A Qualitative Study on the Factors Impeding the Implementation of Evidence-Based Mental Health Practices in Correctional Facilities

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Dedication

To my parents, Dr. Charles and Mrs. Daria Hoffman and sister, Samantha Hoffman, who have done nothing but support me throughout my entire life, especially in the process of completing my doctorate degree. To my grandparents, Dr. Michael Hoffman, and Mrs. Susan Hoffman, thank you so much for always inspiring me to be the best I can be and proving to be proud of me in every accomplishment especially this one. Additionally, to my fiancé John Russo who worked to keep me on track and encourage me through this process. Thank you for all your persistence and motivation with getting me to this point when I struggled to keep it up myself while pursuing a Ph.D.

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Abstract

This three-paper dissertation examines a grounded theory qualitative study conducted with 6 (n=6) New York State formerly employed correctional officers. In all the analyses, a grounded theory approach was used to define themes into more prominent and significant themes, using open, axial, and selective coding. All study participants sample of completed a demographic screening questionnaire (Appendix A) as well as semi-structured interviews (Appendix B) with previously employed correctional officers, which examines the barriers preventing the implementation of evidence-based mental health practice for mentally ill offenders while incarcerated. In all analysis Grounded Theory is used to examine the themes arising from the interviews involving provider barriers, policy barriers, and geographic barriers. All three papers are informed by the Theoretical Frameworks RNR and GLM, examining provider barriers (paper 1), examining policy barriers (paper 2), and geographic barriers (paper 3). Further discussion and study limitations to the study are delineated throughout the three papers, in addition limitations are also included within the introduction and conclusion sections throughout the dissertation.

Introduction to the Dissertation

Problem Statement

Due to the increased rate of mentally ill individuals, which is reported to range from 7% to 16% of the population, being incarcerated this study is essential to understanding the role of policy and providers working with these individuals to successfully transition them back to society (Kennedy, 2012). The problem to be addressed in this study is the lack of knowledge regarding the factors impeding the implementation of evidence-based mental health practices within correctional facilities for mentally ill incarcerated individuals. Particularly the state and department policies and provider barriers between California and New York. The foundation of social work pertains to addressing the needs for the most vulnerable populations and social welfare problems. The social welfare problem is related to the increased rate of mentally ill individuals being incarcerated and released without rehabilitative skills resulting in increased rates of recidivism.

The Problem: Barriers Impeding the Implementation of EBP

Once an individual is found guilty of a crime, they may be sentenced to serve a prison term. On arrival the individual goes through an intake process which includes a mental health assessment and screening. Some individuals who are found to have a mental health condition are provided with medication on arrival. However, the presenting issues are immediate prescription of medication with minimal psychiatric follow-up as well as those with less overt conditions not receiving any form of treatment.

Within the prison population many criminal offenders have co-occurring mental health issues. Co-occurring disorders are perceived as dual diagnosis of a mental illness as well as substance abuse history. Many of these offenders do not receive the services that are necessary

to treat these issues due to lack of accessibility. Studies have shown that the prison system has become the new asylums for those who have mental illnesses. There are not many policies put into place regarding the screening for mental health and once the offender tests positive the access to the services is extremely minimal. It is necessary to now find new policies to provide these people with the services necessary within their "community".

Of particular concern are the training of correctional staff, the availability of qualified mental health professionals (QMHPs), the ability to screen for and accurately diagnose mental illness, and the pharmacological and psychological services that are received.

Methodology

For the present study, a grounded theory qualitative approach was utilized. This approach was to gain a deeper understanding and identify themes associated with the barriers to implementing evidence based mental health practices for mentally ill offenders while incarcerated through the lens of formerly employed correctional officers. Not surprisingly, there are many studies through the lens of other providers or through program evaluations, however this study intentionally recruited formerly employed correctional officers due to the increase in time spent with the vulnerable population.

The researcher interviewed 6 (n=6) study participants. The number interviewed participants fit well into the grounded theory qualitative interviewing standard from Creswell & Poth (2018). Before the qualitative interviews, consent (Appendix E) and demographic data (Appendix F) was collected through a Qualtrics survey (Qualtrics, 2023). If there were literacy issues, the researcher read aloud the consent process and sought their consent to participate in the study. Once the participant met the study criteria and consented to engage in the study, an appointment was created to conduct a recorded one-on-one semi-structured interview. A series of

open-ended questions were used to gain extensive details of the lived experiences of the study participants.

The participants were recruited using snowball sample and self-selected. A digital post was disseminated through LinkedIn, NASW-NY, NASW-NYC, NASW-CA, and other social media platforms. Once the first participant engaged the following participants were collected via word of mouth/snowball sampling. Snowball sampling seeks cases of interest form people who many know other people (Creswell & Poth, 2018). Participants were asked to share the information with any other individuals who may be interested in the study. The researcher reached out via email, phone, and text to professionals within the researchers' network. Approval was obtained from the Western Institutional Review Board prior to interviewing any study participants.

Contributions

To the researcher's knowledge, there are limited studies that focus on the factors impeding the implementation of evidence-based mental health practices within correctional facilities for mentally ill offenders. Current studies and literature focused on quantitative information through surveys, program evaluations, and censuses. The present study discovered the state policies, department policies, and the provider barriers that can be addressed within social work practice. The findings in this current study provide social workers and correctional workers with information on the policies at the state, department, and provider level to potentially improve practical strategies to work with this population. Conclusions of the study informed policy changes to stigma, screenings/assessments, trainings, and ways of addressing the disparate rate of mentally ill offenders incarcerated.

This is the conclusion of the dissertation overview. The next section will discuss the theoretical framework.

Theoretical Framework

This chapter will cover three comprehensive theoretical frameworks that inform the study content and methodology. The three frameworks have significant ties to social work research and furthered the social work professions knowledge by supporting analysis of ways the data creates a foundation for a theory which describes the factors impacting the implementation of evidence-based practice in correctional facilities for mentally ill offenders.

Penrose's Law or Transinstitutionalization

Institutions are social establishments created to house individuals who do not comply/conform to societies social norms/laws. According to Goffman, 1959, there are five types of institutions. The first, are institutions created to care for a person who is thought to be both incapable and harmless. These can be homes for the developmentally disabled, elderly, or orphaned persons. The second, are institutions created to care for those who are unable to care for themselves and deemed a threat to the community. These can be mental hospitals. The third type of institution is organized to protect the community from what are deemed as intentional dangers, these facilities can be correctional facilities. The fourth institution established to better purse technical tasks, such as army barracks, ships, and boarding schools. Finally, the firth establishment is designed as training stations or treats for the religious, such as convents (Goffman, 1959).

It is essential to understand the purpose of varying institutionalizations to better gain insight into what would be most appropriate for the population within this research, the mentally ill and

incarcerated. Utilizing Goffman's, lens on institutions, it seems that there is a gap between the institutions created for mentally ill individuals who are deems "harmful" to society and those without mental illness but considered to be "harmful". Although two separate institutions were created for mentally ill individuals and those who are offenders, there is now a merge between the two creating inappropriate institutions for the individuals being housed.

Transinstitutionalization/Penrose's Law was originally formulated in 1939 by Lionel Penrose. Within his publication on mental disease and crime the was able to identify three findings associated with mental health and criminal justice involvement.

First, Penrose demonstrated that there is a relationship between the number of mental health beds versus the number of state prisons. This relationship was described as "similar to a balloon when pressed on one side expanding the other" (Crecelius, 2016, p.3).

Second, Penrose reported there is a strong negative correlation, -0.62, between the proportion of individuals who are held within state mental hospitals and the state prisons. Ongoing replicated studies have shown there is still a dramatic correlation between the annual mental hospital resident versus state prisoners. (Crecelius, 2016).

The third and final report showed the strong negative correlations between the number of state mental hospital beds and the number of murders. According to Crecelius, 2016, Penrose proposed that by increasing the number of state mental hospital beds could reduce the number of mentally ill individuals incarcerated and the number of murders. The limitation within Penrose's study is that is has only been replicated in countries outside of the Unites States. When compared to transinstitutionalization the finds of his original study do not support it.

Deinstitutionalization was a movement that took place in the late 1940's when the inhumane conditions of the mental institutions were exposed to the public. This resulted in both positive

and negative effects for those who are mentally ill, including involvement in the criminal justice system. In theory this would be a logical concept due to the conditions however the elimination was meant to be for patients what were functional outside of the facilities. (Primeau, et al., 2013). To attempt to address the needs of the mentally ill who commit crimes there is a "revolving door" aspect of in and out of various institutions.

Prins, (2011), assessed the claims for those who favor Reinsitutionalization versus Transisitutionalization. Some researchers and policymakers believe there is a direct connection between deinstitutionalization and the increased rates of incarcerated individuals with serious mental illness. This phenomenon is known as *transinstitutionalization*. Prins (2011) concluded that merely increasing access to state psychiatric hospital beds would likely not reduce the number of people with SMI in jails and prisons. It was noted that the there is a decline in availability of state psychiatric hospital beds and the rise in prevalence of SMI in jails and prisons (p.720). Additionally, many misinterpret deinstitutionalization as a flood of individuals who were released from state psychiatric hospitals only to be arrested and incarcerated. As well, as those who underestimate the effectiveness of high-quality community-based treatment.

The policy question one might reasonably derive from this account, however, is rarely posed: "Would increasing the number of state psychiatric beds (i.e., Reinsitutionalization) reduce the number of people with SMI in jails and prisons?" (p.716). The answer to this question depends on whether the transinstitutionalization hypothesis is an appropriate causal inference. For most of this group, the key to staying out of hospitals, jails, and prisons may be a place to live, a job or some income support, a meaningful relationship or social network, quality healthcare, or linkage to treatment instead of frequent arrest for substance use disorders

fundamental needs that can best be redressed in the community, not psychiatric or correctional institutions.

The Evidence for Reinsitutionalization consists of the basis of people with SMI who become involved in the criminal justice system is the lesser of evils, since treatment conditions in psychiatric hospitals are bound to be better than those in jails and prisons. This reasoning, however, addresses one problem by creating a new (but familiar) one, and avoids tackling the issues at the heart of the matter. Due to the lack of acculturation or assimilation occurring within total institutions the individual is forced to go through a *stripping process*, in which the incarcerated individual is forced to have shifts in his moral career. This creates confusion with the sense of self. In psychiatric hospitals there is a sense of protection towards the patient from themselves as well as others. However, in correctional facilities the priority is "security" and "punishment" (Goffman, 1958). Given that within the process of institutionalization the central focus is to remove those deemed incapable of following societies expectations from society, it fails to establish the necessary interventions for successful reintegration to the community, which would be a much more humanistic approach.

The Evidence Against Transinstitutionalization consisted of many people who are released from state psychiatric hospitals do not appear to end up incarcerated. The characteristics of people with SMI in jails and prisons differ from both the characteristics of people who were deinstitutionalized and the past decades' increasingly forensic state psychiatric hospital population. Although, many agree that community-based treatment works for most people with SMI. It is important to note that individuals with mental illnesses are not a homogenous population. There is an increased access to acute and intermediate psychiatric beds, may, in fact, be necessary for a small but high-risk, high-cost group of people with severe mental illnesses

who cycle through emergency rooms and the criminal justice system without obtaining the treatment they need (Pasic et al. 2005). For these individuals, short- ages of 24-hour hospital care (and for this group and others with SMI, affordable housing more broadly) are indeed a problem.

Risk-Need-Responsivity Model

The Risk-Need-Responsivity (RNR) model was developed by Canadian researchers Bonata, Andrews, and Gendreu in 1990. Although RNR is utilized as an evidence-based practice the underlying traits and theory behind it works to support this research. Cullen and Jonson (2016) wrote the book *"Correctional Theory: Context and Consequences"* to analyze theories and interventions for criminally involved individuals. Cullen and Jonson incorporate the RNR model as a theory for implementing services to reduce rates of recidivism. The RNR model is utilized to assess the risk factors, needs, and treatment interventions for criminally involved individuals to reduce rates of recidivism.

The RNR model consists of three core principles related to how and what interventions should target to address the needs and how interventions should target known predictors of crime and recidivism with the goal of change. However, this must be utilized under the assumption that correctional interventions must be based on criminogenically needs. Bonata, et al., identify two types of predicators, *static predictors,* and *dynamics predictors. Static predictors* are factors from an offender's history that cannot be changed, such as their criminal history. *Dynamic predictors* are factors such as behavioral or cognitive variables that could be changed, such as antisocial values (p.192). It is noted that if there are more *static predictors* than there is still an opportunity to change due to research showing that the salient predictors are also dynamic (criminogenic needs).

The first principle believes the interventions provided should seek to target the known predictors of crime and recidivism with the goal of change, this is also known as the *need's* principle (p.191). There are four "most important" risk factors identified by Andrews and Bonata (2010), which are referred to as the "Big Four". All four of these risk factors are associated with antisocial behaviors, thinking patterns, personality patterns, and associates.

The first is the history of antisocial behaviors which explore early and continuing involvement in the number and various contexts and settings of antisocial behaviors (p.191). This shows a pattern of antisocial behavior dating back prior to incarceration. The second is seeking to explore an antisocial personality pattern. The pattern within the personality can be perceived as pleasure seeking, impulsive, weak sense of self-control, and aggressive tendencies (p.191). This emphasizes impulsivity, challenges in thinking about consequences of behavior, and possible addictive personality traits. The third known as antisocial cognition. This consists of a person's attitude, values/beliefs, rationalization of support associated with crime regarding cognition and emotional states of anger, resentment, and defiance. Given that these are cognitions or thought patterns, they can be altered to facilitate effective, healthy, and prosocial thought processes resulting in changes in feelings and behaviors. Additionally, criminal/reformed criminal or anticriminal identity can play a significant role. This leads to how the person perceives themselves based on their thoughts and actions. The fourth and final factor is antisocial associates. Antisocial associates consist of the individuals that the person surrounds themselves with while engaging in similar antisocial risk factors. When disengaging from antisocial associates it can be isolating and lonely resulting in the person regressing back into antisocial tendencies for immediate social support (p.191).

In addition to the “Big Four” there is also a “Moderate Four” risk factors that have been identified. These include family/marital circumstances with an emphasis on the quality of the relationship, school/work with an emphasis on relationships and performance/awards, leisure/recreation with an emphasis on level of satisfaction, and substance abuse (p.193). The “Big Four” and “Moderate Four” are referred to as the “Central Eight Risk/Need Factors”.

The second principle seeks to provide treatment services grounded in behavioral, social learning, and cognitive-behavioral in nature, also referred to as the *responsivity* principle (p.193). It has been shown through evidence-based interventions that cognitive-behavioral interventions are effective in shifting human behaviors. With the use of CBI for criminogenic needs the development of social learning skills through modelling, practice, role playing, reinforcement, extinction, resource provision, symbolic modelling, and cognitive restructuring can be beneficial for replacing antisocial tendencies (p.194). It is also noted by Cullens, et al., (2016), the reinforcements should be positive, and the services should be intense lasting three to nine months. The goal is for the offender to develop cognitive skills to think differently, coping skills to address emotional dysregulation and impulsivity, as well as skills for limiting access to criminal associates and increasing prosocial actions. It is also noted that many other interventions are not nearly as effective due to the lack of emphasis on recidivism and criminogenic needs being neglected. These ineffective treatment options tend to be less structures, leaving room for minimally supervised self-reflection, verbal interactions, and oriented in insight (p.194), as well as punishment approaches. These are deemed to be ineffective with offenders.

The third principle’s goal is to provide treatment interventions that are used primarily with higher risk offenders with the goal of targeting their criminogenic needs (dynamic risk factors) for change, also referred to as the *risk* principle (p.194). It is thought that these interventions

should be mainly provided to “low risk” offenders rather than “higher risk” due to the likelihood of being open to change, which is untrue due to “high risk” offenders being capable of change. It is thought that higher risk offenders have “more” to change about them. Given limited resources it seems this group should be sought out. According to Cullens, et al., (2016), the less hardened or lower risk offenders generally don’t require intervention due to minimal risk associated with recidivism. The level of risk should not solely rely on the clinical judgement but include Level of Service Inventory. According to research this instrument has a strong predictive validity.

Good Lives Model

The Good Lives Model (GLM) has been described as a strength based, positive psychology, and resorptive alternate to the RNR model of offender rehabilitations (Andrews, et al., 2011). As well as RNR, the GLM is an evidence-based practice which is engraved in theory which has been utilized as support within this research. In addition, it has been presented as a supplement to the RNR regarding an incarcerated individual’s level of motivation and personal identification. The GLM model highlights the fact that offenders are humans with aspirations and goals like nonoffenders. Additionally, the highest level of being able to intrinsically motivate rather than rely on rewards and consequences. The behavior presented by offenders reflects genetic predispositions in addition to personal narratives and perceived identity regarding aspirations. According to the GLM those who engage in criminal behaviors lack the capability to understand the possible outcomes in a fulfilling and socially acceptable manner. This results in a distorted perception of human goods due to crime. GLM includes internal and external factors having an impact on an offender acting in a noncriminal manner. It is assumed the reduction of no criminogenic needs tends to reduce the criminogenic needs automatically.

This creates the most fulfilling life and facilitating a life without offending. This occurs with the introduction of clinical services. These intermediate services within rehabilitation include promotion of achievement of human good "prosocial behavior" and reducing the need to engage in criminogenic needs. During this time, it is essential to explore the importance of noncriminogenic needs to facility long term changes, resulting in feeling fulfilled.

According to GLM this can be obtained through cognitive behavioral interventions. In addition to CBI, collaboration is essential among the offender and providers to create appropriate plans of treatment. During these assessments provided with clinical interventions the offender is gaining insight into their problems, criminogenic needs, strengths, life goals, values/priorities, and what is being achieved through engaging in criminal activities (Andrews, et al., 2013, p.739).

Due to cognitive distortions criminogenic needs a person may perceive their personal narratives and identity to favor criminogenic needs and behaviors. This is where an individualized treatment plan is essential due to everyone having varying needs and values. The treatment plan must incorporate all psychological needs for improving functioning and quality of life while collaborating care with the individuals' systems.

GLM speaks to two objectives, promotion of the offender's ability to achieve human goods *prosocially* and reduce criminogenic needs (Andrews, et al., 2013, p.741). The first objective is like the RNR model of rewards for noncriminogenic alternatives, this becomes an issue due to the limitation of promoting prosocial behaviors. Additionally, the second objective as well holds similar values of RNR. According to Andrews, et al., 2013, the probability of decreasing criminal activity aligns with; the rewards obtained for noncriminal alternatives, the

density of the cost of crime, the cost for noncriminal alternatives, and the densities of the rewards for the crime.

