concern regarding the pandemic, the answers indicate a need for funding to permit hiring additional staff to accommodate time spent with inmates, education, training, reentry programs, and better programs. None of it can be accomplished without funding. The recommendations are a proactive approach to the issues and may minimize the expense of treating as well as incarcerating if the funding is made available. It might also provide safer environments for staff and inmates.

Summary of Findings

Although the participants work at several types of facilities in many different states (and the UK), their job titles vary, and their experience levels are diverse, they came to the same or similar conclusion on many of the 21 questions asked. The frequency in which there was a consensus demonstrates the inadequacies cited in much of the previous literature regarding mentally ill inmates.

The participants who work face-to-face with these individuals on a daily basis (all except P6 who has risen to an administration position) showed a tremendous amount of concern and a dedication to their "clientele" while participating in the interviews. In discussing how she views her role in treating mentally ill inmates and their entrance into prison, P7 stated they needed stability and, "It helps get a 'hug wrapped around them,' that's what I like to call it…" Many of the participants referred to the mentally ill inmates they treat as, "my guys." The interview of P5 was akin to performing two separate interviews. Her ability to compare and contrast the states of DE and NEW JERSEY was illuminating and starkly different. She described the NEW JERSEY farm in which her facility is located and how the programs provide purpose for the mentally ill inmates. In describing the difficulty in treating schizophrenia, her final thought was, "Don't get me wrong, I love my schizophrenics!"

Chapter Summary

Chapter 4 has explained the research method, the hand-coding and hand-theming process, a comprehensive depiction of the participants, and the findings of the research. Although it is apparent there is a Criminal Justice Reform Movement (CJRM) in process,

it is still unclear how much of a focus of that movement will be placed on prisons, much less the mentally ill population in correctional facilities. It is my hope this research and recommendations by the mental health professionals (a.k.a. – those on the front line) will assist in creating the necessary social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to evaluate the efficacy of treatment and therapy for mentally ill inmates with SPMI through the lens of the frontline workers, the mental health professionals who provide the treatment and therapy. I used qualitative methodology and interviewed participants via Zoom meetings. The same 21 questions were asked in the same order to each of the nine participants. In chapter 5, I summarize my interpretation of the findings, the limitations of the study, recommendations, the implications for social change, and a conclusion.

Interpretation of Findings

Although interpretation can be subjective, the responses to many questions from the participants developed a consensus creating a more objective viewpoint. The participants had varying degrees of experience, different job titles, and diverse types of facilities in which they worked. That diversity is significant in view of the similar responses to a majority of questions. It would be expected answers might coincide for individuals working in similar facilities and/or with similar experience levels. However, that is not the case in my research. The uniqueness of each participant, discussed in Chapter 4, was largely irrelevant when reviewing the comparable responses.

I addressed the importation theory and the deprivation theory through questions posed to the participants. As expected, responses indicated both theories can be attributed to the behavior of inmates with SPMI. There was a consensus among participants that unwanted inmate behavior is possibly equally attributable to being deprived freedom,

goods and services, and relationships as much as past experiences (specifically trauma) and existing mental illness. As discussed in the framework in Chapter 1, importation and deprivation theories can be present concurrently and be causal factors simultaneously (Bumberry & Grisso, 1981).

The research question for this study was: How do mental health professionals working in prisons describe their individual perceptions of the quality and availability of mental health care provided to inmates? Though there were differences and/or caveats in the responses provided, participants suggested: a) A comprehensive intake assessment was performed at entry; b) Importation and deprivation theories are contributory factors regarding inmate behavior; c) Therapy is available (limited during the pandemic) and effective; d) Medications are available and have varying degrees of effectiveness depending on the facility's financial capabilities in providing the most effective medications; e) Mental illness was preexisting prior to incarceration; f) Deprivation has a negative effect on SPMI inmates; g) The programs at the respective facilities are effective; h) The percentage of mentally ill inmates is increasing; i) Mentally ill inmates are more likely to be victimized than the aggressor; and j) Funding and resources are necessary to improve the current system.

Limitations

There has been an enormous influx of research requests for correctional facilities due to COVID-19. Prisons are reticent to approve requests not pertaining to the pandemic. The staff and personnel are overwhelmed with such requests, and to accommodate other research, the personnel would have virtually no time to actually

perform their jobs. Some participants described environments in which many mental health professionals refuse work. Therefore, it is understandable the limited staff are not able to assist in the research. That reality made it improbable to conduct this research at a single correctional facility. Therefore, one limitation of my study was there is no ability to compare answers among coworkers in the same prison.

Communication is verbal and nonverbal and has the ability to simultaneously engender meaning (Abduqadirovna, 2022). Since the Walden University IRB informed me it is not acceptable to videotape participants in an interview, the Zoom cameras were turned off and I was unable to visually observe the participants as they answered the questions. The inability to perform face-to-face interviews which would have lent to journal entries explaining facial expressions and body language. The inability to describe nonverbal communication was a second limitation.

Recommendations

It is apparent more research needs to be conducted regarding mentally ill inmates. More specifically, research regarding the viewpoints of mental health professionals working in prisons should be conducted. Much of the information needed to make educated recommendations was derived the interview and transcript from P5's experiences in Delaware and New Jersey. In Delaware, she was required to see 32 inmates per day, there were few or no work programs available to inmates, expensive medications were not accessible, and untrained correctional officers were called in to handle individuals suffering psychotic episodes. In New Jersey, P5 claims she is required to see five inmates per day and is able to give the time and attention they need to address

their symptoms and concerns. The facility is located on a farm and the inmates, including SPMI inmates, are the ones who run the farm. Their chores provide a sense of self-worth and accomplishment. She is able to order any and every medication she requests, regardless of cost. If a correctional officer encounters a potentially psychotic episode, they call P5 to handle it and no further action is taken. The New Jersey facility's health and mental health is run by collegiate individuals from Rutgers University and, according to P5, runs better than any other prison in which she has worked.