By interconnecting the contingencies under three conditions it is thought there can be a prevention of crime. The first effect increases when low-cost alternatives produce high rewards. The second is when the cost for criminal behavior produces a reward from the noncriminal behaviors, such as freedom after being incarcerated. The third relates to prosocial behavior and the settings which facilitate the change. These three points highlight the interconnected nature of criminal and prosocial action, which RNR provided these opportunities as well regarding motivation issues.

Theory and Research

Penrose's Law, Risk-Needs-Responsivity, and Good Life Model has been utilized to as a guide to highlight the needs of mentally ill incarcerated individuals as well as the factors that impede these theoretical foundations from being implemented. Additionally, this helped to provide additional factors to further the understanding behind the importance of interventions for mentally ill offenders and the different needs in comparison to those incarcerated without a mental illness. These theoretical frameworks work to emphasize the need for collaborative care and interprofessional relationships, resulting in higher quality of life, lower criminogenic behaviors/needs, and skill development to improve prosocial outcomes while incarcerated. All three theories inform social work implications, improving, and furthering an understanding of ways to help facilitate evidence-based mental health practice within correctional facilities.

This is the conclusion of the section on theoretical framework. The next section will provide an overview of the three papers.

Overview of Three Papers

Paper 1

The first paper explored the met and unmet needs of mentally ill offenders while currently incarcerated. The research question that the study aimed to answer was, what is the role of state polices on accessibility to evidence-based practice interventions? Using qualitative grounded theory approach, interviewees were asked open ended questions utilizing a semi structured interview guide. First, the study's findings indicate that there are several policies in place that prioritize security which can play a role in limiting accessibility. Secondly, it was found that there are minimal policies in place to assure proper training for correctional staff when working with mentally ill offenders. Lastly, the study findings indicate that there are very minimal screenings to assess for mental illness upon entry. These findings emphasized the need for changes in social work practice, social work education, and research.

Paper 2

The second paper discussed the implications of previous programs put into place to integrate evidence based mental health practice and the impact on treatment and recidivism. The study aimed to answer, what is the role of the department of corrections polices in relation to accessibility to evidence-based practice interventions? A qualitative grounded theory approach highlighted the lived experiences of correctional officers who have worked in correctional facilities with mentally ill offenders. With a series of open-ended questions in addition to program evaluations, the findings highlighted that many study participants subsequently implemented some risk reduction methods without certain trainings to learn the practice wisdom to best work with the population of interest. Results emphasize the role of increased education and training as a necessity among the correctional staff and behavioral health staff.

Paper 3

The third paper discussed the implications of stigma, accessibility, and assessments and their impact on treatment and needs being met given provider barriers. The question this paper seeks to address is how does the relationship between correctional officers and clinical staff impact the accessibility to evidence-based practice interventions? The quotes and examples of the experiences by the study participants have been utilized to illustrate the adverse interactions and/or process that takes place for an incarcerated individual to receive the treatment needed. Previous literature has highlighted the association of care coordination and lack of needs being met creating barriers to care, accessing treatment, and other health inequities.

Study Limitations

There are several limitations for this exploratory research study. First, there are challenges to the external validity of the study, a concern with generalizability. Due to the small sample size, broad generalizations cannot be made towards the general population. Since the study researched a small niche of the population, the findings of the study should not be extended to other parts of the department of corrections or even to the general population of incarcerated individuals without diagnosed mental illness.

This study also faced some recruitment challenges. Initially, the study sought to interview anywhere between 10-20 participants. Firstly, there were some challenges in outreaching and connecting with currently employed correctional officers. Due to the COVID-19 pandemic New York State Department of Corrections placed a hold on the conduction of research within their facilities resulting in the population for the studying being formerly employed correctional officers. Additionally, California's Department of Corrections was not able to be utilized in the sample resulting in the study emphasizing the experience of correctional officers in New York

through interviews and California through previous literature. Secondly, while the researcher continued to outreach to potential participants through other agencies, snowball sampling, and social media the success was minimal. The study interviewed 6 study participants to be included within the study. This fits methodology well in grounded theory study.

Despite the limitations this study is still strong and needed in the exploration to further understanding why the most frequently incarcerated are unable to have their psychological needs met. This study sought and was able to identify barriers regarding state policy, department policy, and among providers. This research will further implicate additional studies into evidence-based mental health practice in correctional facilities.

A Qualitative Study: State Policy Barriers to Evidence-Based Mental Health Treatment in Correctional Facilities

Lauren Hoffman, LMSW

Dissertation Paper #1

Abstract

Background: The estimated number of incarcerated individuals with mental illness range from 7% to 16% and the estimated rate of prevalence is four times higher in men and eight times higher in women who are incarcerated. Offenders who are mentally ill are more likely to recidivate without interventions (Kennedy, 2012). Evidence based practice has been shown to be effective in treating and rehabilitating offenders with mental illnesses (Prins, 2010). There are several barriers to implementing evidence-based mental health practice in correctional facilities starting at the provider level into state policies. **Purpose:** This qualitative study aimed to understand the state policies for mental health treatment within New York and California through the lived experiences of formerly employed correctional officers. **Methods:** A qualitative study was conducted using a demographic screening (Appendix A) and semi-structured interviews with open-ended questions (Appendix B) to interview 6 NYS formerly employed correctional officers between January 2023-May 2023. Using open, axial, and selective coding analysis significant themes were identified. **Results:** The samples mean age was 44.66; 83.33% identified as White and 16.67% identified as Hispanic/Latino, and the samples mean years of employment were 13.33. Three major themes emerged: (1) security, (2) screenings, and (3) systematic barriers and needs. **Conclusions:** State policies, although have good intent have a negative impact on the ability to implement evidence-based mental health practices within correctional facilities. An increase in trainings, accessibility, and communication is needed to reduce the likelihood of subsequent neglect of mentally ill offenders while incarcerated.

Introduction

The estimated number of incarcerated individuals with mental illness range from 7% to 16% and the estimated rate of prevalence is four times higher in men and eight times higher in women who are incarcerated. Offenders who are mentally ill are more likely to recidivate without interventions (Kennedy, 2012). Evidence based practice has been shown to be effective in treating and rehabilitating offenders with mental illnesses (Prins, 2010). There are several barriers to implementing evidence-based mental health practice in correctional facilities starting at the provider level into state policies. The research collected in the literature review demonstrates the barriers to implementing, sustaining, and the efficacy of evidence-based mental health practice in correctional facilities.

Literature Review

A systematic literature review was conducted to explore program implementation and the barriers associated for individuals with mental illness while incarcerated (Figure 1). The search was conducted using a discovery, which simultaneous searches of multiple libraries and journals, which allowed for rapid explorations. Evaluating prior programs and experiences of incarcerated individuals is vital to review the factors impeding the implementation at a policy and provider level. The objective of the present study was to examine the factors impeding the ability to implement evidence-based practice for mentally ill incarcerated individuals in correctional settings. The selected articles must include evidence of mental illness among incarcerated individuals. Additionally, assessing programs that were previously implemented, recidivism rates, accessibility to services, and needs and barriers of services. Race and ethnicity were not included in the search terms since the research is seeking to explore the factors impeding implementation of evidence-based practice among all mentally ill offenders. For the search, the

inclusion criteria included peer-reviewed articles, empirically based articles, articles containing keywords such as correctional mental health care, mental illness, offending behaviors, psychosis, evidence-based practice, cognitive behavioral approaches, evidence-based practice AND mentally ill offenders, recidivism rates AND mentally ill offenders, and barriers to evidence based practice AND correctional facilities. Articles from the last 21 years (2001-2022) The following electronic data bases were utilized for find relevant articles: PsychINFO, Health and Psychosocial Instruments (HAPI), Social Sciences full text, and Social Workers: Help Starts Here. A total of 3,105 articles were found, however 11 were utilized based on the inclusion criteria above. Articles were reviewed by their title, abstracts, and keywords to determine if they were relevant. Additionally, 5 articles were utilized from previous searches pertaining to the study problem. Exclusion criteria included articles written in languages other than English and studies conducted outside of the United States.

Based on the search, the systematic literature review yielded a total of 3,105 articles. Based on the inclusion criteria, a total of 11 articles were selected after reviewing the 3,105 articles, duplicates were removed. The other articles were excluded due to the lack of discussion regarding implementation of evidence-based practice and mentally ill offenders.

History of the Problem in the U.S.

Prior to prisons, mentally ill people were put into institutions providing their history of mental illness was deemed to have an impact on the order of society. This problem was addressed by confining them in medical institutions. This has led society to believe that to reinforce social order we must rid our communities of those unable to follow it. What was and has yet to be taken into consideration is the *why* behind the action. Pustilnik (2005) discusses how the United States criminal system has more interaction with the mentally ill than health care

providers. Pustilnik (2005) explores the impact that "responsibility" has regarding mental illness. The concept of "responsibility" is not an evaluation for a causative effect on mental illness and one's actions. The concept of holding responsibility over mental illness is an arbitrary rationale behind competence. There has now become a parallel between both the mentally ill and criminals to be confined. Similarly, to institutions being created for the mentally ill to be confined, prisons were created to incarcerate people who committed a crime to society.

Originally prisons were not meant to rehabilitate the mentally ill due to not having the means to provide appropriate services. Shenson, Dubler, and Michaels (1990), analyzed the concept of jails and prisons becoming new asylums for the mentally ill. This began in England during the 19th century during the development of reformist theories of punishment. The use of incarceration as a punishment increased moderately throughout history however the environment that these people are spending their time in have only worsened. During this time courts have struggled to create a standard that prisons should be held to regarding the health care provided within their facilities. In 1976, the United States Supreme Court held, "deliberate indifference" to the serious medical needs of their incarcerated individuals is in violation of the Eighth Amendment. The Eighth Amendment protects the citizens against cruel and unusual punishment. This includes the free and the incarcerated citizens of the United States. Unfortunately, most facilities regardless of the standard that should be held tend to fall significantly short (Shenson, Dubler, & Michaels, 1990).

The prison system has been used a place for those who are poor and or a minority to seek free housing, food, and medical treatment. However, if this is the perception holds true, then the services provided should at the very least meet the standard for health care.

The issue of treatment for mentally ill offenders has been prevalent since the beginning of the criminal justice system. Mental health treatment has been neglected for not only incarcerated people but within society. Since there has been a neglect in mental health treatment as a whole Torrey (1995) discusses the concept of prisons becoming America's new mental hospitals. San Diego County Jail was used as an example with a population of incarcerated individuals where 14% of males and 25% of females are on psychiatric medication. The assistance sheriff believes that their facilities have become the bottom-line mental health provider throughout their county (Torrey, 1995, p. 1611). They have found that a majority of those who are mentally ill and committed crimes, the crimes consisted of assault, theft for property or services, disorderly conduct, and alcohol or drug charges. These crimes are less serious than felony charges, regardless these people are sent to the same sentences as those who are cognitively available to make their choices.

The use of prison sentences for those who are severely mentally ill cause an increase in recidivism and a lack of after care. These people struggle to live within the community due to the inability to receive their medications and after care to succeed. Although they are receiving some form of treatment while incarcerated it does not provide them with the services necessary to become an upstanding member within society.

Torrey, et. al., (2010) took a deeper look into the concept of more mentally ill persons being incarcerated rather than in hospitals. Torrey et.al., found as of 2000 the APA estimated roughly 20% of incarcerated individuals were severely mentally ill, and roughly 5% are actively psychotic at any given time (Torrey, et.al, 2010, p. 4). This statistic held true, for example, as of 2002 the Sheriff's Office in Niagara County New York found that 25% of incarcerated individuals have some form of mental problem, also commenting that since the closure of mental

hospitals this population of people are being pushed into jails. This report found there are several problems associated with having a serious mental illness if you are incarcerated. The incarcerated individuals struggling with mental illness are often “frequent flyers” meaning there is a high recidivism rate due to not being prepared to return to the community since the facility was not structured to rehabilitate or treat them. Mentally ill incarcerated individuals also cost more for tax pays, and they tend to stay longer, in Rikers Island Jail the average stay for all incarcerated individual is 42 days however for mentally ill incarcerated individuals is 215 days. This population struggles to comprehend and follow the rules while incarcerated, trending shows they were 19% more likely to be charged with a violation of a facility rule. They are also more likely to commit suicide and be abused (Torrey et.al, 2010).

Historical Judicial Decisions and Policies

Due to the high population of incarcerated individuals diagnosed and struggling with mental illness mental health services must be accessible while incarcerated. There has been a pattern of incarcerated individuals diagnosed with mental illnesses being overlooked and not receiving the help they desperately need. The issue is making these services accessible and proper placement for these incarcerated individuals who struggle to comprehend the reality of their situation.

One key case which created an impact on the necessity of mental health services within prisons was *Palakovic V. Wetzel (2015)*. Incarcerated individual, Brandon Palakovic, was held at State Correctional Institution at Cresson Pennsylvania due to a burglary conviction holding a 16 to 48-month imprisonment sentence. Upon his arrival he notified the mental health staff of his prior suicide attempts, engagement in self-harming behaviors, as well as an active plan for suicide. He was diagnosed with serious mental disorders, which was identified as “suicide

behavior risk". After this diagnosis he was placed on the roster for mental health services. The services began with the administration of an anti-depressant which as a side effect can cause suicidal ideations. While he was incarcerated Brandon actively reported suicidal ideations but did not receive any counseling or evaluation. He reported that any form of mental health evaluation was done through the slot in his cell door while in the solitary confinement unit. Ultimately, Brandon was found hanging in his cell in the solitary confinement unit.

Following his passing Brandon's parents filed a lawsuit against the prison staff for violating his Eighth Amendment right in two ways, by acting with "deliberate indifference" to the inhumane conditions and the inadequate mental health care. Evidence has shown when an incarcerated individual is held in solitary confinement their risk of suicide increases, however regardless of him having suicidal ideations he was still repeatedly isolated. Originally, June 26, 2015, the District Court dismissed their claims to provide the *Palakvoic's* with time to amend their compliant. This was because there was evidence that Brandon received mental health services, the brief evaluations through the slit in the cell door, the court deemed it was an issue of adequacy of treatment not an Eighth Amendment violation. However, on January 12, 2017, the *Palakvoic's* argued their case which led to the court finding that solitary confinement of a mentally ill person is in violation of their Eighth Amendment right. In addition, it was found there was a failure to treat the noted mental illness of this prisoner as well as others.

The largest prison class action lawsuit took place in California. The case of *Plata v. Schwarzenegger (2001)* and *Coleman v. Schwarzenegger (1990)* were separate lawsuits both addressing the health care provided in California state prisons. In 2006 Governor Arnold Schwarzenegger found that the prisons were overcrowded leading to his declaration of state

emergency. These cases addressed issues of overcrowding and the Federal violation of releasing prisoners in addition to the unconstitutional services provided for medical and mental health.

Following *Coleman*, in (*2001) Plata*, another incarcerated individual filed a class action suit alleging the same constitutional violations, in addition to violations of the Americans with Disabilities Act and the Rehabilitation Act. Pala argued the inadequate health care provided to incarcerated individuals is leading to unnecessary pain and suffering, injury, and death among incarcerated individuals. They settle on the California Department of Corrections and Rehabilitation to meet the minimum requirements for health care that would be in compliance with the Eighth Amendment right. In 2006, due to the CDCR being unable to provide evidence of implementation a court appointed receiver was sent to monitor and implement changes.

The cases discussed above provide evidence into prison systems consistent violation of Eighth Amendment rights to incarcerated individuals. In all the aforementioned cases the plaintiffs struggled with accessibility to mental health services and the unconstitutional environment they were confined in. The use of these cases alludes to a fact pattern of neglect within the prison system across the country. Incarcerated individuals in general, especially those with mental illness are being treated as though they have no rights, which is false.

Current Judicial Decisions and Policies

Incarcerated individuals are still entitled to their Eighth Amendment right to be protected from cruel and unusual punishment. The use of solitary confinement has been argued as unconstitutional, however the absence of mental health care is just as unconstitutional. The outcome of all the cases holds the department of corrections responsible and provide them with the opportunity to reform the health care system within the prison. Regardless, of them being held responsible there have been minimal alterations within the department.

The courts have suggested the standard at a minimum to be implemented but that is not enough. The mentally ill prisoners need specialized services that the prison system is unable to provide. Gumz (2004), discusses the lack of social work being utilized within the facilities, mainly because of the underlying inability to create change from the inside. The department of corrections is not created to treat the mentally ill but is created to house criminals. Prisons are supposed to be rehabilitative for most if not all the incarcerated individuals to attempt to reduce the recidivism rates but has now become more punitive than rehabilitative.

The policy changing cases mentioned prior all come to the similar conclusion that the mental health services provided within jails much be modified. Many states created a standard for mental health services within a prison. However, regardless of the court mandating alterations within the prisons, there is still a lack of application within the facilities.

The FIRST STEP Act offers benefits to incarcerated individuals as well as those struggling with re-entry (bop.gov). This act became law federal law on December 21, 2018. Some of the benefits offered allow for fixed good time, availability for prerelease custody, job ready programs, move incarcerated individuals closer to their families, better access to mental health care, better feminine sanitation, and overall prioritizing rehabilitation over penalization.

Individuals with mental illness are one of the most stigmatized groups of individuals. Those who are incarcerated with a co-occurring mental illness are impacted just as greatly. Currently there are minimal interventions provided for individuals who are mentally ill and imprisoned. The access to mental health care just meets the standards held legally, some facilities barely even meet those. However, with the FIRST STEP Act this will change. According to the Federal Bureau of Prisons (2019), the FIRST STEP Act there will be several correctional

reforms. One of which will provide training for BOP employees on how to handle and address incidents involving people with mental illness of cognitive deficits.

The proper use of training for correctional officers and other employees who encounter mentally ill individuals is essential. These individuals struggle with understand some of the basic rules of being incarcerated and with some inabilities to perform day to day tasks officers may become frustrated, where the training to deal with an individual without a mental illness will not work appropriately with someone who does.

In addition to the proper training, the BOP must review the current implementation of this law and how it is impacting the system. While some individuals who are incarcerated are struggling with addition to opioids and heroin, this will also provide medication assisted treatment for those individuals. This also provides better access to medication management for those with other mental and cognitive illnesses. Overall providing better a better environment while in confinement.

Historically the expectations of correctional facilities to be a place to separate those deemed to be in violation of social norms from society have shifted. The issue of mentally ill offenders being placed into correctional facilities alongside with the general population is a disservice to the individual, the general population, as well as the outside community. There are several barriers, legally, ethically, and geographically to appropriately implement mental health services in correctional facilities. The shift from punitive to rehabilitative and heading back to punitive is ongoing without a solution to break this destructive pattern.

To resolve this issue, there must be a higher standard set if facilities are housing mentally ill incarcerated individuals. Some mentally ill incarcerated individuals will spend months on the mental health roster to still go unseen. As part of social work, the core value of social justice is

being utilized to provide reform within the criminal justice system. The criminal justice system is aware of the need for mental health services and has held correctional departments accountable but there is minimal follow up. This creates unconstitutional interventions within the facility.

The lack of mental health services provided and the minimal access to the services that are available is unethical. Everyone is entitled to mental health care services while incarcerated or within society. The stigma behind mental health in general causes many people to be undiagnosed, which is why it is so important for those who committed a crime to understand why they offended and receive rehabilitative services to do so. If a mentally ill incarcerated individual is diagnosed for the first time upon arrival the feelings, they feel is surreal. During this time of their life which should include self-reflection, and this should not be done while they are alone. The new lifestyle they are attempting to adjust to is hard enough without being mentally ill.

The United States criminal justice system is in desperate need of reform. The public is becoming more aware of this with the media coverage but that is not enough. There are incarcerated individuals attempting and succeeding with suicide while incarcerated, and sometimes when they are released. Mentally ill incarcerated individuals need to be seen on a semi-regular basis by a mental health professional to help them adapt to their new environment in addition to transitioning out of the facility. It is unethical to assume that a mentally ill incarcerated individuals could be rehabilitated or able to transition to society the way an incarcerated individual without a diagnosis could. The implementation of evidence based mental health practices within correctional facilities could address the rates of recidivism, suicidality, and proper transition back into society.

Geographic Factors

This section will describe the programing options available to offenders in New York and California. The purpose of discussing the currently provided and/or attempted programs and policies seeking to find areas of improvement related to mental health accessibility and availability. This section contains data and research the Department of Corrections from New York State and California State.

The Office of Mental Health in New York State reported in 2013 that the amount if individuals who receive mental health services while incarcerated has grown, encompassing 15.6% of the overall prison population (NYCAIC, 2014). The Mental Health Alternatives to Solitary Confinement (MHASC) proposed eliminating solitary confinement for mentally ill and suicidal individuals. Due to lack of training DOCCS staff are unsure and unable to properly provide mental health services during a crisis throughout the facility. Although there is an option for an individual to be transferred to a Residential Crisis Treatment program, the environment continues to remain punitive rather than rehabilitative or restorative. Additionally, there are disciplinary Residential Mental Health Unites (RMHUs) and Behavioral Health Units (BHS), however there is minimal individualization as well as reported maltreatment (NYCAIC, 2014). The MHASC reported gratitude in the passing of the SHU Exclusion Law, it is still not enough.

According to the OMH NY The Bureau of Correctional Health Services of the New York City Department of Health and Mental Hygiene are responsible for providing mental care, mental health services, and discharge planning. However, the services that are currently offered are typically inaccessible or unavailable at the time of need. The services currently offered include suicide prevention/crisis intervention, mental health screenings/evaluations, medication management, case management, mental health observation units, and access to inpatient

psychiatric care (omh.ny.gov). However, due to security behind the top priority with this specific population it is very difficult to provide appropriate and ethically aligned clinical care.

The California Department of Corrections and Rehabilitation have adapted a branch specifically to address rehabilitative services (cdcr.ca.gov). The mission is to facilitate successful reintegration from their care back into the community with the necessary tools to maintain sobriety, maintain health, and obtain employment. This is obtained by providing education, treatment, rehabilitative, and restorative programs in a safe and human environment (cdcr.ca.gov). Their three core values include quality, resources, and performance. These values help to guide the framework for DRP staff to create a "Roadmap to Rehabilitation". The DRPs success is attributed to their partnerships with the Division of Adult Institutions (DAI), the Division of Adult Parole Operations (DAPO), and Enterprise information Systems (EIS).

The "Roadmap to Rehabilitation begins on the day an offender is admitted into the facility and is continued throughout their release to the community or until community supervision has ended. The roadmap consists of seven steps. The first step takes place when the offender is admitted. This consists of assessments of risk of reoffending and criminogenic needs. The assessments are the California Static Risk Assessment (CSRA), Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), Test of Adult Basic Education (TABE), Division of Adult Institutions (DAI) Security Assessments, and Healthcare evaluations (cdcr.ca.gov). Step two is when the classification process begins. The offender meets with their correctional counselor and the classification committee to determine the appropriate programing and rehabilitative placements. Step three starts the programing from day 30 up to 60 months left of their sentence. The programing includes education, innovative grant/ offender activity groups, library services, and recreational programs. Step four builds off step three starting at 40 to 60

months left to service to assist with higher education needs with career and technical training and college programing (cdcr.ca.gov).

During Step five which takes place in the last 12-24 months of their sentence. This step introduces community-based re-entry programs. These programs include Custody to Community Transitional Reentry Program (CCTRP), Male Community Reentry Program (MCRP), Transitions Reentry Program, CAL-ID Program, and Cognitive Behavioral Interventions (CBI). Step six begins in the last 210 days of serving to address interdependency and successful reentry where the offender meets with DAPO staff and is assessed using the COMPAS for criminogenic needs post-incarcerations. Step seven is the final step of transitioning back into the community by connecting the offender to Day Reporting Centers (DRC), Community Based Coalition (CBC), Parolee Service Center (PSC), Transitional Housing Program (THP), and Specialized Treatment for Optimized Programing (STOP) (cdcr.ca.gov).

Within New York State's and California's Departments of Correction there are programs provided to address crises and transitional needs. However, both states have minimal evidence-based mental health practice interventions being provided to incarcerated individuals with serious mental illness concurrently throughout their sentence. There is a need to address coping skills, emotional regulation, accessibility to providers, and early interventions being an option. If California was able to implement and introduce the Cognitive Behavioral Interventions prior to the last 1-2 years of an offender's sentence, there could be an increase in overall well-being while incarcerated and upon reentry.

Purpose of the Study

This study aims to gain an in-depth understanding of the state policies through the lens of formerly employed correctional officers working with mentally ill offenders. For this current

study, a qualitative grounded theory approach was used. The results of this study are intended to improve and understand the policies at a state level for mentally ill offenders while incarcerated to mitigate their risk of suffering, limited accessibility, and overall treatment. The study seeks to answer the following research question: What is the role of state polices on accessibility to evidence-based practice interventions?

Methods

Research Design and Setting

Although evidence-based interventions are vastly studied, the is limited research on the rationale behind the limited implementation of evidence-based mental health interventions for mentally ill offenders while incarcerated. There is also a vast amount of information regarding the re-entry process and factors in decreasing rates of recidivism. While we correlate certain policies, theories, and interventions that are deemed effective, we cannot explore or develop a relevant understanding without diving deeper into the barriers providers, policymakers, and mentally ill offenders face while attempting to obtain appropriate treatment interventions.

Data that has been collected around this information is presented through systematic literature reviews, narratives of released incarcerated individuals, and clinical providers. While there is limited information on the experiences of the correctional officers supervising mentally ill offenders, in addition to ways of addressing the barriers identified in previous research. This research intends to re-shape how the social work profession, policy makers, and correctional staff can better facilitate evidence-based practice interventions for mentally ill offenders while incarcerated.

Creswell & Poth (2018) suggest qualitative researchers embrace the concept of diverse realities founded within the participants experiences within the study. This is an inductive and

emerging methodology which allows for flexibility regarding the interpretation of findings. Additionally, qualitative research tends to be context dependent. This allows for a greater area of coverage, such as socially, politically, and historical factors that impact the increasing number of mentally ill offenders held in correction facilities (Creswell & Poth, 2018). This aligns with Penrose's Law/Transinstitutionalization and seeks to understand the impact of increasing mentally ill offenders held in inappropriate environments in addition to RNR and GLM which seek to address the risk, needs, responsivity of offenders and emphasizing their strengths to replace antisocial behavior with prosocial behavior. This alludes to skill development to healthily cope with distressing internal and external factors.

Data and Subjects

This research utilized snowball sampling. Snowball sampling has been utilized until saturation has been met. According to Creswell and Poth (2018), saturation takes place when the researcher is analyzing the data and creating categories, during this time the categories are assessed for level of support and if the researcher no longer needs additional information to support the identified category (p.318). It is also suggested a minimum of 20 participants are used in Grounded Theory, there for this study will sample until saturation is met utilizing a saturated sample.

Inclusionary rather than exclusionary criteria are chosen because it helps the researcher to be explicit with their sample and allows for diversity. While the sample is focused on the barriers related to mentally ill incarcerated individuals receiving evidence-based practice services while incarcerated, it allowed for diversity while interviewing previously employed correctional officers on their experiences and interactions with this population. The sample consisted of previously employed correctional officers who have been assigned to work or have worked with

mentally ill offenders within private and state prisons, emphasizing their perceived needs, accessibility to their needs, and factors that could improve their general well-being.

Correctional officers are included in this study due to the limitations associated with interviewing currently and formerly incarcerated mentally ill offenders. They can speak to their experiences regarding level of training, collaborative care, accessibility, risks, needs, and current responsivity provided within the facilities. The correctional officers have worked in either California State and/or New York State private and/or state-run prisons.

When the sample has reached saturation, the researcher may begin to use *discriminant sampling*. This step is not necessary however utilizing Creswell and Pith (2018) grounded theory methods, it is recommended discriminant sampling be utilized to meet saturation. This also helps to provide evidence and support to the emerging factors of the study (Creswell & Poth, 2018). Constant comparison is suggested to be utilized throughout the data analysis in comparing patterns and attempts in aiding the researcher to further understand the events.

The sample has been recruited using networking systems such as LinkedIn, Social Media Platforms, flyers posted at community programs/groups for correctional employees, The California State Department of Corrections and Rehabilitation (assuming the application is approved if not then this population will be recruited through the same networking systems), as well as through word of mouth (snowball sampling). A preliminary questionary has been sent via Qualtrics to assure inclusionary criteria are met. Inclusionary criteria include those previously working in NYS and/or California State private and/or state-run correctional facilities and have experience with mentally ill offenders within the last 4 years. Exclusionary criteria have been included those who have no experience with mentally ill offenders.

Procedures

Data collection was conducted in two parts: a demographic questionnaire (Appendix A) and an interview. The interview was be offered through video technology via Zoom and consist of a 60-minute recorded interview. The participant and researcher coordinated a date, time, and circumstance for the interview to take place. The first contact was via email response to the potential participant, thanking them for their interest in addition to the Consent Form as well as the resource sheet. The email included the link to the Qualtrics questionnaire. After clicking on the link, the participant provided consent to participate prior to completion of the survey as outlined within the consent form. If the participants meet the inclusion criteria, they have been contacted via telephone or email to schedule an interview time and method. The researcher applied to CDCR to access currently employed correctional officers, however, was unsuccessful. Due to NYSDOCCS not taking on new research due to COVID-19 restrictions and limited resources the population has shifted to previously employed correctional officers. The application for CA is still pending however, to provide additional accessibility researcher has extended the population to previously employed correctional officers in CA.

Each interview via Zoom was recorded, the participants may choose if they would like to have their camera turned on or off, however the researcher had her camera on. The zoom audio recordings were transcribed using *Transcribe by Wrealy*, an AI transcription service. All interview recordings are stored on the researcher's laptop with a password protected file, a backup file was kept on a password protected google drive which is affiliated with the researchers University. All data that has been collected will be kept for three years. To assure confidentiality and a safe space, the researcher conducted all interviews in a private space (home

office space or University empty space). The participant chooses the location which best suits their need.

If at any point a participant was no longer comfortable or became upset by the interview questions or content, they may choose to withdrawal at any time, and their data and information will be destroyed at their request. At no time during the interviews did this take place. The researcher offered a resource sheet to all participants to support them in their discomfort or distress.

Measurement

There are two main measurements within this study, the first is a demographic questionnaire (Appendix A) sent via email through a Qualtrics links. The demographic measurement asked if the individual consents to participation within this study as well as demographic information: age, race, gender, years of experience in corrections, and years of experience with mentally ill offenders. Inclusionary criteria for the study consisted of the following: correctional officers who previously worked in either New York or California, who have experience working with mentally ill offenders. Exclusionary criteria included those who have no experience with mentally ill offenders.

The second measurement instrument is the interview guide (Appendix B), which contains twelve questions that were used during the 60-minute interview. The data was then collected and coded from these questions. This served to address the overall research question and discover a deeper understanding of: *"What factors are impeding the implementation of evidence-based practice for incarcerated mentally ill offenders?"*

Data Analysis

The data analysis methods mirrored Strauss and Corbin's Grounded Theory, which means the data analysis occurred alongside with data collection. This collaborative process can provide for more relevant or irrelevant concepts to be immediately identified and addressed (Corbin & Strauss, 1990). In grounded theory, the concepts are units of analysis, what arises from the data illustrates the action, event, or incident will be utilized as the data unit. All concepts developed must be related and can be utilized later in the research to assist in investigating *what, how, before* and *after* each concept (Corbin & Strauss, 1990). The analysis has also utilized constant comparison to help prevent researcher bias due to each concept being challenged and viewed with new data upon each new interview. The data analysis also included open, axial, and selective coding. This assisted in narrowing the data into core concepts or 'themes' that ultimately informed the factors and themes derived.

An additional essential component of the grounded theory data analysis is documenting ('memo-ing'). This is when the research takes note of the constant changes and re-grouping of categories and codes through the method of constant comparison. Throughout the coding process, memos were utilized to track the evolving factors as well as patterns. These patterns consist of changes in complexity, clarity, saturation, and accuracy (Creswell & Poth, 2018). A codebook was also utilized to further assist in ensuring rigor and usage of codes. Memos in this usage are not just the researchers' ideas, they aided in formulating a deeper understanding of the data collected. This begins with the first coding session and continues throughout the research process. This also included writing the results and employed to support the discussion of findings (Corbin & Strauss. 1990).

The codebook in addition to the themes emerged from the data as evidence was collected and analyses through the progression simultaneously. The researcher engaged in active memo writing and reflexivity to ensure all themes and theories that emerge are unbiased and based alone on the data provided by the participants. Demographic information on each participant and future participants from a discriminant sample will be presented in a chart within the appendices to allow for transparency of the sample participants sample details (Appendix F).

To demonstrate rigor and reliability, several methods are described in this subsection to enhance this study. There have been on going arguments regarding validation within qualitative research has been working to establish a universal understanding and systematic procedure to identify and prove validation (Creswell & Poth, 2018). Authenticity was established by identifying the following methods in the proposed study: reflexivity, clarifying researcher bias, and generating a rich, thick, description. Reflexivity involves the researcher disclosing their understanding of any biases, values, and experiences with the subject of the study and population to create transparency and provide insight into their perspectives and ideas (Creswell & Poth, 2018). The researcher shares some level of identification with the population being studied, bracketing was used as a best reflective practice to reduce bias. With the understanding that the researcher has experience within their personal life with formally mentally ill and formally incarcerated individuals, it is essential to reflect on the subjective interpretation of the data being collected.

The researchers experience with this population is minimal, this may create a power dynamic among those she may interview. Within this power dynamic, all questions and ideas that may arise from participants that the researcher openly answered while limiting sharing of personal information that could skew the data collected. Participants were encouraged to wait

until the end of the interview to engage in questions and voicing of concerns with the research, at that point they were given the opportunity to withdrawal from the study. The researcher also acknowledges that strong feelings and reactions to opinions she hears may be triggering. Themes related to social justice and equity within the interview may illicit challenging and informative conversations during the interviews. The researcher intends to only amplify the voice of the participants and the experiences voiced by them regarding the vulnerable population of the mentally ill incarcerated individual. Additional questions and clarification from the participants were used to obtain the most understanding of the data as possible. This form of validation criteria is a detail account of the evidence for or against the formulated themes and factors. This provided by inclusion of details on the environment, atmosphere, physical descriptions, movement descriptions, and activity descriptions (Creswell & Poth, 2018). The readers will understand from the beginning through to the end within the data the *how* and the *why* based on the thick data description and evidence provided.

To address reliability coding systems Atlas.ti and employing higher-quality electrics to record and transcribe data was utilized (Creswell & Poth, 2018). The researcher proposes using peer debriefing and auditing methods as fit within the rigor and structure provided by Strauss & Corbin's (1990) grounded theory and data analysis methodology.

RESULTS

Participant Characteristics

The study participants were interviewed from January through May 2023. A total of six (n=6) study participants met the study criteria and agreed to participant in the study. A demographic table is provided within Appendix F. Open, axial, and selective coding were used to

analyze using Atlas.ti. Most participants were male (83.33%), White (83.33%), and have an average of 13.3 years' experience.

Themes

Three major themes emerged from the analysis: (1) security, (2) screenings, and (3) systematic barriers and needs.

Theme 1: Security

The first theme that emerged from the data was the state policies that emphasize and prioritize security over accessibility and appropriate forms of mental health treatment. All six (n=6) participants reported feeling that security could prevent consistency with medication management, knowledge of treatment options, and the access to confidential interventions. Findings within these themes are reflective of state policies being a barrier to implement evidence-based mental health practices in correctional facilities.

> Participant 3: *"Everything has to be taken into account, security, comes first and then everything else comes second."*
>
> Participant 4: *"As long as you guys have security yourself, you know, because they would need to have an escort. Also then yeah, we sit outside of the session the whole way through."*
>
> Participant 5: *"I would say no security didn't get in the way, I mean, you know like, I didn't know what kinds of medication they were on, so I think confidentiality was done well."*

Theme 2: Screenings

Most participants discussed the brief screening for mental illness which took place during the intake process. The other experience of one of the participants whose sole post was on the mental observation unit varies from the others. Although most of the sample report knowing the baseline signs of someone in emotional distress it is not as in depth as it could be in addition to interventions associated with when they are in need. The results within this theme are reflective of the beliefs regarding RNR and GLM.