Many participants discussed three medications they believed to be effective but were unavailable to inmates: Invega, Wellbutrin, and Abilify. Some participants suggested the medications have proven to be highly effective, yet they are too expensive for their facility to be able to afford with current budgets. P5 had a patient (inmate) at a women's institution who was going to be at the facility for a very short time period. She explained how she had to, in her words, "throw a fit" to get the inmate the necessary medication. She explained the inmate would have decompensated and therapy and treatment would need to start over when the inmate was paroled. Other participants suggested the medication was not provided partly due to inmates selling the medication to other inmates. Many participants suggested that can be avoided by crushing the tablets at the time they are dispensed or giving them shots of the medication.

Largely, the participants in this study confirmed results of decades of studies that illustrate inadequacies in mental health treatment behind bars. However, a lack of resources has also been historically a reasoning behind the recommendations the participants made. The participants' answers demonstrate a need for prisons to be a focus

on the CJRM in order to attain public, staff, and inmate safety as well as save taxpayer money and achieve true justice. It appeared as though much of the standard operating procedures by many facilities in which the participants worked have continued to do things the same way they have been done for decades. A failure to improve processes and seek out evidence-based practices (such as those described in the New Jersey facility) will create a continuation of the same problems and the same results if using the same solutions. Additionally, as suggested by P6, it is imperative for COs to receive mental health training.

Implications for Social Change

An obvious obstacle in the CJS is the rate of recidivism. Many programs have been created in order to address the issue. However, the rates frequently continue to rise or remain consistent. In New Jersey, the governor enacted an early release program following the onset of the pandemic to alleviate the overcrowding; he called the program "Public Health Credits" (PHC). Thousands of inmates were released early. One year later, statistics were gathered and only 9% of those released were returned to custody (Yi, 2022). Not only does this information lends to the recommendations section above, it also demonstrates the implications for social change. It appears as though New Jersey has a formula for creating the necessary changes for the betterment of societies across the nation as well as within prisons.

The majority of inmates have family members outside of prison. Those family members are a part of a society. They may understand their loved one has committed a crime; however, they should be able to expect their family member receives adequate

treatment in all respects. If an individual's mental illness was a proximate cause of the commission of the crime, it is likely that individual and society would benefit more from being in a facility with a primary objective of providing mental health treatment.

Conclusions

Each participant with an acute mental health unit at their facility suggested the beds in that unit were filled at all times. This potentially indicates there are many more inmates in the general population who would also benefit from occupying a bed in the acute unit, yet there is no room for them. Most correctional facilities have been operating in the same manner for decades with limited or no changes and/or improvements to processes. However, according to the literature and the participants in this study, the percentage of mentally ill inmates has steadily increased. Torrey et al. (2017) ominously warns, "Treat or Repeat." This may be proven true by P5's information that New Jersey prisons do treat mentally ill inmates and Yi (2022) informed New Jersey has less of a recidivism rate. Blount (2019) informs the recidivism rate is lower among individuals processed through the diversionary program, MHC. This program is precisely the venue for individuals whose mental illness was a causal factor in the commission of their crime. Though Hoge's (2022) focus is largely on transition and outpatient treatment, he also noted the deinstitutionalization movement has created a large population of mentally ill inmates. It is time to destigmatize and decriminalize mental illness and treat these individuals without depriving them of their freedom. Therapeutic jurisprudence is a concept that will help society as well as the individual involved in the criminal justice system.

References

Abbott, P., DiGiacomo, M., Magin, P., & Hu, W. (2018). A scoping review of qualitative research methods used with people in prison. *International Journal of Qualitative Methods*, *17*(1), 1–15. https://doi.org/10.1177/1609406918803824

Abduqadirovna, K. G. (2022). Etiquette in communication: Verbal and non-verbal forms of behavior. *Analytical Journal of Education and Development*, *2*(1), 105–108.

AbuDagga, A., Wolfe, S., Carome, M., Phatdouang, A., & Torrey, E. F. (2016). *Individuals with serious mental illnesses in county jails: A survey of jail staff's perspectives* (pp. 1–74) [A Research Report From Public Citizen's Health Research Group and The Treatment Advocacy Center]. https://www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.

Anchundia, C. E., & Fonseca C., E. R. (2020). Resources for Reproducibility of Experiments in Empirical Software Engineering: Topics Derived From a Secondary Study. *IEEE Access*, *8*, 8992–9004. https://doi.org/10.1109/ACCESS.2020.2964587

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice, 16 psych. Pub. Pol. And l. 39. *Psychology, Public Policy, and Law*, *16*(39), 39–54.

Angell, B., Matthews, E., Barrenger, S., Watson, A. C., & Draine, J. (2014). Engagement processes in model programs for community reentry from prison for people with serious mental illness. *International Journal of Law and Psychiatry*, *37*(5), 490–500. https://doi.org/10.1016/j.ijlp.2014.02.022

Arstein-Kerslake, A., & Black, J. (2020). Right to legal capacity in therapeutic jurisprudence: Insights from critical disability theory and the convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, *68*, 1–10. https://doi.org/10.1016/j.ijlp.2019.101535

Baird, C. (2017). *Criminogenic Needs* (Briefing 3 of 6; Criminogenic Needs, pp. 1–6). National Council on Crime and Delinquency. https://www.nccdglobal.org/sites/default/files/criminogenic_needs.pdf

Barrenger, S. L., Draine, J., Angell, B., & Herman, D. (2017). Reincarceration risk among men with mental illnesses leaving prison: A risk environment analysis. *Community Mental Health Journal*, *53*(8), 883–892. https://doi.org/10.1007/s10597-017-0113-z