> Participant 2: *"There's a screening process but if you are free from the street, and if there's no past history on any criminal offenses, then it gets to a point where its one-on-one trying to learn as much as you can really quick. Most times medication is brought up and reasons for it and then we have to do our own investigations, maybe possibly call outside doctors to find out what type of treatment or help or maybe an individual and even know they had that issue and what they're learning about it when they get arrested. But there is a screening process and a learning curve as days go by your get to realize what issues they have and try to help it."*

Another participant discussed the screening process as well as the alleged advantages that can be abused as follows:

> Participant 5: *"Usually starts off an intake like they'll ask you a ton of questions so for instance you know you were a blood or a crip and you're going to get into a housing area, you know I mean it sounds you know and I'm not really biased because I am an older correctional officer but they would sometimes say they were homosexual jus tot say they were put into a specific housing unit to stay away from gang members and would later tell me like yeah I'm not gay but I*

know if I go in with the crips I'll be slashed. So, you know they also say that when they are going to kill themselves, so that means they get an officer that has to sit outside their cell and every 15 minutes log that they are there. When it's sleeping overnight you know, saw alive, breathing body, stomach going up and down, every 15 minutes you have to log that but usually its during intakes. But sometimes when the word gets out that they can get this medication right away a lot of the times they started out saying that they have mental issues."

Theme 3: Systematic Barriers and Needs

Systematic barriers such as certain policies and procedures do not always align with the needs of a mentally ill incarcerated individual. Many participants reported the process for an intake interested in seeking mental health services post-intake/initial screenings. The findings within this theme are related to the RNR and GLM. These barriers preventing the needs from being met led to increased disruption within treatment and consistency:

Participant 1: *"I don't know if it has changed but when I was there you would disclose how an inmate felt, that he had to speak to somebody about medication or just to speak to somebody. In general, you would fill out a form. And I think they had like 72 hours or whatever it is to either send the inmate to the clinic or to speak to a therapist or whoever it was or, you know, and he would speak to them if they ever had any issues with his medication or anything and that's the way it was supposed to be taken care of. They would speak with an officer and also would submit a form that will be submitted into the clinic."*

Participant 2: *"…we had a big psychology staff. I think that should be the norm in a prison environment because you know staff as well sometimes we are dealing*

> *with stuff and seeing things that we need somebody to talk to about and home life….They are not hiring that the you know the department didn't have as many people, it gets harder to talk to somebody, you get close to a certain person, but then they leave."*

Another participant had a different outlook given that he had been employed at a federal facility located within NYS:

> Participant 3: *"We know their basic needs like food, clothing, and so forth. I deal with the minimum-security inmates and take them to and from visits to the doctor. The unfortunate part about life is that you know we aren't like NYS with the "catch and release", once an inmate is in the federal location they are stuck here."*

Discussion

This study has highlighted the state policies and procedures associated with security, screenings, and systematic barriers and needs. The significant themes allude to the findings which are supportive of both theoretical frameworks used for this study. Policies provided to the participants illuminated that using RNR which alludes to the risks associated with recidivism which can predict antisocial behaviors which interventions are needed to address. While this study looked at previous legal cases and the experiences of formerly employed correctional officers GLM and RNR highlight how interventions are essential early as well as consistency for this population.

The study highlights the need to reduce the gap of inequitable screenings, "learning on the go", consistency, and security being factors that imped the ability to implement evidence-

based practice for mentally ill offenders at a state level. Further trainings in crisis intervention, mental health screenings, and a smoother process to obtain treatment is needed.

Theme 1: Security

The first theme that emerged from the collected data identified that many study participants identified security as a priority and potentially a barrier to effective treatment. Many participants discussed their process and knowledge of policies and accessibility to interventions. A similar finding highlighted there is a link to mental health staffing on accessibility as well. This finding implied that there are also barriers at provider levels which will be explored further in paper 3.

Theme 2: Screenings

The second theme that emerged from the research includes the screening process. This was identified by all participants as taking place upon intake. This process was identified as being ask several questions mainly associated with psychiatric and medical history as well as if the person knows they have a mental illness which not all are aware of. It was also identified that if it is not disclosed upon intake it is up to the incarcerated individual to seek out assistance and/or the correctional staff to be aware of baseline signs of emotional distress. In this theme, this finding alluded to those additional screenings, trainings, and a more private way of disclosing needs are essential as there is a stigma behind mental health and seeking treatment.

Theme 3: Systematic Barriers and Needs

Mentally ill offenders while incarcerated make up a good portion of individual incarcerated as mentioned through Penrose Law since the deinstitutionalization took place. At this point due to Transisitutionalization where the mentally ill go from one institution to another, the prison system has become the new psychiatric hospitals. However, the issue is that due to

security being the top priority and the staffing not specializing in mental health treatment the likelihood of recidivism increases as well as a decrease in the rehabilitative factor. There is a need to prioritize evidence-based mental health practices within correctional facilities for mentally ill offenders.

Implications

Implications for Practice

Social workers were active within prisons during the 1970s. Their role consisted of providing services such as presentence investigation and supervision, counseling regarding assisting them in adjusting to the prison environment, and discharge/transitional planning. (Gumz, 2004). Even when social workers were active within the prison population there was minimal emphasis on treatment for mental health.

In 1974 the Martinson report was filed which questioned the level of effectiveness of the treatments being offered for the incarcerated individuals. Following the report Gumz, believes this may have influenced the amount of social works still willing to work within this community. When considering social justice social work has been calling for the distribution of equality of goods and services within society. However, social worker as a profession must conclude that there needs to be an emphasis on restorative justice. Gumz (2004), suggests, with the use of a holistic approach there can be justice for the victim, offender, and the community, which are all relevant. This emphasizes the importance of restorative justice within correctional facilities. This may also assist in attracting more social service providers to be willing to work in correctional facilities. There needs to be more emphasis on social work and social justice within prisons to provide the rehabilitative services.

This puts an additional strain on the social workers duty to provide their clients with dignity and worth as well as integrity. Incarcerated individuals in general struggle to perceive themselves in a positive light regardless of mental illness. However, due to prison populations having a high rate of mental health problems the need for services is prominent. For those who struggle with mental health and need services they cannot access them which leads to negative outcomes both while imprisoned and once released. Researchers Hopkin, et al., (2018) reviewed the interventions necessary for properly transition an incarcerated individuals with mental illness out of prison back to society. Their research found that the prisoners need for social workers to provide them with integrity. Social workers must be aware of services and continue to stay up to date regarding services that are offered. This principle helps the social worker provide their client with dignity, competence, and integrity.

Implications for Social Work Ethics and Values

Ethics are used to help govern a person's behavior and ability to understand right from wrong at a micro and macro level. Social Workers have a code of ethics which guide our ability enhance the well-being and meet the basic needs of human life, with an emphasis on those who are vulnerable, oppressed, and living in poverty. The code of ethics also provides social works with the ability to promote changes in social justice on behalf of the client. Ethics provide professionals with the ability to find a gray area to help and alter the needs of a community or client while also protecting the professional.

The Nation Association of Social Works (NASW) Code of Ethics consist of six core values: service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence. To provide the population with the best experience the combination of these values with the principles that follow them allow for the best human experience.

The value of service alludes to the ethical principle of helping people in need while addressing social problems. (NASW, 2021) Social workers tend to work in agencies to which they must conform to their separate values outside of the code of ethics. Social workers in prisons are part of an agency where they must alter their personal and professional beliefs. As staff in the prison's agency, social workers provide initial mental health assessments, irregularly monitor, and meet with those who have a mental illness, in addition to meeting with incarcerated individuals nearing release to create a plan of discharge. Due to the lack of funds available to mental health services in prisons it causes a strain on many of the core values necessary to provide the best human experience.

The lack of emphasis on mental health services creates an unspoken standard of it not being a priority or necessity. This triggers a discrepancy within social workers to abide by the prisons core values and their own. A second source of strain for the social worker may face is with correctional officers. Social workers who perceive the incarcerated individual as needing rehabilitation rather than punishment differ from the correctional officers who view them with disapproval, hostility, or rejection because of their guilty verdict (Dane & Simon, 1991). This perception of the incarcerated individuals creates a stigma of criminal rather than mentally ill which leads to the negative public opinion of the two being positively correlated.

This also prevents the social worker to provide social justice for this population. The incarcerated individuals are vulnerable and oppressed due to their current situation. Social workers are needed to change social justice issues and promote sensitivity. Social workers within prisons are very minimal in comparison to correctional officers or other staff. The humanistic outlook of social workers tends to cause those within the correctional staff to view their perspective as lesser than their own. According to, Dane and Simon (1991) it was found that

social workers can be perceived by correctional officers as “soft” on criminals and easily manipulated. This perception of social service works continues to enable minimal mental health services that could potentially be implemented because this population doesn’t need or deserve it.

Implications for Research

This study provides foundational knowledge to increase future qualitative research. Future studies are needed to explore the effectiveness of additional trainings, screenings, procedural/policy changes towards rehabilitative rather than punitive. There is a limited representation of correctional officers’ views within research. Recruiting additional correctional officers in addition to exploring additional states within The United States of America is suggested. The state policies need to focus on rehabilitation and treatment to prepare for a successful reentry and healthier process while incarcerated.

Limitations

There are limitations to this study. Due to the small sample size, broad generalizations could not be made to the larger population. The data is representative of formerly employed correctional officers in New York and relied on literature and secondary data collected from California to connect the two. Given that the study is limited to New York and California, as mentioned prior an opportunity to diversity the sample further by seeking out alternative states would be necessary. As with all qualitative research, the compensation and social desirability bias can impact the study participants responses to the questions provided during the interviews. Secondly, the perception of the correctional officer rather than the incarcerated individuals themselves could be a limitation as well. Lastly, there are some recruitment challenges that should indicated. The research study proposed to interview between 10-20 participants,

consequently 6 study participants were interviewed, which is still methodologically sound within grounded theory qualitative study (Creswell & Poth, 2018).

Despite the limitations this study is still strong and needed in the exploration to further understanding why the most frequently incarcerated are unable to have their psychological needs met. This study sought and was able to identify barriers regarding state policy. This research will further implicate additional studies into evidence-based mental health practice in correctional facilities.

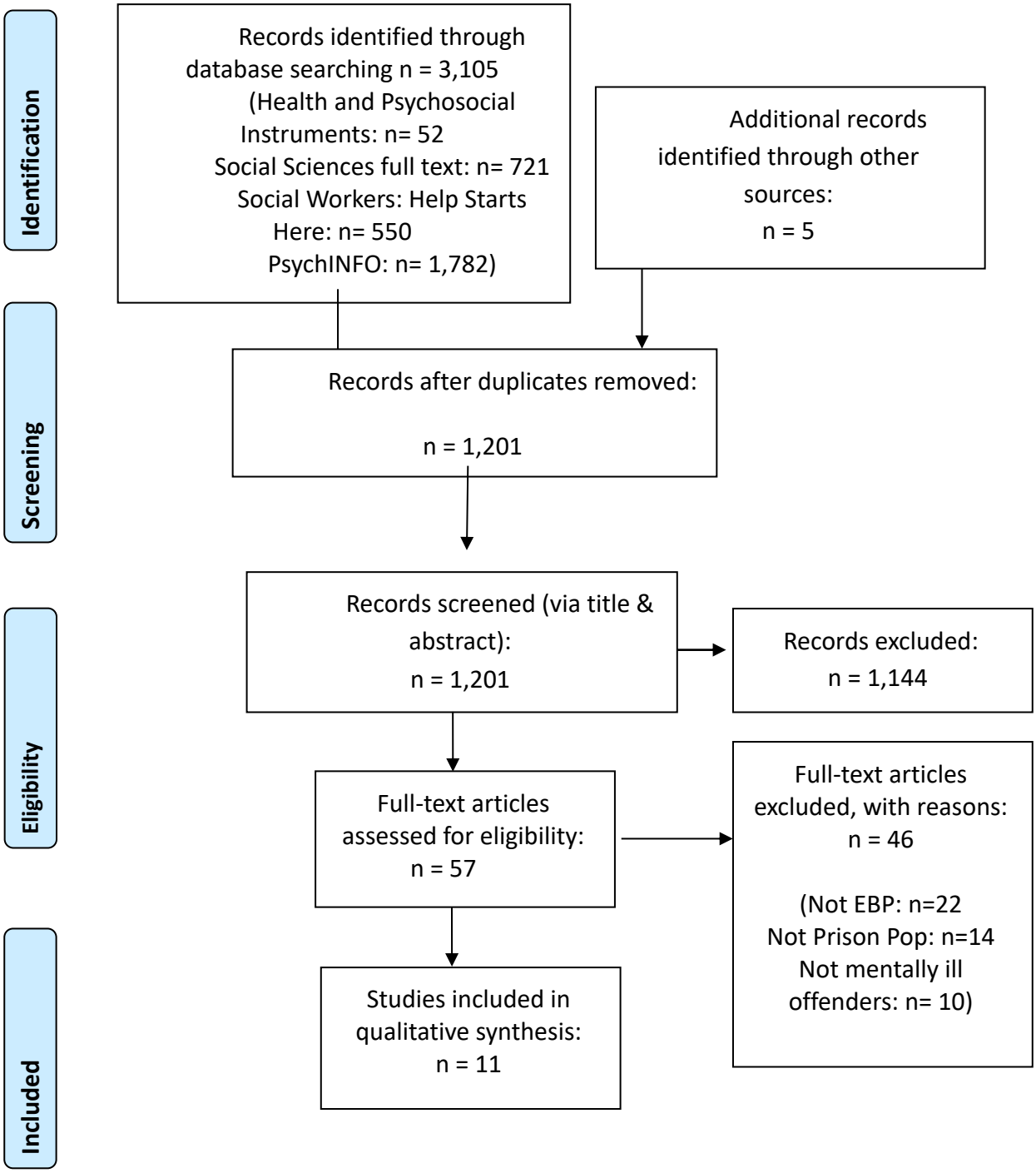
Conclusion

The findings from this study highlight the need to state policy shifts regarding the barriers that imped the implementation of evidence-based mental health practices within correctional facilities. Connecting state policies to rehabilitative support rather than punitive can shift rates of recidivism and shift the “new psychiatric hospitals” to more inclusive and beneficial for the community itself. It is also essential to address the role of stigma and the impact on this population. The alignment of these themes keeps improving and tailor the possibility of policy change in the future to alleviate the rotating door of mentally ill offenders landing in correctional facilities.

Table 1: Demographic Table

Characteristic	n	%
Age	6	44.66
Gender		
Male	5	83.33%
Female	1	16.67%
Race/Ethnicity		
White	5	83.33%
Hispanic/Latino	1	16.67%
Years of Employment	6	13.3
Experience with Mentally Ill Offenders	6	100%
New York State Employment	6	100%

Figure 1. Flow chart depicting inclusion and exclusion process



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A Qualitative Study: Department Policies within Correctional Facilities Impeding the Implementation of Evidence-Based Mental Health Practice

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Dissertation Paper #2

Abstract

Background: Correctional facilities are legally mandated to provide psychiatric services to their mentally ill incarcerated individuals. The services provided must be "adequate". Adequacy is measured using assessments and screenings, treatment beyond seclusion and observation, provision by QMHPs, documentation, medication management, and suicide prevention efforts. Although this may seem like the bare minimum for providing mental health interventions, these standards are not always met due to understaffed facilities and underfunded resources. They aim to provide care equal to the care offered within the community. This would provide security and treatment, which would alter the environment from punitive to rehabilitative (Jacobs & Giordano, 2017). **Purpose:** This qualitative grounded theory approach highlights the policies implemented within correctional facilities through the lens of formerly employed correctional officers to improve department procedures and policies. **Methods:** A qualitative grounded theory approach with a demographic survey (Appendix A) and open-ended questions during a semi-structured interview (Appendix B) was used among 6 participants from New York between January and May 2023. Using open, axial, and selective coding through Atlas.ti was used to identify significant themes. **Results:** The samples mean age was 44.66; 83.33% identified as White and 16.67% identified as Hispanic/Latino, and the samples mean years of employment were 13.33. Three major themes emerged: (1) interventions, (2) accessibility, and (3) communication among departments. **Conclusions:** The current interventions offered highlight the use of medication management however regarding accessibility there are patterns of disconnect and lack of consistency. Additionally, there are barriers regarding correctional officers and ability to communicate with other staffing from other departments such as the mental health

providers/medical providers. Implications for social work practice, values, and policy are delineated.

Introduction

According to the OMH NY The Bureau of Correctional Health Services of the New York City Department of Health and Mental Hygiene are responsible for providing mental care, mental health services, and discharge planning. However, the services that are currently offered are typically inaccessible or unavailable at the time of need. The services currently offered include suicide prevention/crisis intervention, mental health screenings/evaluations, medication management, case management, mental health observation units, and access to inpatient psychiatric care (omh.ny.gov). However, due to security behind the top priority with this specific population it is very difficult to provide appropriate and ethically aligned clinical care.

The California Department of Corrections and Rehabilitation have adapted a branch specifically to address rehabilitative services (cdcr.ca.gov). The mission is to facilitate successful reintegration from their care back into the community with the necessary tools to maintain sobriety, maintain health, and obtain employment. This is obtained by providing education, treatment, rehabilitative, and restorative programs in a safe and human environment (cdcr.ca.gov). Their three core values include quality, resources, and performance. These values help to guide the framework for DRP staff to create a "Roadmap to Rehabilitation". The DRPs success is attributed to their partnerships with the Division of Adult Institutions (DAI), the Division of Adult Parole Operations (DAPO), and Enterprise information Systems (EIS).

Within New York State's and California's Departments of Correction there are programs provided to address crises and transitional needs. However, both states have minimal evidence-based mental health practice interventions being provided to incarcerated individuals with

serious mental illness concurrently throughout their sentence. There is a need to address coping skills, emotional regulation, accessibility to providers, and early interventions being an option. If California was able to implement and introduce the Cognitive Behavioral Interventions prior to the last 1-2 years of an offender's sentence, there could be an increase in overall well-being while incarcerated and upon reentry.

Literature Review

A systematic literature review was conducted to explore program implementation and the barriers associated for individuals with mental illness while incarcerated (Figure 2). The search was completed using a discovery which connects the search with a multitude of libraries and journals which allowed for rapid exploration of results. The purpose was to evaluate prior programs implemented as well as the experiences among incarcerated individuals. This was vital to the review process in exploring the factors impeding the implementation at a policy and provider level. The objective of the present study was to examine the factors across department policies impeding the ability to implement evidence-based practice for mentally ill incarcerated individuals in correctional settings. The selected articles must include evidence of mental illness among incarcerated individuals. Additionally, assessing programs that were previously implemented, recidivism rates, accessibility to services, and needs and barriers of services. Race and ethnicity were not included in the search terms since the research is seeking to explore the factors impeding implementation of evidence-based practice among all mentally ill offenders.