Bebbington, P., Jakobowitz, S., McKenzie, N., Killaspy, H., Iveson, R., Duffield, G., & Kerr, M. (2017). Assessing needs for psychiatric treatment in prisoners: Prevalence of disorder. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *52*(2), 221–229. https://doi.org/10.1007/s00127-016-1311-7

Besney, J. D., Angel, C., Pyne, D., Martell, R., Keenan, L., & Ahmed, R. (2018). Addressing women's unmet health care needs in a Canadian remand center: Catalyst for improved health? *Journal of Correctional Health Care*, *24*(3), 276–294. https://doi.org/10.1177/1078345818780731

Blount, M. (2019). Mental health courts: Mental illness, diversion programs and recidivism [Ph.D., Walden University]. In *ProQuest Dissertations and Theses*. http://search.proquest.com/pqdtlocal1005747/docview/2309942109/abstract/2126717FE1194F82PQ/1

Bowler, N., Phillips, C., & Rees, P. (2018). The association between imported factors and prisoners' mental health: Implications for adaptation and intervention. *International Journal of Law and Psychiatry*, *57*, 61–66. https://doi.org/10.1016/j.ijlp.2018.01.001

Bronson, J., & Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates*. 17.

Bronson, J. M., & Berzofsky, M. E. (2017). *Indicators of mental health problems reported by prisoners and jail inmates , report 2011-12* (Bureau of Justice Statistics NCJ 250612; pp. 1–17). U.S. Department of Justice. https://pdfs.semanticscholar.org/f4ad/2be77c5a5f7a5e6e45958d4e1c8bdd4e2af7.pdf

Bumberry, W. M., & Grisso, J. T. (1981). Importation versus inmate socialization as the primary determinant of perceptions of halfway house residents. *Journal of*

Community Psychology, *9*(2), 177–187. https://doi.org/10.1002/1520-6629(198104)9:2<177::AID-JCOP2290090210>3.0.CO;2-G

Bursac, R., Raffa, L., Solimo, A., Bell, C., & Ford, E. (2018). Boundary-spanning care: Reducing psychiatric rehospitalization and self-injury in a jail population. *Journal of Correctional Health Care*, *24*(4), 365–370. https://doi.org/10.1177/1078345818792055

Butler, M. (2020). Using Specialised Prison Units to Manage Violent Extremists: Lessons from Northern Ireland. *Terrorism and Political Violence*, *32*(3), 539–557. https://doi.org/10.1080/09546553.2017.1388791

Byrne, G., & Ní Ghráda, Á. (2019). The application and adoption of four 'third wave' psychotherapies for mental health difficulties and aggression within correctional and forensic settings: A systematic review. *Aggression and Violent Behavior*, *46*, 45–55. https://doi.org/10.1016/j.avb.2019.01.001

Capuzzi, E., Pini, E., Malerba, M. R., Cova, F., Lax, A., Mauri, S., Ornaghi, A., Provenzi, M., Rubelli, P., Sergio, M. R., Truisi, E., & Clerici, M. (2019). Factors associated with referrals to high security forensic services among people with severe mental illness and receiving inpatient care in prison. *International Journal of Law and Psychiatry*, *62*, 90–94. https://doi.org/10.1016/j.ijlp.2018.11.003

Cheesman, F. L., Graves, S. E., Holt, K., Kunkel, T. L., Lee, C. G., & White, M. T. (2016). Drug court effectiveness and efficiency: Findings for Virginia. *Alcoholism Treatment Quarterly*, *34*(2), 143–169. https://doi.org/10.1080/07347324.2016.1148486

Chow, W. S., Ajaz, A., & Priebe, S. (2019). What drives changes in institutionalised mental health care? A qualitative study of the perspectives of professional experts. *Social Psychiatry and Psychiatric Epidemiology; Heidelberg*, *54*(6), 737–744. http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s00127-018-1634-7

Cohen, S. (2019). Q&A: A look at the issue of mentally ill inmates in jails. *Canadian Press*. https://advance-lexis-com.ezp.waldenulibrary.org/document/?pdmfid=1516831&crid=9e2f4e14-2722-45e2-8959-26a46374316e&pddocfullpath=%2Fshared%2Fdocument%2Fnews%2Furn%3AcontentItem%3A5WC8-VRV1-DY9S-T243-00000-00&pdcontentcomponentid=253760&pdteaserkey=sr1&pditab=allpods&ecomp=pp79k&earg=sr1&prid=eb2edc47-143a-4198-93f2-32eb1c2dd0ee

Collins, T. N., Avondoglio, J. B., & Terry, L. M. (2017). Correctional psychopharmacology: Pitfalls, challenges, and victories of prescribing in a correctional setting. *International Review of Psychiatry*, *29*(1), 34–44. https://doi.org/10.1080/09540261.2016.1235017

Costopoulos, J. S., & Wellman, B. L. (2017). The effectiveness of one mental health court: Overcoming criminal history. *Psychological Injury and Law*, *10*(3), 254–263. https://doi.org/10.1007/s12207-017-9290-x

Cummins, I., & Edmondson, D. (2016). Policing and street triage. *The Journal of Adult Protection; Brighton*, *18*(1), 40–52. http://dx.doi.org.ezp.waldenulibrary.org/10.1108/JAP-03-2015-0009

Dahlberg, H., & Dahlberg, K. (2019). The question of meaning—A momentous issue for qualitative research. *International Journal of Qualitative Studies on Health & Well-Being*, *14*(1), 1–12. https://doi.org/10.1080/17482631.2019.1598723