For the search, the inclusion criteria included peer-reviewed articles, empirically based articles, articles containing keywords such as correctional mental health care, mental illness, offending behaviors, psychosis, evidence-based practice, cognitive behavioral approaches, evidence-based practice AND mentally ill offenders, recidivism rates AND mentally ill

offenders, and barriers to evidence based practice AND correctional facilities. Articles from the last 21 years (2001-2022) The following electronic data bases were utilized for find relevant articles: PsychINFO, Health and Psychosocial Instruments (HAPI), Social Sciences full text, and Social Workers: Help Starts Here. A total of 3,105 articles were found, however 9 were utilized based on the inclusion criteria above. Articles were reviewed by their title, abstracts, and keywords to determine if they were relevant. Additionally, 5 articles were utilized from previous searches pertaining to the study problem. Exclusion criteria included articles written in languages other than English and studies conducted outside of the United States.

Based on the search, the systematic literature review yielded a total of 3,105 articles. Based on the inclusion criteria, a total of 9 articles were selected after reviewing the 3,105 articles, duplicates were removed. The other articles were excluded due to the lack of discussion regarding implementation of evidence-based practice and mentally ill offenders.

The results from the literature review highlighted many interventions that are effective evidence-based practice as well as the providers that are available and their limitations. However, the social work literature on evidence-based practice for mentally ill offenders while incarcerated is limited due to the current literature focusing on re-entry, recidivism, and community care.

The National Survey on Drug Use and Health dating from 2008-2014 was analyzed researcher Ali, et al., in 2018. Although, this data was based on non-incarcerated individuals with mental illness who have had experiences within the criminal justice system, it speaks to time spent incarcerated. To best conceptualize the correlation, three separate multivariable logistic regression models were used to calculate the odds ratios based on the unmet perceived mental health needs without relation to previous treatment experiences over the last 12 months. Additionally, it seeks to find the odds ratios of the unmet needs of these individuals who have as

well obtained treatment in the last year as well as those who did not. The perceived unmet needs were broken down into six categories: affordability, accessibility, stigma, treatment priority, fear, and other reasons.

This study found there is an association between criminal justice involvement and unmet mental health needs throughout these individual groups. It was found without treatment interventions for 12 months affordability was the highest factor for unmet needs as well as stigma. With the group who obtained treatment they found the unmet need is related to a level of dissatisfaction with adequacy, responsivity, and/or quality of services. The highlighted unmet needs of adequacy and accessibility speak to the department and provider barriers regarding the conflict faced between professional and agency policies and ethics.

Due to the need for additional information, Comartin, et al., (2021) conducted an exploratory study into the practices within correctional facilities to meet the needs of mentally ill incarcerated individuals. Researchers Comartin, et al., (2021) sought to compare two types of factors. The two types are identified as staff observation and a standardized screening instrument. According to the data collected individuals identified through staff observation were significantly more likely to receive jail and community-based services even though the only screening tool identified had significantly greater behavioral health risks. During the observation period if an incarcerated individual screens positive for having mental health needs the process consists of referral to, and receipt of services.

Regarding the staff observation assessment, staff are to ask questions about their perceived mental and physical health needs in addition to assessing their behavior. Questions may relate to history of mental illnesses, history of suicidality or attempts/hospitalizations, along with medication management. In addition to the on-site observation, needs can be identified by

cationic, erratic, or delusional behaviors noted by jail staff or the transporting law enforcement. The correctional staff is identified as the main staff observers, with consistent trainings on signs and symptoms of mental illness and suicidality as well as crisis intervention skills are essential and effective. However, the concern becomes if the correctional officers are considered QMHPs whom would be best in assessing, screening, and diagnosing mental illness symptomology.

Although legally it is required of government agencies to have a process for identifying mental health needs, it is up to the individual jail to establish the questions to meet this threshold. In this study out of the 80 jails a majority reported a process but not jail reported use of a validated screening instrument (p.9). In replacement they created their own questions which range from history of treatment for any medical condition, medication management, and hospitalizations. Although, without the training of correctional staff or clinical professionals the likelihood of missing mental health needs increase. It is suggested that there is a need for a standardized and validated screening instrument be utilized.

The two identified screening tools when used are provided within 72 hours of admission. The two screenings are Brief Jail Mental Health Screen (BJMHS) and Kessler-6 (K6). The BJMHS consists of 11 items on a questionnaire to measure symptoms associated with three major and persistent mental illnesses (schizophrenia, bipolar disorder, and major depressive disorders) (p.9). This is a practical tool for jails to utilize due to taking 2.5 minutes to complete roughly. A positive score helps to differentiate among the three identified disorders at time of booking and 6 months prior. The K6 consists of 6 questions that measure non-specific psychological distress occurring within the last 30 days. The screen consists of a 5-category scare from “none at this time” to “all of the time”. This can detect historical diagnoses of SMI and

functional impairments. This tool has been used to screen for SMI in the criminal and legal systems in addition to being valued by gender in jail settings.

Once the SMI is identified a referral should be made to a qualified mental health professional for further assessment and interventions. The goal of treatment by these professionals is to provide psychoeducation and access to medication management. Due to this study taking place in jails the stay for the mentally ill incarcerated individuals is sorter with little to no notification for discharge. Due to this structure, there is an emphasis on crisis intervention and suicide prevention. However, those with longer term stays it is recommended by the researchers that the jails provide more extensive treatment. This is identified as verbal therapies, skill building, discharge planning, court assistance, and post-booking diversion efforts.

Although it is recommended by the APA (2016), that the identification process be completed by trained professionals in mental health, due to the lack of appropriate mental health providers and trainings to correctional staff there is an increased need for use of screening instruments. The use of instruments can complement the lack of clinically trained staff. The staff training on addition to the screening instrument is recommended for identification and a smoother transition back to the community. Those who are identified with a SMI by staff observation were more likely to receive and obtain necessary services than those who do only use the standardized screening tools. This implies the need for system level changes by implementing evidence-based practice, reassessing funding for QMHPs, and appropriate communication among interprofessional.

In 2018 researchers Kolodziejczak, et al., assessed barriers and facilitators to effective mental health care in correctional facilities. The critical areas of concern identified include: the level of training for correctional officers, availability of qualified mental health professions,

accuracy associated with diagnosis and screenings, and accessibility to pharmacological and psychological services. Among many correctional facilities there has been a shortage of qualified mental health providers (QMHPs) and lack of effective services (Kolodziejczak, et al., 2018). One of the main barriers is the lack of sufficient funds for mental health interventions. When a QMHP is practicing in a correctional facility they struggle with high caseloads and much lower salaries, resulting in a high turnover rate of staff. Additionally, when it comes to participation it is much more difficult for rapport to be built when the mentally ill incarcerated individual is mandated to be there, and again the turnover right is high. It is essential for correctional staff within these institutions to receive sufficient mental health training, as the benefits of such investments have been documented.

To address accuracy regarding assessing and screening for mental illness a two-tiered screening process was adapted. The proposed two-tiered screening process (Martin et al., 2016) would allow for a more accurate assessment of mental illness while also decreasing the likelihood of overdiagnosis at the time of intake and preventing incarcerated individuals with serious impairment from slipping through the cracks. There is also great need for research into new or improved interventions through clinical trials to develop empirically supported treatments. Additionally, measuring the improvement of incarcerated individuals' mental health through outcome studies would help evaluate the efficacy of currently utilized treatments. Group therapy is a cost-effective option that can be tailored to many types of treatment. Finally, establishing a comprehensive and attainable treatment plan for release is essential to break the cycle of repeated incarceration for those with mental illness.

Correctional facilities were never intended and are not capable of providing appropriate services to such a diverse clinical population. Correctional facilities typically treat mentally ill

incarcerated individuals the same as other incarcerated individuals with no special allowances, which has led to several alarming consequences. Mentally ill incarcerated individuals are disproportionately charged with rule infractions and sent to disciplinary courts across all types of institutions. It is noted that most rule violations are either a direct result of an incarcerated individual's mental illness or the staff's lack of training.

Of particular concern are the training of correctional staff, the availability of qualified mental health professionals (QMHPs), the ability to screen for and accurately diagnosis mental illness, and the pharmacological and psychological services that are received.

First, the programs available to mentally ill incarcerated individuals are based on state and federal standards. Although it is helpful to have a set of standards it seems these standards are targets for the "general population" with minimal shift for those who have serious mental illness. Some states have incorporated Mental Health Courts as a diversion program, which has been shown to be effective in reducing recidivism and improving treatment continuity. However, it is still unknown why more evidence-based treatment interventions are not being provided for either short term or long term mentally ill offenders.

Lastly, the literature review highlighted the policy factors and theoretical models such as RNR that can increase accessibility, interventions, and decrease recidivism rates. The state and federal standards seem to fall short of the unmet needs perceived by mentally ill offenders. Additionally, due to the emphasis on safety and security being the priority in correctional facilities the policies in place conflict with the NASW code of ethics.

The use of mental health courts has been implemented for individual with mental illness. A participant's perspective on mental health court was conducted by researcher Kennedy (2012). Kennedy (2012) suggested mental health courts assist offenders with mental illness by providing

access to treatment, individualized treatment plans, and community connections. This diversion program seeks to limit the offenders with mental illness from entering a jail or prison. The Weber County Mental Health Court began a specialized docket in April 2011 with Weber County Mental health authority to begin MHC. The community connects to housing authority, food banks, and law enforcement. The "treatment team" consists of the judge, prosecutor. Defense attorney, mental health service providers, and a representative from the jail and probation staff. This team meets weekly prior to the court proceeding to collaborate care for each individual "client". The recommendations occur after progress discussions take place.

To be eligible for MHC an individual must be nonviolent defender who has not been charged with a sex offender crime or incarcerated individuals who have been diagnosed by the local mental health authority as having a "treatable mental illness." Additionally, the clinical eligibility for participation consists of serious and persistent mental illness (schizophrenia, schizoaffective disorder, other psychotic disorders, or bipolar disorder), voluntary election to participate, a misdemeanor or felony charge, and residing in the jurisdiction of the court. However, they will be deemed ineligible if the charges change to a sexual offense, violent crime, or driving under the influence. In addition to a primary diagnosis of a developmental disability and/or no primary diagnosis of a SMI as well as if they are ruled to have diminished capacity or not guilty by reason of insanity.

The results were interpreted based on three areas of identified goals being treatment engagement, effective use of resources, and public safety. It is reported the clients felt more engaged with the treatment process including the judge and therapist. Among all participants that were interviewed, positive regard to MHC was reported. Four of the six clients discussed outside resources in the interview. Three of four expected to have access to more resources such as

housing or employment. Five of six discussed their experience with medication management as a helpful resource. Additionally, all clients were "tracked" regarding their time spent incarcerated before and after MHC participation. All clients saw a reduction in time spent incarcerated.

Purpose of the Study

There is a gap within the knowledge surrounding the policies and procedures that take place within correctional facilities at a department level. Building on the already published knowledge of the expectations of how a correctional facility runs regarding opportunities for mentally ill offenders, this research aims to further understand the procedures and the impact on the incarcerated individuals through the lens of formerly employed correctional officers. Using qualitative grounded theory, the research question for this study is as follows: What is the role of the department of corrections polices in relation to accessibility to evidence-based practice interventions?

Methods

Research Design and Setting

There is limited research on the rationale and barriers behind the lack of implemented evidence-based practice interventions for mentally ill offenders while incarcerated. Although evidence-based practice interventions are vastly studied there is a gap within correctional facilities. However, there is also many studies and information regarding the re-entry process as well as factors that reduce rates of recidivism, we can correlate certain policies, theories, and interventions that are deemed effective, we cannot explore or develop a relevant understanding without diving deeper into the barriers providers, policymakers, and mentally ill offenders face while attempting to obtain appropriate treatment interventions.

The data collected around this information previously has been provided through systematic literature reviews, narratives of formerly incarcerated individuals, and clinical providers. The gap was found within the limited information on the experiences of the correctional officers supervising mentally ill offenders, in addition to ways of addressing the barriers identified in previous research. This research intends to re-shape how the social work profession, policy makers, and correctional staff can better facilitate evidence-based practice interventions for mentally ill offenders while incarcerated.

Qualitative researchers embrace the concept of varying realities within the participants experience within the study (Creswell & Poth, 2018). Inductive and emerging methodology allows for flexibility in interpreting the findings. Qualitative research relies heavily on context. Being context dependent, it allows for a greater area of coverage, such as socially, politically, and historical factors that influence the increasing number of mentally ill offenders held in correction facilities (Creswell & Poth, 2018). This aligns with Penrose's Law/Transinstitutionalization and works to further understand the effect of increasing mentally ill offenders held in inappropriate environments. Additionally, the Risk-Needs- Responsivity Model in combination with the Good Lives Model whose goal is to seek to address the risk, needs, responsivity of offenders while emphasizing their strengths to replace antisocial behavior with prosocial behavior. These models allude to skill development to healthily cope with distressing internal and external factors to improve overall well-being and quality of life outside of correctional facilities.

Data and Subjects

Snowball sampling has been utilized until saturation has been met. Saturation is defined by Creswell and Poth (2018) as when the researcher is analyzing the data and creating themes to which the categories are evaluated for support once the researcher no longer needs additional

information to support the identified theme (p.318). Saturation was met when researcher collaboratively met with her committee to review the themes collected as well as the codebook to assure similar themes are presented within the limited sample size provided. It is also suggested a minimum of 20 participants are used in Grounded Theory, there for this study sampled until saturation is met utilizing a saturated sample.

The researcher used inclusionary rather than exclusionary criteria to better facilitate an explicit sample while allowing for diversity. Diversity is provided while interviewing previously employed correctional officers and their relation to the barriers faced by mentally ill incarcerated individuals receiving evidence-based interventions while incarcerated. Previously employed correctional officers with experience in working with mentally ill incarcerated individuals were used within the sample. The perceived needs of these individuals and their access to services as well as factors that couple improve their overall well-being are emphasized.

Due to the limitations associated with interviewing previously and/or currently incarcerated mentally ill offenders, correctional officers are included in this study. Correctional officers can provide insight into their level of training, accessibility to services, collaborative care experiences, risks, needs, as well as the level responsivity provided. The correctional officers have worked in New York State private and/or state-run prisons.

The sample met saturation, which was confirmed through meetings with the researchers committee to assess and evaluate the interviews and themes derived from them. Although Creswell and Poth (2018) suggest *discriminant* sampling when saturation has not been met, this was not necessary in this study. Constant comparison is suggested and has been utilized throughout the data analysis in comparing patterns and attempts in aiding the researcher to further understand the events.

The researcher engaged in the recruitment process using networking systems such as LinkedIn, Social Media Platforms, flyers posted at community programs/groups for correctional employees, The California State Department of Corrections and Rehabilitation (due to lack of response from the CDCR this was an unsuccessful recruitment from them) as well as through word of mouth (snowball sampling). Initially a demographic questionnaire (Appendix A) was sent via Qualtrics to assure inclusionary criteria are met. Inclusionary criteria include those previously working in NYS and/or California State private and/or state-run correctional facilities and have experience with mentally ill offenders within the last 4 years. Exclusionary criteria included those who have no experience with mentally ill offenders.

Procedures

The process of data collection was conducted in two parts: a demographic questionnaire (Appendix A) and an interview (Appendix B). The interview was offered through video technology via Zoom and consisted of a 60-minute recorded interview. The date, time, and circumstances for the interview was coordinated by the researcher and the participant. First contact was made The first contact was made via email response to the potential participant, expressing gratitude for their interest in participating as well as providing the Consent Form (Appendix E) as well as the resource sheet. The email included the link to the Qualtrics questionnaire. Once the participant clicked on the link, they consented to participate prior to the completion of the survey as disclosed in the consent form. Once the participants met the inclusion criteria, the researcher contacted them via telephone or email to schedule an interview time and explain the method. An application was sent to CDCR to request access to currently employed correctional officers, however, this was unsuccessful. Additionally, through another application to NYSDOCCS it was determined that they are not taking on new research due to

COVID-19 restrictions and limited resources the population has shifted to previously employed correctional officers. The application for CA is still pending however, to provide additional accessibility researcher extended the population to previously employed correctional officers in CA. WIRB researcher began outreach to potential participants in both NYS and CA after approval (Appendix C).

All interviews were conducted via Zoom and recorded. The option for the participant to have their camera on or off was left to them, however the researcher had her camera turned on. *Transcribe by Wrealy*, an AI transcription service was used to import the Zoom audio recordings where transcribing took place. All interview recordings were stored on the researcher's laptop with a password protected file, a backup file was kept on a password protected google drive which is affiliated with the researchers University. All data that has been collected will be kept for three years and then destroyed. To assure confidentiality and a safe space, the researcher conducted all interviews in a private space (home office space). The participant was able to choose the location which best suits their needs.

The option for the participant to withdrawal from the interview was provided if they became uncomfortable or distressed by the questions or content. It was also disclosed if this option was taken the data collected as well as their information would be destroyed. At no time did any participant request to withdrawal from the interview. The researcher offered a resource sheet to all participants to support them in their discomfort or distress.

Measurement

This study utilized two forms of measurements; a demographic questionnaire (Appendix A) sent via email as well as an interview guide (Appendix B). The demographic measurement began with the individual consenting to participation within this study. This was followed by

demographic information: age, race, gender, years of experience in corrections, and years of experience with mentally ill offenders. Inclusionary criteria for the study consisted of the following: correctional officers who previously worked in either New York, who have experience working with mentally ill offenders. Exclusionary criteria included those who have no experience with mentally ill offenders.

The second measurement instrument is the interview guide, which consisted of twelve questions that were used during the 60-minute interview. Additional questions were asked due to the interview being semi-structed to obtain further information and clarification. The data was then collected and coded from these questions. This served to address the overall research question and discover a deeper understanding of: *"What factors are impeding the implementation of evidence-based practice for incarcerated mentally ill offenders?"*

Data Analysis

The data analysis process was grounded in Strauss and Corbin's Grounded Theory, which means the data analysis occurred alongside with data collection. Engaging in the data analysis this was provided more insight into relevant and/or irrelevant concepts to be identified immediately and addressed (Corbin & Strauss, 1990). In grounded theory, the concepts are units of analysis, the themes that arose from the data illustrates the event or the incident used as the data unit. All concepts developed were related and can be utilized later in the research to assist in investigating *what, how, before* and *after* each concept (Corbin & Strauss, 1990). Constant comparison was utilized throughout the analysis process to assure researcher bias was prevented as well as challenges and new perspectives that arose with the new data. Open, axial, and selective coding were included throughout this process. Engaging in this three-part selection of

themes provided a narrowing of core concepts or ‘themes’ that ultimately inform the factors and themes derived.