Daquin, J. C., & Daigle, L. E. (2018). Mental disorder and victimisation in prison: Examining the role of mental health treatment. *Criminal Behaviour & Mental Health*, *28*(2), 141–151. https://doi.org/10.1002/cbm.2056

de Souza, D. S., Ventura, C. A. A., Carrara, B. S., Moll, M. F., & Mendes, I. A. C. (2020). Exercise of human rights of institutionalized persons: Perception of psychiatric hospital professionals. *Revista Brasileira De Enfermagem*, *73*(1), 1–8. http://dx.doi.org.ezp.waldenulibrary.org/10.1590/0034-7167-2018-0519

DeHart, D., & Iachini, A. L. (2019). Mental health & trauma among incarcerated persons: Development of a training curriculum for correctional officers. *American Journal of Criminal Justice*, *44*(3), 457–473. http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s12103-019-9473-y

Delgado, D., Breth, A., Hill, S., Warburton, K., & Stahl, S. M. (2020). Economics of decriminalizing mental illness: When doing the right thing costs less. *CNS Spectrums*, 1–5. https://doi.org/10.1017/S1092852919001792

DeLisi, M., Trulson, C. R., Marquart, J. W., Drury, A. J., & Kosloski, A. E. (2011). Inside the prison black box: Toward a life course importation model of inmate behavior. *International Journal of Offender Therapy and Comparative Criminology*, *55*(8), 1186–1207. https://doi.org/10.1177/0306624X11383956

Dempsey, C., Quanbeck, C., Bush, C., & Kruger, K. (2020). Decriminalizing mental illness: Specialized policing responses. *CNS Spectrums*, *25*(2), 181–195. https://doi.org/doi:10.1017/S1092852919001640

di Giacomo, E., & Clerici, M. (2020). Violence and mental disorders in jails. In B. Carpiniello, A. Vita, & C. Mencacci (Eds.), *Violence and Mental Disorders* (pp. 203–209). Springer International Publishing. https://doi.org/10.1007/978-3-030-33188-7_11

Dierenfeldt, R., Scott, S., Iles, G., & Smith, M. (2020). Examining college student perceptions of criminal justice outcomes among persons with mental illness. *International Journal of Offender Therapy and Comparative Criminology*, 1–23. https://doi.org/10.1177/0306624X19899642

Dinerstein, R. D. (2016). The Olmstead imperative: The right to live in the community and beyond. *Inclusion*, *4*(1), 16–20. https://doi.org/10.1352/2326-6988-4.1.16

Ellis, H., & Alexander, V. (2017). The mentally ill in jail: Contemporary clinical and practice perspectives for psychiatric-mental health nursing. *Archives of Psychiatric Nursing*, *31*(2), 217–222. https://doi.org/10.1016/j.apnu.2016.09.013

Fisler, C. (2015). When research challenges policy and practice: Toward a new understanding of mental health courts. *The Judge's Journal*, *54*(2), 6.

Freudenreich, O. (2020). History of Schizophrenia Care. In O. Freudenreich (Ed.), *Psychotic Disorders: A Practical Guide* (pp. 451–464). Springer International Publishing. https://doi.org/10.1007/978-3-030-29450-2_34

Goldberg, R. C. (2016). The antidotes to the double standard: Protecting the healthcare rights of mentally ill inmates by blurring the line between Estelle and Youngberg. *Yale Journal of Health Policy, Law, and Ethics*, *16*(Winter), 111–145.

Gonzalez, J. M. R., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health; Washington*, *104*(12), 2328–2333.

Gottfried, E. D., & Christopher, S. C. (2017). Mental disorders among criminal offenders: A review of the literature. *Journal of Correctional Health Care*, *23*(3), 336–346. https://doi.org/10.1177/1078345817716180

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house." *Administrative Issues Journal: Education, Practice & Research*, *4*(2), 12–26. https://doi.org/10.5929/2014.4.2.9

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Harki, G. A. (2019). For many inmates, mental illness is a death sentence. *American Jails*, *33*(2), 8–17.

Harvey, J., & Powell, J. (2020). Factors influencing the implementation of self-management solutions in healthcare: An interview study with NHS managers | British Journal of Healthcare Management. *British Journal of Healthcare Management*, *26*(3), 1–12.

Helfgott, J. B., Hickman, M. J., & Labossiere, A. P. (2016). A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program. *International Journal of Law and Psychiatry*, *44*, 109–122. https://doi.org/10.1016/j.ijlp.2015.08.038

Hoban, R. (2021). NC House counters Senate budget with more funding for mental health, home and community services. *North Carolina Health News*, 1.

Hoffman, R., Hirdes, J., Brown, G. P., Dubin, J. A., & Barbaree, H. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry*, *47*, 28–35. https://doi.org/10.1016/j.ijlp.2016.02.031

Hoge, S. K. (2022). Providing transition and outpatient services to the mentally ill released from correctional institutions. In R. B. Greifinger (Ed.), *Public Health Behind Bars: From Prisons to Communities* (pp. 445–460). Springer US. https://doi.org/10.1007/978-1-0716-1807-3_30

Honegger, L. N. (2015). Does the evidence support the case for mental health courts? A review of the literature. *Law and Human Behavior*, *39*(5), 478–488. https://doi.org/10.1037/lhb0000141

Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). Interventions at the transition from prison to the community for prisoners with mental illness: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research; New York*, *45*(4), 623–634. http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s10488-018-0848-z

Hutchison, D. (2017). Inadequate mental health services for mentally ill inmates. *Whittier Law Review, 4*(39), 161–179.