Documenting throughout the analysis process was provided as well, which is a core component of grounded theory also known as (‘memo-ing’). This is when the research takes note of the constant changes and re-grouping of categories and codes through the method of constant comparison. Memos helped to track evolving factors as well as patterns throughout the coding process. These patterns consist of changes in complexity, clarity, saturation, and accuracy (Creswell & Poth, 2018). A codebook was also utilized to further assist in ensuring rigor and usage of codes. Memos in this usage are not just the researchers’ ideas, they aided in formulating a deeper understanding of the data collected. This begins with the first coding session and continues throughout the research process. This also included writing the results and employed to support the discussion of findings (Corbin & Strauss. 1990).

To demonstrate rigor and reliability, several methods are described in this subsection to enhance this study. There have been on going arguments regarding validation within qualitative research has been working to establish a universal understanding and systematic procedure to identify and prove validation (Creswell & Poth, 2018). Authenticity was established by identifying the following methods in the proposed study: reflexivity, clarifying researcher bias, and generating a rich, thick, description. Reflexivity involves the researcher disclosing their understanding of any biases, values, and experiences with the subject of the study and population to create transparency and provide insight into their perspectives and ideas (Creswell & Poth, 2018). The researcher shares some level of identification with the population being studied, bracketing was used as a best reflective practice to reduce bias. With the understanding that the researcher has experience within their personal life with formally mentally ill and formally

incarcerated individuals, it is essential to reflect on the subjective interpretation of the data being collected.

The researchers experience with this population is minimal, this may create a power dynamic among those she may interview. Within this power dynamic, all questions and ideas that may arise from participants that the researcher openly answered while limiting sharing of personal information that could skew the data collected. Participants were encouraged to wait until the end of the interview to engage in questions and voicing of concerns with the research, at that point they were given the opportunity to withdrawal from the study. The researcher also acknowledges that strong feelings and reactions to opinions she hears may be triggering. Themes related to social justice and equity within the interview may illicit challenging and informative conversations during the interviews. The researcher intends to only amplify the voice of the participants and the experiences voiced by them regarding the vulnerable population of mentally ill incarcerated individuals. Additional questions and clarification from the participants were used to obtain the most understanding of the data as possible. This form of validation criteria is a detail account of the evidence for or against the formulated themes and factors. This was provided by inclusion of details on the environment, atmosphere, physical descriptions, movement descriptions, and activity descriptions (Creswell & Poth, 2018). The readers will understand from the beginning through to the end within the data the *how* and the *why* based on the thick data description and evidence provided.

To address reliability coding systems Atlas.ti and employing higher-quality electrics to record and transcribe data was utilized (Creswell & Poth, 2018). The researcher proposes using peer debriefing and auditing methods as fit within the rigor and structure provided by Strauss & Corbin's (1990) grounded theory and data analysis methodology.

Results

Participant Characteristics

The study participants were interviewed from January through May 2023. A total of six (n=6) study participants met the study criteria and agreed to participant in the study. Open, axial, and selective coding were used to analyze using Atlas.ti. Many participants were male (83.33%), White (83.33%), and have an average of 13.3 years' experience.

Themes

The results below are organized by the participants perspective collected during the study which will discuss three major themes emerged: (1) interventions, (2) accessibility, and (3) communication among departments.

Interventions

The accounts of six (n=6) participants discussed their perception of treatment interventions provided to mentally ill incarcerated individuals while they are incarcerated given the policies set in place within the department of corrections. Despite the increase in mentally ill incarcerated individuals' interventions have yet to adjust to meet the needs of their most frequently incarcerated. The result from this theme highlights which interventions are typically offered as well as barriers associated with the interventions.

> Participant 1: *"When they come in they go to speak with the social workers and psychiatrists who deem that someone should go to the mental observation unit. They end up in mental observations, housing areas rather than general population. Inmates go out for medication so in GP house you could call out medication and you let the guys go and get their medication from the medication window, mental observation inmates are*

given their medications taking to the housing area and it's given to them at the window with the station and observe."

Participant 2: *"Unfortunately, or frothingly, I have been on several suicide watch sittings, which is just keeping an eye and noting the suicide watch inmates. We had a special unit that was called SHU (special housing unit), which was, individuals on medication and being sought after by the psych department. And that was a very sensitive area and not too many people or at any time can go in the unit. Because this would trigger certain inmates and depending on what their status was with their case, they just try to keep that area at a close watch, so it didn't disturb anything or anybody or cause anybody to do something that was harmful for themselves."*

Participant 3: *"In my opinion probably where I work they are cared for, and their needs are met. I mean sometimes you know they may say that there are not getting the frequency that they would like. You know put them at ease and then maybe find out what their issues are. And you get some help, that is a much better outcome than getting aggressive then and again you know."*

When participant three was asked if there are services that could be improved on he replied with:

Participant 3: *"Actually I think that the mental services for inmates are actually good. All officers to stay at the prison we don't have to quit clarify things, where you're a cook, whether you're a doctor, whether you're a chaplain, or anybody else you are all trained to perform the*

> *duties of an officer. Taught me progression in firearm, how to take an inmate down use of force all these things. So, my point being is that it's the bureau is so short staffed right now that people like me who don't work in a unit every day are being forced to work a unit or in my case transport prisoners out the hospital because I am certified in that but put the other department at a law. How do you take three psychologists away and there's only you and a lot of mentally ill people to help."*

Theme 2: Accessibility

Study participants discussed policy and procedural barriers that imped accessibility and consistency associated with their treatment interventions. Results from this theme illuminate the systematic barriers and engagement in protecting themselves to be safe from protentional employment issues resulting in a form of neglect regarding timely interventions and accessibility.

> Participant 1: *"...so mainly it's up to the offenders to then reach out to an officer and say, 'hi I need to talk to someone' and request the form and that's usually how the ball gets rolling for that. Now mind you, I have been out for many seven years that I haven't really dealt with because things change. What is considered and not considered to be better areas, but you deal in the areas where maybe you don't deal with mental observation inmates, you know the new officers are the ones that basically get rotated into these areas."*

As mentioned by participant 1 the officers that work in certain units is consistently rotated in addition to the primary officers being new with limited experience while working with an

extremely vulnerable population. Participant 1 continues to express his experience associated with working with mentally ill offenders:

> *"This image you see that they have mental issues, and you can tell by their hygiene, you know there are specific things an inmate displays. They have problems with the way they speak and what happens in the segregation. A lot of the guys that would get in trouble and end up in the punitive segregation which I don't think exists anymore, but they would go to the mental observation around you and get out of the 23-hour lock down. So, a lot of these inmates are experienced they know how to manipulate the system and they also take a little meaner in reference to their harder in reference to dealing with other inmates there, manipulate them a bit more that the guys this is their route towards getting out of the 23 hours lock down would be the mental observation, so they end up being in that housing area. That's a dawn in a dorm room setting a lot of the times what I see is that they guys manipulate and sometimes abuse and take over the housing area."*

Participant 1 has identified a major barrier to accessibility and the safety associated becoming compromised by other incarcerated individuals who are allegedly working towards manipulating the system resulting in a disrupted and dysregulated mental observation unit. This can cause a significant negative impact on rehabilitation, accessibility, and the actual interventions taking place. In addition to participant 5 who identified manipulation as a barrier as well.

> *"Sometimes I'll give you for instance if you were a blood and you were in a housing area, and they wanted to send you to cut another member a lot of times*

> *they would use these tactics to get out of that house. A higher-ranking person wants this done so they would try and get out of that housing area into another one to get to that other inmate."*

Theme 3: Communication Among Departments

Coordination of care is essential when treating to caring for an individual. For the correctional officers not placed within the specific mental observation units they are responsible for the well-being of those incarcerated individuals. Once an incarcerated individual expresses interest in services or is displaying behaviors that align with an emotionally disturbed person it is their responsibility and the incarcerated individuals to seek out mental health providers. This theme highlighted the ways of communicating when possible for the officers to the providers as well as vice versa.

Participant 5 was asked about care coordination and accessing providers to which he responded with:

> *"They officers watching the unit and they would open the dates and that person would call. Sometimes you don't need a captain because don't forget when you start your tour a captain comes in twice in an eight-hour shift, So they count on you to be able to debrief and say if anything new happened or anything you need to report. No were okay or yes you know inmate 15 is saying he's going to hang it up or that he's going to hurt himself then you know the two of us would normally go there kind of go over everything. Sometimes they say they will cut his arms; I think it was too hard because sometimes people appeared to be so normal but they*

> *kind of knew how to really get out of the housing area they would just do what they had to do."*

When redirected towards the communication with mental health staff participant 5 responded:

> *"Social workers more because they would sometimes be like the right-hand side. One on one with the inmate when they left, they would say yeah he's going through a tough time, or his dad is dying. So sometimes it wasn't always killing himself or each other, you know sometimes we could have various reasons but most of the social workers would connect with us. The doctors rarely did, I think that was due to HIPAA laws we would never know. Like sometimes they would say they would come to the housing area, and they might say you know get the person to talk by last names. Get Logan you know Smith could, they would come they'd have a little dixie cup to take the pill in front of them and then for like fun they would like to show me 'hey I got another one' and then they would trade it or whatever they would do."*

Many participants discussed manipulation and issues with medication and speaking with social workers as factors that imped the ability to implement evidence based mental health practices. Additionally, many participants seemed avoidant to speak further on the negative aspects of the role of their colleagues.

Discussion

This qualitative study aimed to examine the experiences of correctional officers and mental health treatment. Findings from this study are congruent with the theory of Penrose and RNR used within this study. Utilizing the lens from the theory of Penrose regarding deinstitutionalization and transinstitutionalization explains the minimally equipped aspects of the department of corrections to properly care for mentally ill offenders. It was found that individuals who need mental observation can be disrupted by other incarcerated individuals, alternative motivations for taking medications, and limited contact with psychological staff. Given that there is an increase in mentally ill offenders being incarcerated it seems that there are attempts at improving care and care coordination however the consistency and using evidence-based practices can only improve further.

Interventions

The courts have suggested the standard for mental health treatment at a minimum to be implemented but that is not enough. The mentally ill prisoners need specialized services that the prison system is unable to provide. Gumz (2004), discusses the lack of social work being utilized within the facilities, mainly because of the underlying inability to create change from the inside. The department of corrections is not created to treat the mentally ill but is created to house criminals. Prisons are supposed to be rehabilitative for most if not all the incarcerated individuals to attempt to reduce the recidivism rates but has now become more punitive than rehabilitative. Many states created a standard for mental health services within a prison. However, regardless of the court mandating alterations within the prisons, there is still a lack of application within the facilities.

This study found that the participants are aware of certain policies and workflow for when and how mentally ill offenders can obtain treatment interventions. Although the workflow seems to have some barriers alone, that continues to speak to the needs to revitalize the process for obtaining assistance.

Accessibility

This study found that participants believe that there is access to medication management and therapy should it be requested by the incarcerated individual or on behalf by a correctional officer due to seeing certain signs. Although there are treatment options the access can become closed when there are other incarcerated individuals allegedly manipulating the system and disrupting the space for the mentally ill individuals. Additionally, it seems accessibility can be limited by forms and paperwork that could take up to 72 hours to process. Not all participants discussed being able to provide access to treatment interventions but believe that staffing can play a role in the barriers towards accessibility. Notwithstanding, this current study suggests that accessibility is limited by security as a top priority as well as inappropriate use of the mental observation units.

Communication Among Departments

This study found that participants believe there can be barriers to communication including HIPAA. Given that the incarcerated individuals who are provided mental health interventions, medication management, may not be in a mental observation unit but within the general population it is essential to be aware of the status of each incarcerated individual you are responsible for. It has been made clear that there is limited contact with the doctors themselves but mostly through the social workers who are seeking out certain incarcerated individuals. Additionally, is seems as though communication only takes place in the moment of a crisis rather

than are a debriefing process. The process of debriefing and coordinating the care and status updates for mutually seen mentally ill offenders could only continue to improve treatment and rehabilitate behaviors.

Implications

Implications for Social Work Practice

There are several practical strategies that the social work profession can implement to address the department policy factors that imped the implementation of evidence based mental health practices. Study participants expressed implementing practical strategies to reduce risk and improve overall well-being. These interventions are available to the mentally ill incarcerated individuals however with further trainings and education by social workers to correctional staff can continue to improve care and well-being.

The Nation Association of Social Works (NASW) Code of Ethics consist of six core values: service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence. To provide the population with the best experience the combination of these values with the principles that follow them allow for the best human experience.

The value of service alludes to the ethical principle of helping people in need while addressing social problems. (NASW, 2021) Social workers tend to work in agencies to which they must conform to their separate values outside of the code of ethics. Social workers in prisons are part of an agency where they must alter their personal and professional beliefs. As staff in the prison's agency, social workers provide initial mental health assessments, irregularly monitor, and meet with those who have a mental illness, in addition to meeting with incarcerated individuals nearing release to create a plan of discharge. Due to the lack of funds available to

mental health services in prisons it causes a strain on many of the core values necessary to provide the best human experience.

The lack of emphasis on mental health services creates an unspoken standard of it not being a priority or necessity. This triggers a discrepancy within social workers to abide by the prisons core values and their own. A second source of strain for the social worker may face is with correctional officers. Social workers who perceive the incarcerated individual as needing rehabilitation rather than punishment differ from the correctional officers who view them with disapproval, hostility, or rejection because of their guilty verdict (Dane & Simon, 1991). This perception of the incarcerated individuals creates a stigma of criminal rather than mentally ill which leads to the negative public opinion of the two being positively correlated.

This also prevents the social worker to provide social justice for this population. The incarcerated individuals are vulnerable and oppressed due to their current situation. Social workers are needed to change social justice issues and promote sensitivity. Social workers within prisons are very minimal in comparison to correctional officers or other staff. The humanistic outlook of social workers tends to cause those within the correctional staff to view their perspective as lesser than their own. According to, Dane and Simon (1991) it was found that social workers can be perceived by correctional officers as “soft” on criminals and easily manipulated. This perception of social service works continues to enable minimal mental health services that could potentially be implemented because this population doesn’t need or deserve it.

Implications for Policy

Social workers were active within prisons during the 1970s. Their role consisted of providing services such as presentence investigation and supervision, counseling regarding

assisting them in adjusting to the prison environment, and discharge/transitional planning. (Gumz, 2004). Even when social workers were active within the prison population there was minimal emphasis on treatment for mental health.

In 1974 the Martinson report was filed which questioned the level of effectiveness of the treatments being offered for the incarcerated individuals. Following the report Gumz, believes this may have influenced the amount of social works still willing to work within this community. When considering social justice social work has been calling for the distribution of equality of goods and services within society. However, social worker as a profession must conclude that there needs to be an emphasis on restorative justice. Gumz (2004), suggests, with the use of a holistic approach there can be justice for the victim, offender, and the community, which are all relevant. This emphasizes the importance of restorative justice within correctional facilities. This may also assist in attracting more social service providers to be willing to work in correctional facilities. There needs to be more emphasis on social work and social justice within prisons to provide the rehabilitative services.

This puts an additional strain on the social workers duty to provide their clients with dignity and worth as well as integrity. Incarcerated individuals in general struggle to perceive themselves in a positive light regardless of mental illness. However, due to prison populations having a high rate of mental health problems the need for services is prominent. For those who struggle with mental health and need services they cannot access them which leads to negative outcomes both while imprisoned and once released. Researchers Hopkin, et al., (2018) reviewed the interventions necessary for properly transition an incarcerated individual with mental illness out of prison back to society. Their research found that the prisoners need for social workers to provide them with integrity. Social workers must be aware of services and continue to stay up to

date regarding services that are offered. This principle helps the social worker provide their client with dignity, competence, and integrity.

Implications for Research

There is knowledge regarding evidence-based mental health practice and the disconnect regarding the criminal justice systems perception of how to treat a mentally ill individual who also committed a crime. This research study intentionally sought to recruited formerly employed correctional officers as they are the forefront of working with the incarcerated individuals while incarcerated. The study provided a steppingstone into the perception of the officer and their ability to do their job effectively while working to create a rehabilitative and effective space for mentally ill incarcerated individuals. Future research is needed to further investigate the efficacy of improving department policies and workflow among the officers, incarcerated individuals, and other staff to improve interventions and quality of care.

Limitations

There are limitations to this study. Due to the small sample size, broad generalizations could not be made to the larger population. The data is representative of formerly employed correctional officers in New York and relied on literature and secondary data collected from California to connect the two. Given that the study is limited to New York and California, as mentioned prior an opportunity to diversity the sample further by seeking out alternative states would be necessary. As with all qualitative research, the compensation and social desirability bias can impact the study participants responses to the questions provided during the interviews. Secondly, the perception of the correctional officer rather than the incarcerated individuals themselves could be a limitation as well. Lastly, there are some recruitment challenges that should indicated. The research study proposed to interview between 10-20 participants,

consequently 6 study participants were interviewed, which is still methodologically sound within grounded theory qualitative study (Creswell & Poth, 2018).

Despite the limitations this study is still strong and needed in the exploration to further understanding why the most frequently incarcerated are unable to have their psychological needs met. This study sought and was able to identify barriers regarding department policies which could provide insight into areas of improvement as well as policy analysis within future research.

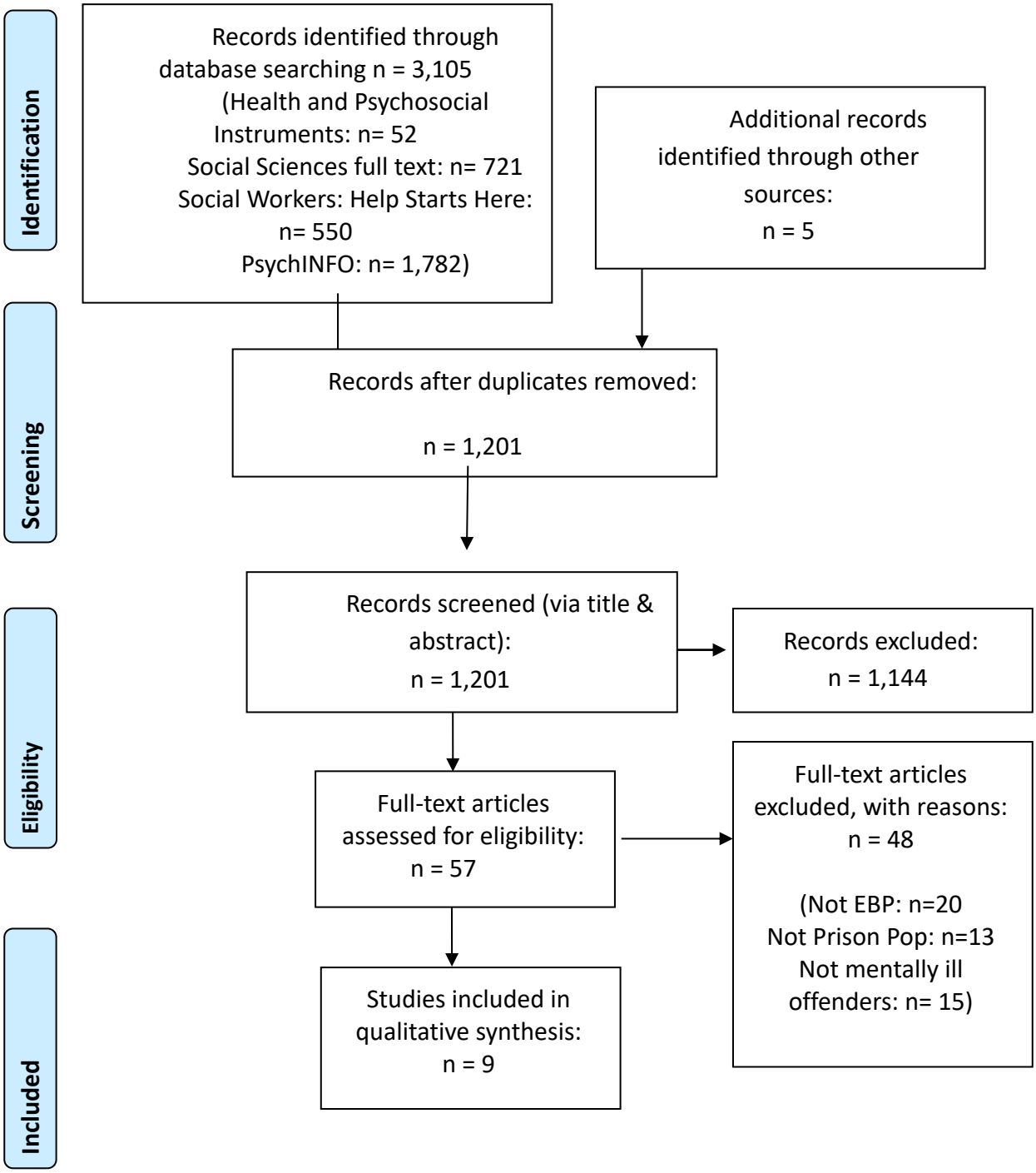
Conclusion

This study explored the department policies through the lens of formerly employed correctional officers as a barrier that impedes the implementation of evidence-based mental health practices in correctional facilities for mentally ill offenders. Incorporating care coordination, accessibility, and treatment interventions available strategies within social work academia will elevate social workers presence within the criminal justice system and correctional facilities. Integrating the appropriate channels for care and having education provided to the correctional officers is needed. Findings from this analysis also highlight the critical need to improve accessibility and consistency to interventions. This study strongly suggests implementing future research into the effectiveness of improving accessibility and the implementation of interventions. For example, it is unknown the process of applying to start an initiative for an evidence-based mental health treatment program. Thus, this increases our understanding of how to apply and/or start the process of addressing skill developing for prosocial behaviors and thought patterns.

Table 1: Demographic Table

Characteristic	n	%
Age	6	44.66
Gender		
Male	5	83.33%
Female	1	16.67%
Race/Ethnicity		
White	5	83.33%
Hispanic/Latino	1	16.67%
Years of Employment	6	13.3
Experience with Mentally Ill Offenders	6	100%
New York State Employment	6	100%

Figure 2. Flow chart depicting inclusion and exclusion process



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A Qualitative Study: The Provider Barriers Impeding the Implementation of Evidence-Based Mental Health Practices in Correctional Facilities for Mentally Ill Incarcerated Individuals

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Dissertation Paper #3

Abstract

Background: There have been programs that are evidence-based mental health interventions that have been successfully integrated into correctional facilities throughout the United States. Although there have been programs integrated there is still an overpowering amount of untreated mentally ill incarcerated individuals, which this paper will explore the provider and program barriers. **Purpose:** This qualitative grounded theory approach highlights the policies implemented within correctional facilities through the lens of formerly employed correctional officers to improve department procedures and policies. **Methods:** A qualitative grounded theory approach with a demographic survey (Appendix A) and open-ended questions during a semi-structured interview (Appendix B) was used among 6 participants from New York between January and May 2023. Using open, axial, and selective coding through Atlas.ti was used to identify significant themes. **Results:** The samples mean age was 44.66; 83.33% identified as White and 16.67% identified as Hispanic/Latino, and the samples mean years of employment were 13.33. Three major themes emerged: (1) care coordination, (2) participation, and (3) knowledge of the program. **Conclusions:** There are programs that have been successfully integrated however the themes that emerged highlight the additional barriers to use, access, and knowledge of existence. Additionally, there are barriers regarding correctional officers and ability to communicate with other staffing from other departments such as the mental health providers/medical providers. Implications for social work practice, values, and policy are delineated.

Introduction

Originally prisons were not meant to rehabilitate the mentally ill due to not having the means to provide appropriate services. Shenson, Dubler, and Michaels (1990), analyzed the concept of jails and prisons becoming new asylums for the mentally ill. This began in England during the 19th century during the development of reformist theories of punishment. The use of incarceration as a punishment increased moderately throughout history however the environment that these people are spending their time in have only worsened. During this time courts have struggled to create a standard that prisons should be held to regarding the health care provided within their facilities. In 1976, the United States Supreme Court held, "deliberate indifference" to the serious medical needs of their incarcerated individuals is in violation of the Eighth Amendment. The Eighth Amendment protects the citizens against cruel and unusual punishment. This includes the free and the incarcerated citizens of the United States. Unfortunately, most facilities regardless of the standard that should be held tend to fall significantly short (Shenson, Dubler, & Michaels, 1990).

The prison system has been used a place for those who are poor and or a minority to seek free housing, food, and medical treatment. However, if this is the perception holds true, then the services provided should at the very least meet the standard for health care.

The issue of treatment for mentally ill offenders has been prevalent since the beginning of the criminal justice system. Mental health treatment has been neglected for not only incarcerated people but within society. Since there has been a neglect in mental health treatment as a whole Torrey (1995) discusses the concept of prisons becoming America's new mental hospitals. San Diego County Jail was used as an example with a population of incarcerated individuals where 14% of males and 25% of females are on psychiatric medication. The assistance sheriff says,

“we've become the bottom-line mental health provider in the county” (Torrey, 1995, p. 1611). They have found that a majority of those who are mentally ill and committed crimes, the crimes consisted of assault, theft for property or services, disorderly conduct, and alcohol or drug charges. These crimes are less serious than felony charges, regardless these people are sent to the same sentences as those who are cognitively available to make their choices.

The use of prison sentences for those who are severely mentally ill cause an increase in recidivism and a lack of after care. These people struggle to live within the community due to the inability to receive their medications and after care to succeed. Although they are receiving some form of treatment while incarcerated it does not provide them with the services necessary to become an upstanding member within society.

Torrey, et. al., (2010) took a deeper look into the concept of more mentally ill persons being incarcerated rather than in hospitals. Torrey et.al., found “As of 2000 the American Psychiatric Association estimated about 20% of incarcerated individuals were severely mentally ill, with 5% actively psychotic at any given time” (Torrey, et.al, 2010, p. 4). This statistic held true, for example as of 2002 the Sheriff’s Office in Niagara County New York found that 25% of incarcerated individuals have some form of mental problem, also commenting that since the closure of mental hospitals this population of people are being pushed into jails. This report found there are several problems associated with having a serious mental illness if you are incarcerated. The incarcerated individuals struggling with mental illness are often “frequent flyers” meaning there is a high recidivism rate due to not being prepared to return to the community since the facility was not structured to rehabilitate or treat them. Mentally ill incarcerated individuals also cost more for tax pays, and they tend to stay longer, in Rikers Island Jail the average stay for all incarcerated individuals is 42 days however for mentally ill

incarcerated individuals is 215 days. This population struggles to comprehend and follow the rules while incarcerated, trending shows they were 19% more likely to be charged with a violation of a facility rule. They are also more likely to commit suicide and be abused (Torrey et.al, 2010).

Literature Review

A systematic literature review was conducted to explore program implementation and the barriers associated for individuals with mental illness while incarcerated (Figure 3). This systematic literature search utilized a discovery to expedite search by simultaneously searching various libraries and journals. Program evaluations in combination with the experience of incarcerated individuals and correctional facility providers are vital to review in identifying the factors impeding the implementation at a provider level. The objective of the present study is to examine the factors impeding the ability to implement evidence-based practice for mentally ill incarcerated individuals in correctional settings through the lens of provider barriers. The selected articles must include evidence of mental illness among incarcerated individuals. Additionally, assessing programs that were previously implemented, recidivism rates, accessibility to services, and needs and barriers of services. Race and ethnicity were not included in the search terms since the research is seeking to explore the factors impeding implementation of evidence-based practice among all mentally ill offenders.

For the search, the inclusion criteria included peer-reviewed articles, empirically based articles, articles containing keywords such as correctional mental health care, mental illness, offending behaviors, psychosis, evidence-based practice, cognitive behavioral approaches, evidence-based practice AND mentally ill offenders, recidivism rates AND mentally ill offenders, and barriers to evidence based practice AND correctional facilities. Articles from the

last 21 years (2001-2022) The following electronic data bases were utilized for find relevant articles: PsychINFO, Health and Psychosocial Instruments (HAPI), Social Sciences full text, and Social Workers: Help Starts Here. A total of 3,105 articles were found, however 24 were utilized based on the inclusion criteria above. Articles were reviewed by their title, abstracts, and keywords to determine if they were relevant. Additionally, 5 articles were utilized from previous searches pertaining to the study problem. Exclusion criteria included articles written in languages other than English and studies conducted outside of the United States.

Based on the search, the systematic literature review yielded a total of 3,105 articles. Based on the inclusion criteria, a total of 24 articles were selected after reviewing the 3,105 articles, duplicates were removed. The other articles were excluded due to the lack of discussion regarding implementation of evidence-based practice and mentally ill offenders.

The results from the literature review highlighted many interventions that are effective evidence-based practice as well as the providers that are available and their limitations. However, the social work literature on evidence-based practice for mentally ill offenders while incarcerated is limited due to the current literature focusing on re-entry, recidivism, and community care.

Perceived Unmet Needs of Mentally Ill Offenders and Providers

This section will illustrate the identified perceived unmet needs of the mentally ill incarcerated individuals as well as the identified provider barriers. The systematic literature review resulted in six studies describing the perceived unmet needs of mentally ill incarcerated individuals as well as the barriers faced by providers to conduct appropriate services.

In 2018 researchers Kolodziejczak, et al., assessed barriers and facilitators to effective mental health care in correctional facilities. The critical areas of concern identified include: the level of training for correctional officers, availability of qualified mental health professions,

accuracy associated with diagnosis and screenings, and accessibility to pharmacological and psychological services. Among many correctional facilities there has been a shortage of qualified mental health providers (QMHPs) and lack of effective services (Kolodziejczak, et al., 2018). One of the main barriers is the lack of sufficient funds for mental health interventions. When a QMHP is practicing in a correctional facility they struggle with high caseloads and much lower salaries, resulting in a high turnover rate of staff. Additionally, when it comes to participation it is much more difficult for rapport to be built when the mentally ill incarcerated individual is mandated to be there, and again the turnover right is high. It is essential for correctional staff within these institutions to receive sufficient mental health training, as the benefits of such investments have been documented.

To address accuracy regarding assessing and screening for mental illness a two-tiered screening process was adapted. The proposed two-tiered screening process (Martin et al., 2016) would allow for a more accurate assessment of mental illness while also decreasing the likelihood of overdiagnosis at the time of intake and preventing incarcerated individuals with serious impairment from slipping through the cracks. There is also great need for research into new or improved interventions through clinical trials to develop empirically supported treatments. Additionally, measuring the improvement of incarcerated individuals' mental health through outcome studies would help evaluate the efficacy of currently utilized treatments. Group therapy is a cost-effective option that can be tailored to many types of treatment. Finally, establishing a comprehensive and attainable treatment plan for release is essential to break the cycle of repeated incarceration for those with mental illness.

Correctional facilities were never intended and are not capable of providing appropriate services to such a diverse clinical population. Correctional facilities typically treat mentally ill

incarcerated individuals the same as other incarcerated individuals with no special allowances, which has led to several alarming consequences. Mentally ill incarcerated individuals are disproportionately charged with rule infractions and sent to disciplinary courts across all types of institutions. It is noted that most rule violations are either a direct result of an incarcerated individual's mental illness or the staff's lack of training.

Of particular concern are the training of correctional staff, the availability of qualified mental health professionals (QMHPs), the ability to screen for and accurately diagnosis mental illness, and the pharmacological and psychological services that are received.

A qualitative analysis of the challenges faced by psychiatric mental health nurses working in correctional facilities were conducted by researchers Kucira, et al., in 2019. Challenges were identified regarding the stigma behind mental health in general as well as by others in the correctional facility. The stigma creates a sense of shame among those in need of assistance resulting in many individuals going unserved. Additionally, there is limited resources available regarding time able to be spent with a mentally ill incarcerated individual and the amount of QMHPs. Due to heavy caseloads, it is difficult to provide each mentally ill incarcerated individual with the necessary care when time is limited as well as staffing. Furthermore, there is ongoing conflict between the restrictive formalities of providing mental health care in correctional facilities when the priority is security rather than rehabilitation. This creates a barrier for accessing mentally ill incarcerated individuals, providing a private and safe space, and implementing creative interventions. However, medication management is provided, this is not the end all be all option. Medication management is not as successful alone as it would be in addition to evidence-based interventions.

Due to the barriers within interprofessional relationships and perceptions of roles, collaborative care among QMHPs and correctional staff is strained. Researcher Twitchell, et al., (2021) explored interprofessional collaborative practice for mental health professionals working with justice involved individuals. This study explores the efficacy of a six-day training provided to practitioners based on the Interprofessional Collaborative Practice (ICP) framework and competencies. This was implemented due to many social workers providing in county mental health systems work with clients who are involved within the criminal justice system with criminal behaviors.

The training program began in 2011 when California laws shifted nonviolent offenders from prisons and parole to local community supervision. This was mainly due to overcrowding and the "lethal" prison conditions (Twitchell, et al., 2021). With this shift nonviolent offenders with mental health issues were under the supervision of the county probation department. The use of RNR was highlighted as a validated treatment approach. Due to the shift providers are at risk of producing negative outcomes due to lack of cross-system communication. Although the culture and philosophies and central motivating factors for providers greatly differ between mental health and correctional facilities this program helps to facilitate a culture which encourages sharing of knowledge while maintain respect in the scope of practice.

Not only does the training address communication but it helps to assist with identifying values and ethics for interprofessional practice. This is the first "competency" which is defined as working with individuals across other professions to maintain mutual respect and shared values (p.408). The goal in this situation is to bridge the public safety and behavioral/mental health schools of thought.

The second competency is *roles and responsibilities*, which is defined as the use of self-awareness of the providers role as well as other professions to assess and address the health care needs of their patients with the goal of promoting and advancing the health of vulnerable populations (p.409). The central focus of this competency is to increase understanding and communication among the roles and responsibilities of professions with work with clients and their families.

The third competency is *interprofessional communication*, defied as care coordination and cross communication with the patient, their families, communities, and trends in their health as well as other field to improve responsivity to support a team approach to further promote and maintain preventative care and treatment (p.409). This focuses on effective and respectful communication between professionals, clients, and their systems. Although there are policies regarding confidentiality for mental health and legal history this creates barriers to communication. Additionally, miscommunication can occur to profession specific training and common terminology. The ICP model with RNR helps to identify and define vocabulary for cross-system communication.

The fourth and final competency is *teams and teamwork* defined as applying the values and principles of building relationships among team dynamics to improve efficacy in various team roles to plan, deliver, and evaluate the patient and/or population centered care as well as health programs and policies that emphasize safety, time, efficacy, and equity (p.413). This focuses on working effectively as a team which is essential in collaborative care.

As mentioned in Kolodziejczak, et al., (2018), communication among providers is a major barrier in providing effective treatments for mentally ill incarcerated individuals. Although Twitchell, et al., (2021) explores the connection for outside providers this could be an effective

model to provide for professionals within the correctional facilities to encourage collaborative care.

A quantitative study was conducted in 2015 by researchers MacDonald, et al., defining the needs of the most frequently incarcerated individuals at Rikers Island in New York City. They utilized the Correctional Health Services electronic health record to identify 800 patients admitted in 2013. Of those 800 they analyzed those who have returned since November 2008. Using a randomly selected control group of another 800 incarcerated individuals admitted in 2013 the use of descriptive statistics and cross tabulations though December 2014. It was found that those who are frequently incarcerated had a mean of 21 incarcerations, with an average of 11-day stays, representing 18,713 admissions. Of those individuals most were significantly older (42 vs 35 years old) in addition to having a serious mental illness (19% vs 8.5%). Substance abuse was also noted at 95.9% vs 55.6%. Based on the findings it is evident that frequently incarcerated individuals have a chronic mental illness and substance use problem in addition to criminogenic behaviors. The research suggests and highlights the need for implementation of a tailored supportive housing program to improve outcomes and tend to be less costly.

Data collected from the National Survey on Drug Use and Health from 2008-2014 was analyzed by researcher Ali, et al., in 2018. This data was based on non-incarcerated individuals with mental illness who have had experiences within the criminal justice system. To understand the association, three separate multivariable logistic regression models were used to calculate the odds ratios of: perceiving an unmet mental health need regardless of previous treatment in the prior 12 months, the unmet needs of those who obtained services in the last 12 months, and those who did not. The perceived unmet needs were broken down into six categories: affordability, accessibility, stigma, treatment priority, fear, and other reasons.

The study found that criminal justice involvement is associated with perceived unmet mental health needs among all identified groups. Those who did not receive any treatment in 12 months reported affordability being the highest factor for unmet needs as well as stigma. For those who did obtain treatment the unmet need is related to possible dissatisfaction with adequacy, responsivity, and/or quality of services. A greater understanding is needed, as identified by the researchers regarding the factors mentioned above. The highlighted unmet needs of adequacy and accessibility speak to the provider barriers regarding the conflict faced between professional and agency policies and ethics.