Jachimowski, K. G. (2018). The relationship between mentally disordered inmates, victimization, and violence. *Journal of Offender Rehabilitation, 57*(1), 47–65. https://doi.org/10.1080/10509674.2017.1416438

Jacobs, A. M., Buthe, T., Arjona, A. M., Arriola, L. R., Bellin, E., Bennett, A., Björkman, L., Bleich, E., Elkins, Z., Fairfield, T., Gaikwad, N., Chestnut Greitens, S., Hawkesworth, M., Herrera, V., Herrera, Y. M., Johnson, K. S., Karakoç, E., Koivu, K., Kreuzer, M., … Yashar, D. (2020). *Transparency in qualitative research: An overview of key findings and recommendations (introduction to working paper series: qualitative transparency deliberations, working group final reports)* (SSRN Scholarly Paper ID 3430025). Social Science Research Network. https://doi.org/10.2139/ssrn.3430025

Jakobowitz, S., Bebbington, P., McKenzie, N., Iveson, R., Duffield, G., Kerr, M., & Killaspy, H. (2017). Assessing needs for psychiatric treatment in prisoners: Met and unmet need. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *52*(2), 231–240. https://doi.org/10.1007/s00127-016-1313-5

Jones, R. M., Patel, K., & Simpson, A. I. F. (2019). Assessment of need for inpatient treatment for mental disorder among female prisoners: A cross-sectional study of

provincially detained women in Ontario. *BMC Psychiatry, 19*(98), 1–9. https://doi.org/10.1186/s12888-019-2083-x

Jüriloo, A., Pesonen, L., & Lauerma, H. (2017). Knocking on prison's door: A 10-fold rise in the number of psychotic prisoners in Finland during the years 2005–2016. *Nordic Journal of Psychiatry, 71*(7), 543–548. https://doi.org/10.1080/08039488.2017.1351579

Kane, E., Evans, E., & Shokraneh, F. (2018). Effectiveness of current policing-related mental health interventions: A systematic review. *Criminal Behaviour & Mental Health, 28*(2), 108–119. https://doi.org/10.1002/cbm.2058

Kendall, S., Redshaw, S., Ward, S., Wayland, S., & Sullivan, E. (2018). Systematic review of qualitative evaluations of reentry programs addressing problematic drug use and mental health disorders amongst people transitioning from prison to communities. *Health & Justice*, *6*(1), 1–4. https://doi.org/10.1186/s40352-018-0063-8

Kennedy, D. B., & Savard, D. M. (2018). Delayed in-custody death involving excited delirium. *Journal of Correctional Health Care, 24*(1), 43–51. https://doi.org/10.1177/1078345817726085

Krameddine, Y. I., & Silverstone, P. H. (2015). How to Improve Interactions between Police and the Mentally Ill. *Frontiers in Psychiatry*, *5*(196), 1–5. https://doi.org/10.3389/fpsyt.2014.00186

Kucirka, B. G., & Ramirez, J. (2019). Challenges of treating mental health issues in correctional settings. *Journal of Psychosocial Nursing & Mental Health Services*,

57(7), 7–11. http://dx.doi.org.ezp.waldenulibrary.org/10.3928/02793695-20190612-02

Lahm, K. (2016). Official incidents of inmate-on-inmate misconduct at a women's prison: Using importation and deprivation theories to compare perpetrators to victims. *Criminal Justice Studies, 29*(3), 214–231. https://doi.org/10.1080/1478601X.2016.1154263

Lamb, H. R., & Weinberger, L. E. (2019). Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed. *CNS Spectrums*, 1–8. https://doi.org/10.1017/S1092852919001524

Lambert, E. G., Hogan, N. L., Block, L. M., Berthelot, E. R., & Morrow, W. J. (2020). Examining the relationship between supervisor trust and administration trust with job involvement among private prison staff. *Criminology, Criminal Justice, Law & Society, 21*(1), 60–73.

Landess, J., & Holoyda, B. (2017). Mental health courts and forensic assertive community treatment teams as correctional diversion programs. *Behavioral Sciences & the Law*, *35*(5–6), 501–511. https://doi.org/10.1002/bsl.2307

Leidenfrost, C. M., Scalco, M. D., Randall, E., Martin, P. S., Sinclair, S. J., Stewart, T. J., Schoelerman, R., & Antonius, D. (2018). Effectively assessing treatment needs in incarcerated seriously mentally Ill individuals: The utility of the Personality Assessment Inventory—Level of Care Index. *Journal of Correctional Health Care*, *24*(2), 145–155. https://doi.org/10.1177/1078345818761670

Lester, J. N., Cho, Y., & Lochmiller, C. R. (2020). Learning to do qualitative data analysis: A starting point. *Human Resources Development Review*, *19*(1), 1291–1315. https://doi-org.ezp.waldenulibrary.org/10.1177/1534484320903890

Linehan, M. M. (1987). Dialectical behavioral therapy: A cognitive behavioral approach to parasuicide. *Journal of Personality Disorders, 1*(4), 328–333.

MacKain, S. J., & Baucom, T. (2008). Medication management skills for mentally ill inmates: Training is not enough. *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention*, *1*(1), 118–130. https://doi.org/10.1037/h0100438

Martin, M. S., Potter, B. K., Crocker, A. G., Wells, G. A., Grace, R. M., & Colman, I. (2018). Mental health treatment patterns following screening at intake to prison. *Journal of Consulting and Clinical Psychology*, *86*(1), 15–23. https://doi.org/10.1037/ccp0000259

Matejkowski, J., Conrad, A., & Ostermann, M. (2017). Does early onset of criminal behavior differentiate for whom serious mental illness has a direct or indirect effect on recidivism? *Law and Human Behavior*, *41*(1), 68–79. https://doi.org/10.1037/lhb0000231

Matlasz, T. M., Brylski, J. L., Leidenfrost, C. M., Scalco, M., Sinclair, S. J., Schoelerman, R. M., Tsang, V., & Antonius, D. (2017). Cognitive status and profile validity on the Personality Assessment Inventory (PAI) in offenders with serious mental illness. *International Journal of Law and Psychiatry*, *50*, 38–44. https://doi.org/10.1016/j.ijlp.2016.10.003

Matrone, M., Kotzalidis, G. D., Romano, A., Bozzao, A., Cuomo, I., Valente, F., Gabaglio, C., Lombardozzi, G., Trovini, G., Amici, E., Perrini, F., De Persis, S., Iasevoli, F., De Filippis, S., & de Bartolomeis, A. (2022). Treatment-resistant schizophrenia: Addressing white matter integrity, intracortical glutamate levels, clinical and cognitive profiles between early- and adult-onset patients. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *114*, 110493. https://doi.org/10.1016/j.pnpbp.2021.110493

Meyers, T. J., Infante, A. A., & Wright, K. A. (2018). Treating the seriously mentally ill in prison: An evaluation of a contingency management program. *Corrections Today*. https://doi.org/10.1080/23774657.2018.1530077

Mills, A., Durepos, G., & Wiebe, E. (2012). *Encyclopedia of Case Study Research*. SAGE Publications, Inc. https://doi.org/10.4135/9781412957397

Misra, S. (2016). Mentally ill and behind bars. *Current Psychiatry*, *15*(5), E4–E5.

Moon, M. M., & Tillinghast, S. (2020). Irwin, John, and Donald R. Cressey: Importation theory. *Encyclopedia of Criminological Theory*, 487–489. http://dx.doi.org/10.4135/9781412959193.n132

Moore, K. E., Folk, J. B., Boren, E. A., Tangney, J. P., Fischer, S., & Schrader, S. W. (2018). Pilot study of a brief dialectical behavior therapy skills group for jail inmates. *Psychological Services*, *15*(1), 98–108. https://doi.org/10.1037/ser0000105

Morris-MacLean, L., Posner, E., Thomson, S., & Wood, E. J. (2019). *Research ethics and human subjects: A reflexive openness approach* (SSRN Scholarly Paper ID

3332887). Social Science Research Network. https://doi.org/10.2139/ssrn.3332887

Mulay, A. L., Kelly, E., & Cain, N. M. (2017). Psychodynamic treatment of the criminal offender: Making the case for longer-term treatment in a longer-term setting. *Psychodynamic Psychiatry*, *45*(2), 143–173. https://doi.org/10.1521/pdps.2017.45.2.143

Mulay, A. L., Vayshenker, B., West, M. L., & Kelly, E. (2016). Crisis Intervention Training and Implicit Stigma Toward Mental Illness: Reducing Bias Among Criminal Justice Personnel. *International Journal of Forensic Mental Health*, *15*(4), 369–381. https://doi.org/10.1080/14999013.2016.1208308

Mulvey, E. P., & Schubert, C. A. (2017). Mentally ill individuals in jails and prisons. *Crime & Justice*, *46*, 231–277.

Nardi, M., Levinson, C., Lawrence, M., Kamauff, A., Wilby, J., & Burge, W. (2017). Evidence-based decision support for managing the mentally ill inmate population. *2017 Systems and Information Engineering Design Symposium (SIEDS)*, 150–155. https://doi.org/10.1109/SIEDS.2017.7937706

Otter. (2022). *Otter.ai Reviews 2022: Details, Pricing, & Features | G2*. Otter.Ai. https://www.g2.com/products/otter-ai/reviews

Perera, I. M., & Sisti, D. A. (2019). Mass shootings and psychiatric deinstitutionalization, here and abroad. *American Journal Of Public Health*, *109*(S3), S176–S177. https://doi.org/10.2105/AJPH.2018.304764

Price, L. A. (2019). *Millon clinical multiaxial inventory-IV (MCMI-IV) profile patterns and scale score correlates for jail inmates referred for mental health services*. The College of Psychology of Florida Institute of Technology. https://repository.lib.fit.edu/bitstream/handle/11141/3046/PRICE-DOCTORALRESEARCHPROJECTDRP-2021.pdf?sequence=1&isAllowed=y

Robert Wood Johnson Foundation. (2006). *The Interpretivist Paradigm*. Qualitative Research Guidelines Project. http://www.qualres.org/HomeInte-3516.html

Rukus, J., & Kulkarni, V. S. (2019). Easier said than done: Methodological challenges in exploring prevalence of mental health illness among rural jail inmates in the United States. *Ohio State University*, 258–272.

Scott, C. L. (2020). Jail diversion: A practical primer. *CNS Spectrums*, 1–8. https://doi.org/10.1017/S1092852919001834

Segal, A. G., Frasso, R., & Sisti, D. A. (2018). County jail or psychiatric hospital? Ethical challenges in correctional mental health care. *Qualitative Health Research, 28*(6), 963–976. https://doi.org/10.1177/1049732318762370

Shaffer, J. S., Russo, J., Woods, D., & Jackson, B. A. (2019). *Managing the seriously mentally ill in corrections*. 1–35. https://doi.org/10.7249/rr2698

Shapiro, G. K., Cusi, A., Kirst, M., O'campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health Services Research; New York, 42*(5), 606–620. http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s10488-014-0594-9

Slate, R. N. (2017). Deinstitutionalization, criminalization of mental illness, and the principle of therapeutic jurisprudence. *Southern California Interdisciplinary Law Journal, 26*, 341–355.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. https://doi.org/10.1177/2049463714541642

Staton, M. D. (2019). Professional interaction in mental health courts: Processing defendants with mental illness. *The Qualitative Report*, *24*(8), 1967–1989.

Stone, J. (2019). *WNC to lose $9 million in mental health funding*. Smoky Mountain News. https://www.smokymountainnews.com/archives/item/27527-wnc-to-lose-9-million-in-mental-health-funding

Stuart, H. (2017). Mental illness stigma expressed by police to police. *Israel Journal of Psychiatry and Related Sciences*, *54*(1), 1–6.

Szasz, T. (2004). Psychiatric fraud and force: A critique of E. Fuller Torrey. *Journal of Humanistic Psychology*, *44*(4), 416–430. https://doi.org/10.1177/0022167804268133

Taylor, F. (2018, December 18). Report says NC's not on track to comply with federal settlement on mental health services. *The News & Observer*, 1 of 1.

Thomas, S., & Watson, A. (2017). A focus for mental health training for police. *Journal of Criminological Research, Policy and Practice; Bingley*, *3*(2), 93–104. http://dx.doi.org.ezp.waldenulibrary.org/10.1108/JCRPP-01-2017-0005

Tiidenberg, K. (2018). Research ethics, vulnerability, and trust on the internet. In J. Hunsinger, L. Klastrup, & M. M. Allen (Eds.), *Second International Handbook of Internet Research* (pp. 1–15). Springer Netherlands. https://doi.org/10.1007/978-94-024-1202-4_55-1

Tiry, E., Shukla, R., & Mallik-Kane, K. (2020). *Evaluating medicaid access for halfway house residents: A research partnership with the Connecticut Department of Correction* (A Research Report From National Criminal Justice Reference Service No. 254667; pp. 1–51). Department of Correction. https://www.ncjrs.gov/pdffiles1/nij/grants/254667.pdf

Torrey, E. F., Dailey, L., Lamb, R., Sinclair, E., & Snook, J. (2017). *Treat or repeat: A state survey of serious mental illness, major crimes and community treatment* (Office of Research and Public Affairs No. 1; pp. 1–131). Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/storage/documents/treat-or-repeat.pdf

Torrey, E. F., Entsminger, K., Geller, J., Stanley, J., & Jaffe, D. J. (2015). *The shortage of public hospital beds for mentally ill persons: A report of the treatment advocacy center* (pp. 1–42). https://mentalillnesspolicy.org/wp-content/uploads/shortage-hosp-beds.pdf

Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The treatment of persons with mental illness in prisons and jails: A state survey*. 1–116.

Van Deinse, T. B., Bunger, A., Burgin, S., Wilson, A. B., & Cuddeback, G. S. (2019). Using the consolidated framework for implementation research to examine implementation determinants of specialty mental health probation. *Health & Justice*, *7*(1), 1–12. http://dx.doi.org.ezp.waldenulibrary.org/10.1186/s40352-019-0098-5

Van Horn, S. A., Morgan, R. D., Brusman-Lovins, L., Littlefield, A. K., Hunter, J. T., Gigax, G., & Ridley, K. (2019). Changing lives and changing outcomes: "What works" in an intervention for justice-involved persons with mental illness. *Psychological Services, 16*(4), 693–700. https://doi.org/10.1037/ser0000248

Velasquez, S., Bauchowitz, A., Pyo, D., & Pollock, M. (2020). Implementation of a specialized program to treat violence in a forensic population. *CNS Spectrums*, 1–6. https://doi.org/10.1017/S1092852919001883

Wagner, P., & Bertram, W. (2020). "What percent of the U.S. is incarcerated?" (And other ways to measure mass incarceration). *Prison Policy Initiative*. https://www.prisonpolicy.org/blog/2020/01/16/percent-incarcerated/

Waldron, S., & Waldron, D. (2020). Beyond the corridors of the mind. *Jung Journal, 14*(2), 49–63. https://doi.org/10.1080/19342039.2020.1742555

Wang, J., Wang, Y., Huang, H., Jia, Y., Zheng, S., Zhong, S., Chen, G., Huang, L., & Huang, R. (2020). Abnormal dynamic functional network connectivity in unmedicated bipolar and major depressive disorders based on the triple-network model. *Psychological Medicine, 50*(3), 465–474. https://doi.org/10.1017/S003329171900028X

Warburton, K., McDermott, B. E., Gale, A., & Stahl, S. M. (2020). A survey of national trends in psychiatric patients found incompetent to stand trial: Reasons for the reinstitutionalization of people with serious mental illness in the United States. *CNS Spectrums*, 1–7. https://doi.org/doi:10.1017/S1092852919001585

Wester, S. (2018). *The mentally ill within the criminal justice system. An analysis examining techniques developed within criminal justice to adapt to the growing mentally ill populations* [University Honors College, Middle Tennessee State University]. http://jewlscholar.mtsu.edu/xmlui/handle/mtsu/5630

Wheeldon, J., & Faubert, J. (2009). Framing experience: Concept maps, mind maps, and data collection in qualitative research. *International Journal of Qualitative Methods*, *8*(3), 68–83. https://doi.org/10.1177/160940690900800307

Wilson, A. B., Farkas, K., Bonfine, N., & Duda-Banwar, J. (2018). Interventions that target criminogenic needs for justice-involved persons with serious mental illnesses: A targeted service delivery approach. *International Journal of Offender Therapy and Comparative Criminology*, *62*(7), 1838–1853. https://doi.org/10.1177/0306624X17695588

Winters, G. M., Greene-Colozzi, E., & Jeglic, E. L. (2017). Preventing suicide in forensic settings: Assessment and intervention for inmates with serious mental illness. *Journal of Correctional Health Care*, *23*(4), 383–397. https://doi.org/10.1177/1078345817725047

Wood, J. D., & Watson, A. C. (2016). Improving police interventions during mental health-related encounters: Past, present and future. *Policing and Society, 27*(3), 289–299.

Yi, K. (2022, January 7). *A year after NJ released thousands early from prison, only 9% are back in custody*. Gothamist. https://gothamist.com

Yourdictionary.com. (n.d.). *Believability synonyms | Best 12 synonyms for believability*. Retrieved February 27, 2022, from https://thesaurus.yourdictionary.com/believability

Zdanowicz, M. T. (2015). Keeping the mentally ill out of jail: Sheriffs as litigants. *Albany Government Law Review, 8*, 536–562.

Appendix A: Interview Protocol and Invitation/Consent Form

Interview Protocol

1. Please describe the type of facility in which you work; include the number of inmates and the number of staff if known.
2. Please discuss your title, the number of years in your current position, and any relevant previous experience.
3. Please describe how inmates are assessed at this facility during intake; include types of questions as well as who administers the intake in regards to mental health assessment.
4. Please discuss the number of inmates with serious mental illness or serious and persistent mental illness (SPMI) at the facility and relevant diagnoses. In your response to this question, please include what you believe to be or what you know to be the percentage of mentally ill inmates with SPMI at the facility.
5. What are your thoughts regarding SPMI inmate's behaviors evolving from being deprived freedom, goods and services, and heterosexual relationships?
6. What are your thoughts regarding SPMI inmate's behaviors stemming from the diagnosis, beliefs, and experiences they may have had prior to entering prison?
7. Please explain the types of therapy (i.e. – group, individual, counseling, psychiatrist, psychologist, etc.) available to inmates. Please also explain special housing accommodations.
8. Please explain why you believe the therapy is or is not effective.
9. Please discuss your perception of medication available to inmates at your facility.
10. Please explain why you believe the medication is or is not effective.
11. Please discuss your thoughts on the inmates with SPMI and if you believe the illness was pre-existing prior to incarceration.
12. Please discuss your thoughts regarding the prison/jail environment and if you believe inmates experiencing deprivation has a negative effect on the diagnosis.
13. If there are programs at your facility which cater to mentally ill inmates, please discuss them with as much detail as possible.
14. Please explain if you believe the programs are or are not effective.
15. Please describe interactions, treatments, and therapy sessions with mentally ill inmates you have had or witnessed.
16. Please explain if you believe mentally ill inmates tend to improve in their mental health status or if you believe they tend to decompensate while incarcerated at your facility.
17. Please discuss your beliefs regarding the increase or decrease of the mentally ill individuals at your facility and how the increase or decrease affects your job.
18. Please discuss the inmates you have treated or had contact with who were adjudicated in Mental Health Court.
19. Please discuss your viewpoint regarding mentally ill inmates and their propensity to be violent in the prison.

20. Please discuss your viewpoint regarding mentally ill inmates and their propensity to be victimized in the prison.
21. Please provide any additional thoughts you may have on this topic which were not addressed in the questions you answered.

Invitation/Consent Form

You are invited to take part in a research study about the quality and availability of mental health care for inmates with serious and persistent mental illness (SPMI). The research is focused on the perspective of mental health professionals working in prisons. Among other issues, intake procedures, treatment, and therapy programs regarding SPMI inmates will be addressed. The researcher is a student in the Walden Ph.D. program in forensic psychology. As part of the dissertation, the researcher is performing a study by conducting interviews with mental health professionals working in prison settings. The questions asked will delve into the personal experiences of the mental health professionals in these positions. The researcher is interviewing mental health professionals who have worked in prisons for a minimum of one year (the combined experience does not need to be at the current correctional institution). This form is part of a process called "informed consent" to allow you to understand this study.

This study is being conducted by a researcher named Tara Harvey, who is a doctoral student at Walden University.

Background Information

The purpose of this study is to determine the type of mental health care inmates with SPMI receive during incarceration as perceived by their mental health professionals.

Procedures

This study involves the following step:

- Take part in an interview. Due to COVID restrictions, the interviews will be conducted remotely via computer or telephone. The interviews will be audio recorded, and confidentiality will be maintained. (approximately 45 min – 1 hour)

The following are a sample of the questions which will be asked in the interview:

1. Please describe how inmates are assessed at this facility during intake; include types of questions asked as well as who administers the intake for mental health assessment.
2. Please explain the types of therapy (i.e. – group, individual, counseling, psychiatrist, psychologist, etc.) available to inmates. Please also explain special housing accommodations.

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer. The researcher will respect your decision to participate or not. You will be treated the same at your correctional facility regardless of your decision and you will be allowed to change your mind at any time the study is being conducted. Additionally, if you choose not to answer a question or prefer to end the interview early, you will be allowed to do so. The researcher seeks 8-10 volunteers for this research. The researcher will contact individuals and will send an email to all volunteers to inform them if they were or were not selected for participation.

Risks and Benefits of Being in the Study:
Being in this study could involve some minor risks that can be encountered in daily life, such as finding an hour of time in which you cannot be disturbed (for confidentiality). Your specific wording of answers to questions may make you identifiable to colleagues with whom you work. With the protections in place, this study would pose minimal risk to your well-being. The study offers no direct benefits to volunteers. The aim of the study is to benefit society by learning from the "front-line" professionals (you) the individual perspectives regarding care of inmates with SPMI.

Payment:
This study will not provide payment to volunteers.

Privacy:
The researcher is required to protect your privacy. Your identity will be kept confidential within the limits of the law. The emails containing your consent and audio recordings (and transcripts) of interviews will be placed off-line in a password protected folder. The recorded interviews will identify you as a participant and a number (e.g. – Participant 1, Participant 2, etc.). The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else which may identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the researcher is required to remove all names and identifying details before sharing; this would not involve another round of obtaining informed consent. The data will be kept for a minimum of five years as required by Walden University.

Contacts and Questions:
You may ask questions to the researcher by calling XXX-XXX-XXXX or emailing her at XXXXXXXX@waldenu.edu. If you want to talk privately about your rights as a participant or any potentially adverse parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is **02-12-21 0748650** and it expires on **February 11, 2022.**

You may wish to retain the email of the consent form for your records and can ask the researcher or Walden University to forward a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by replying to this email with the words, “I consent.”