Additional research was conducted to further identify the practices in jails that are struggling to meet the needs of their mentally ill incarcerated individuals. Researchers Comartin, et al., (2021) conducted an exploratory study comparing two types of mental health identification. The two types are identified as staff observation and a standardized screening instrument. According to the data collected individuals identified through staff observation were significantly more likely to receive jail and community-based services even though the only screening tool identified had significantly greater behavioral health risks. During the observation period if an incarcerated individual screens positive for having mental health needs the process consists of referral to, and receipt of services.

Regarding the staff observation assessment, staff are to ask questions about their perceived mental and physical health needs in addition to assessing their behavior. Questions may relate to history of mental illnesses, history of suicidality or attempts/hospitalizations, along with medication management. In addition to the on-site observation, needs can be identified by cationic, erratic, or delusional behaviors noted by jail staff or the transporting law enforcement. The correctional staff is identified as the main staff observers, with consistent trainings on signs

and symptoms of mental illness and suicidality as well as crisis intervention skills are essential and effective. However, the concern becomes if the correctional officers are considered QMHPs whom would be best in assessing, screening, and diagnosing mental illness symptomology.

Although legally it is required of government agencies to have a process for identifying mental health needs, it is up to the individual jail to establish the questions to meet this threshold. In this study out of the 80 jails a majority reported a process but not jail reported use of a validated screening instrument (p.9). In replacement they created their own questions which range from history of treatment for any medical condition, medication management, and hospitalizations. Although, without the training of correctional staff or clinical professionals the likelihood of missing mental health needs increase. It is suggested that there is a need for a standardized and validated screening instrument be utilized.

The two identified screening tools when used are provided within 72 hours of admission. The two screenings are Brief Jail Mental Health Screen (BJMHS) and Kessler-6 (K6). The BJMHS consists of 11 items on a questionnaire to measure symptoms associated with three major and persistent mental illnesses (schizophrenia, bipolar disorder, and major depressive disorders) (p.9). This is a practical tool for jails to utilize due to taking 2.5 minutes to complete roughly. A positive score helps to differentiate among the three identified disorders at time of booking and 6 months prior. The K6 consists of 6 questions that measure non-specific psychological distress occurring within the last 30 days. The screen consists of a 5-category scare from “none at this time” to “all of the time”. This can detect historical diagnoses of SMI and functional impairments. This tool has been used to screen for SMI in the criminal and legal systems in addition to being valued by gender in jail settings.

Once the SMI is identified a referral should be made to a qualified mental health professional for further assessment and interventions. The goal of treatment by these professionals is to provide psychoeducation and access to medication management. Due to this study taking place in jails the stay for the mentally ill incarcerated individuals is sorter with little to no notification for discharge. Due to this structure, there is an emphasis on crisis intervention and suicide prevention. However, those with longer term stays it is recommended by the researchers that the jails provide more extensive treatment. This is identified as verbal therapies, skill building, discharge planning, court assistance, and post-booking diversion efforts.

Although it is recommended by the APA (2016), that the identification process be completed by trained professionals in mental health, due to the lack of appropriate mental health providers and trainings to correctional staff there is an increased need for use of screening instruments. The use of instruments can complement the lack of clinically trained staff. The staff training on addition to the screening instrument is recommended for identification and a smoother transition back to the community. Those who are identified with a SMI by staff observation were more likely to receive and obtain necessary services than those who do only use the standardized screening tools. This implies the need for system level changes by implementing evidence-based practice, reassessing funding for QMHPs, and appropriate communication among interprofessional.

Program Evaluations

This section further illustrates programs that have been implemented in correctional facilities throughout the United States of America. The systematic literature review resulted in eleven studies describing the efficacy of the interventions as an attempt to engage and link

successful and unsuccessful implementation of evidence-based mental health practice interventions.

A phenomenological and grounded qualitative analysis was conducted to further understand the narratives of mentally ill incarcerated individuals. Researcher Jacobs, et al., (2017), conducted a qualitative analysis utilizing in-depth interviewing of mentally ill incarcerated individuals. The sample was collected through purposeful sampling with the following inclusion criteria; diagnosed mental illness and at least two experiences of jail detainment. They conducted their research at social service organization in a West coast city. The organization provides services to individuals who are justice-involved with mental illnesses. The data was collected via interviews with participants and memos for the authors own discretion.

The premise of the interviews consisted of obtaining narratives of incarcerated individuals experiences with services for mental health offered in jail, including the benefits and limitations to the service offered. In discussing the cultural and structural context of jails emphasizing the characteristics of the facilities and environment which the incarcerated individuals are held. The prison structure is complex with routines and isolation leading to a culture that accentuates “disciple, hierarchy, social stratification, and toxic masculinity” (p. 265). The role of a correctional officer also plays a large part in the culture within the facility. Correctional officers have been described as cynics, suspicious, group solidarity, and filled with hyper-masculinity that intensifies to the largely experiences hostility taking place. If this is the perception among mentally ill incarcerated individuals of the most frequently seen correctional staff, this enables the stigma behind mental health and weakness.

Due to these experiences’ mentally ill incarcerated individuals tend to spend more time within jail than a person without a mental illness. Several factors impact the frequency of

mentally ill offenders versus another offender. The adjustment period can become confusing for individuals attempting to adapt to the new structure and culture they are forced to live in. The confusion leads to feelings of frustration, isolation, vulnerability, and stress. These feelings cause mentally ill incarcerated individuals to struggle to follow the procedures and handle stressful social interactions with other incarcerated individuals. Mentally ill incarcerated individuals are also at higher risk of receiving infractions, solitary confinement, self-injurious behaviors, and both physical and sexual assault (Jacobs & Giordano, 2017).

In conclusion of the study, it was found that the narratives provided by the mentally ill incarcerated individuals contradicted the title “new mental hospitals”. It was concluded that the needs of these mentally ill incarcerated individuals are both not being met and are not continuous forms of treatment.

The transitional period from prison to the community is just as important and difficult for mentally ill incarcerated individuals as the initial transition. Hopkin et al., (2018) conducted a systematic review of the importance of resources and services during the transition from prison to community for incarcerated individuals with mental illnesses. This study assesses the importance of this period of transition due to the heightened stress on the individual and their families upon release. Due to the rate of incarcerated individuals with mental health issues and the high rates of recidivism this period it is essential for a smooth transition from prison to community.

There is evidence that interventions during the transitional period provided a reduction in recidivism and reoffending amongst the mentally ill incarcerated individuals. However, these minimal improvements were not statistically significant. It is unclear if the interventions provided upon release may cause the individual to feel overly supervised, providing a similar

feeling to being incarcerated. Although, this study assesses the transitional period out of prison back to society, the level of stress and lack of successful reintegration speaks volumes to what could be different if these supports were provided throughout their stay. If one of the main stressors is the individual's confidence with transitioning this could be strengthen with the development of healthy coping skills and more prosocial behavioral interventions.

The risks associated with reincarceration, and mental illness was analysis by researchers Barrenger, et. al., (2017). A qualitative analysis was conducted using Constructivist Grounded Theory. A randomized control testing of the effectiveness of the Critical Time Intervention for this population made it possible for the researchers to determine if this form of re-entry is reliable and valid. These participants engaged in open and closed ended interviewing to allude to a possible pattern amongst cases.

This research is part of a larger study aiming to assess the effectiveness of Critical Time Intervention for men with mental illness transitioning to the community. This population of individuals incarcerated then released with mental illnesses have an increased risk of death due to heart disease, homicide, suicide, and substance abuse overdose within the first two weeks of release. This speaks to the need for substance dependency interventions, coping skills to address emotional dysregulation, and connections to the appropriate mental and physical health providers upon release and prior to release. The background material provided emphasizes the need for comprehensive understanding of risk factors that lead to reincarceration.

Researchers attained their goal of determining the production of risk factors among men with mental illness leaving prison. However, the researchers suggest further research is necessary to formulate a direct correlation to reincarceration and identifying while implementing re-entry interventions to improve the individual's likelihood of success.

Due to the limited amount of QMHPs in correctional facilities peer specialists with mental health and incarceration experiences have been sought as an option for providing support. Barrenger, et al., (2020), assessed the impact of peer specialists with mental health and incarceration experiences. One key component identified for successful reintegration is the importance of engaging in work and many of these individuals become peer specialists. With this factor being identified it can allude to the need for vocational and professional interventions necessary as well as skills for conflict resolution and empathy within the helping field. These skills can and should be developed prior to release. This study utilized a phenomenological approach to investigate the recovery pathways for peer specialists with incarceration histories. The findings show that with a recovery-oriented approach there was an increase in hope, feelings of connectivity, identity, meaningfulness, and empowerment were significant. These positive feelings provided an increase in prosocial behaviors, recovery, and activation of lifestyle changes to reduce rates of recidivism.

A program for Accelerating Clinical Effectiveness (PACS) was developed under the New York City jail system. The goal was to achieve and maintain clinical stability for mentally ill offenders. The PACE units are therapeutic environments, staffed by multidisciplinary mental health teams and supported by specially trained correctional staff. Services included daily therapeutic groups, incentives-based unit activities, individual therapy, medication management, and comprehensive social work/ re-entry services. Ford, et al., (2020) assessed the clinical outcomes of the Program for Accelerating Clinical Effectiveness (PACE). This retrospective, observational cohort study included 302 adult males incarcerated more than 14 days with diagnoses of serious mental illness, typically schizophrenia spectrum and other psychotic disorders (81%), most (68%) with a violent felony as their most severe charge, matched with

patients of similar characteristics (control group) by using propensity score matching. The findings of this study suggest with the PACE program there was an increase in improvements related to psychiatric medication compliance and decrease in injuries due to violence. Additionally, the changes implemented created a notable culture shift within correctional facilities related to mental health services. According to this study, the implementation of this program was successful in improving compliance and increase in prosocial behaviors. As mentioned prior, the violations experienced by mentally ill offenders are due to difficulties adjusting to their new environment which with the use of evidence-based interventions can become smoother than without.

As mentioned prior the PACE program was successful for incarcerated individuals with serious mental illness. An additional study was conducted by researchers Cullen et al., (2012), utilizing a multisite randomized trail assessing the efficacy of a cognitive skills intervention for men with serious mental illness. The participants were specifically noted as violent with antisocial behavioral outcomes. The sample consisted of eighty-four male mentally ill incarcerated individuals with a psychotic disorder and a history of violence. These participants were recruited from medium secure forensic hospitals. Participants were randomized to receive the Reasoning and Rehabilitation (R&R) program, consisting of 36 two-hour sessions in comparison to treatment as usual (TAU). Incidents of violence and antisocial behavior were identified as verbal aggression, substance use, and leave violations. All of which were assessed during treatment and at 12-months posttreatment.

Relative to the TAU group, incident rates of verbal aggression and leave violations during the treatment period were significantly lower in the R&R group; the effect on verbal aggression was maintained at 12-months posttreatment. Half of those randomized to receive R&R did not

complete treatment. Post hoc analyses were therefore conducted to compare treatment responses in program completers and noncompliers. It was found that incidents of violence, verbal aggression, and leave violations during treatment were significantly lower in program completers. Additionally, there were significant effects based on program completion in relation to verbal aggression and substance use at 12-months posttreatment. It was shown that R & R lead to a significant reduction in incidents of antisocial behavior within this population in addition to a greater impact on those who completed the treatment. This study continues to highlight the efficacy associated with cognitive skill development and prosocial behaviors.

New York City worked to implement an additional novel mental health program called Beyond the Bridge. This program was designed to provide residential based cognitive behavioral therapy in the mental observation units in jail. Glowa-Kollisch, et al., (2014), completed a program evaluation. The researchers utilized propensity score matching and a dose–response analysis. There were significant reductions in all outcomes when they compared program participants with an earlier cohort of patients residing on the mental observation unit before programming began. However, when they compared program participants with a cohort of other patients residing on the units at the same time but who chose not to participate only time spent on suicide watch unit and recidivism were significantly reduced. This continues to highlight the importance of evidence-based interventions having a successful role in increasing prosocial behaviors and improving antisocial behaviors with the goal of reducing recidivism.

The ARRAY program for offenders with mental illness who are incarcerated was analyzed between a university counselor education program and the mental health unit (MHU) in a regional prison located in the midsouth region of the United States. Cox, et al., (2015) conducted a piolet evaluation of the ARRAY program for offenders with mental illness who are

incarcerated. The MHU at this prison is composed of one building with four dormitories and several utility and multipurpose rooms in the center. The four dormitories are each capable of housing 30 incarcerated individuals under the supervision of trained security staff. Unlike other sections of the facility, MHU staff do not rotate between buildings, which allows them to build awareness of incarcerated individuals symptoms and reduces conflict as staff and incarcerated individuals adjust to each other. This also helps to facilitate rapport between the provider and the mentally ill incarcerated individuals, which will increase compliance, accessibility, crisis interventions, and more consistent care.

The programming in the MHU includes community groups, access to medical and psychiatric care, and specialty treatment programs. The specialty treatment programs (e.g., sex offender treatment, substance abuse programs) may be open to all incarcerated individuals and do not target the unique problem clusters of OMI.

With the use of 3 participants reporting improvement in self-reported psychiatric symptoms, however, those with psychotic features found minimal efficacy with this program. It was found that with the completion rate of 38%, it is likely that future studies involving more participants may safeguard against attrition resulting from self-selection out of the program, transfer from the building for disciplinary reasons, and discharge. A greater participant sample would also allow for randomization into ARRAY, alternative treatment, and waitlist conditions, allowing for more robust findings.

San Quentin Prison in California holds a therapeutic program in which the goal is to find the connection between ecological factors, ethics, and personal transformation through engagement in gardening and environmental literacy. Benham (2014) assessed the utility and significance of the connection between ecological factors and rehabilitative benefits. Data was

collected primarily through the field assessing men who are incarcerated who have a focus on the Insight Garden Program. Additionally, a mixed methods approach was used which included open-ended qualitative interviews and three multiple choice questions measuring self-agency. Two control groups were utilized from the same housing unit. This included incarcerated individuals who participated in other programs except gardening and those who do not engage in programming.

The results of this program found participates described it as a positive contribution to their personal transformation. Additionally, the strong emphasis on ecological growth offers vocational, intellectual, emotional, and spiritual growth, which results in a lower rate of recidivism. The use of ecological connection has shown to provide a bi-directional healing process providing an acute recovery to be made in both directions. This program has been adapted and introduced into eleven prisons in California serving men, women, and youth. Additionally, the IGP is programming in two facilities in Indiana and one in Ohio. Similarly, New York attempted to introduce a similar program within Rikers Island. In 1997 the Horticultural Society of New York introduced The Green House (The HORT, 2022). The Green House is encompassed by horticultural therapists as well as trained instructors serving over 500 incarcerated individuals. These individuals are taught offenders how to relate to their lives, improve critical thinking skills, and improve collaborative teamwork. The program seeks to reduce recidivism rates by 40%. Additional facilities within New York State have attempted to introduce therapeutic horticultural initiatives.

A qualitative analysis regarding how an individual can cope with reentry was conducted by Phillips, (2008) utilizing a phenomenological framework. Two themes were identified: the barriers faced during re-entry and the coping skill utilized by those individuals. Participants were

collected through the Philadelphia Prison System including 20 male incarcerated individuals. These individuals have either pled guilty or have been found guilty of a crime, resulting in at least one incarceration, in addition to no current open cases. The data was collected through interviews. The themes were put in a list a statement used to describe the participant's experience.

The findings suggest the most common barriers found in this research consisted of substance cravings, employment and finances, housing, emotional pain, and family difficulties. The most predominant coping skill used was avoidance. It is reported the participants initially felt optimistic regarding their release but expressed feelings of substance cravings, practical barriers, and/or feeling overwhelmed. Ultimately the avoidance resulted in recidivism.

This research sought to assess the use of coping skills in retrospect to being released. With this being noted, it provides an opening for future research to assess both successful and unsuccessful re-entry and role coping skill development plays in success. This also helps to provide insight into the need for evidence-based practice and skill development while incarcerated to prepare for re-entry to the community.

Limited studies have focused on in-depth experiences of women in correctional facilities. Dalley (2014), assessed the impact on female offenders from asylums to jails. The research provides an in-depth examination of women's mental illnesses and etiology. It also provides a critical analysis of risk factors and assessment tools that jail staff and administrators may use to help identify mentally ill female incarcerated individuals. The article concludes with a discussion of post release issues and programs.

The situation confronted by many mentally ill persons today is remarkably like the situation that they were experiencing in 1850 when Dorothea Dix decried the inhumane

treatment of housing these people in jails. As Immarigeon (2011) suggested, ‘‘Psychiatric beds are disappearing, and jails are growing’’ (p. 1). It is clear, however, that other more appropriate methods would provide cost-effective and humane treatment that would also reduce recidivism and increase the likelihood of creating productive citizens. Dalley (2014) suggests based on the findings, the impact of proactive interventions such as diversion programs, jail programing initiatives, cultivate a continuum of care comprehensive system, increase the role of Medicaid funding for offenders, demand external oversight of jail treatment programs, require the transfer of cost savings to local or state entities. These factors play a large role in recidivism and efficacy in providing care to mentally ill offenders.

An additional evidence-based intervention is Mindfulness-Based Interventions. Researchers Per, et al., (2020) conducted a meta-analysis evaluating the efficacy of mindfulness-based interventions for incarcerated populations. This meta-analysis of 22 studies (N = 2,265, 75% male) quantified the effectiveness of MBIs in incarcerated populations on key psychological outcomes and criminogenic needs.

From pre–post studies indicated MBIs had a small to moderate effect on all outcomes, but this was not supported by controlled studies. Studies with older participants, more females, and longer treatment length demonstrated slightly greater effects. Results from pre–post analyses demonstrated significant reductions in psychological outcomes (depression, anxiety, and stress) and criminogenic needs (impulsivity, self-dysregulation, anger, substance use behavior, and attitude). Although all the included studies used mindfulness as the main intervention component, there was significant diversity among the treatment protocols. Although some used standardized treatments, other studies used a modified version of existing standardized treatments that varied in terms of protocol and treatment length. However, it was suggested that

MBI can be an effective intervention to incorporate development of prosocial behaviors and decreasing the urge to act on criminogenic needs.

A systematic review of psychological therapies for prisoners with mental health problems were assessed by researchers Yoon, et al., (2017). The researchers included the following inclusion criteria: piolet studies and cluster randomized trials, however nonrandomized trials and case studies were excluded. The participants consisted of prisoners ranging from juveniles, remand, and detainees. Individuals who were released into the community, hospitalized, or in therapeutic environments were excluded. The following interventions were included: cognitive behavioral therapy, dialectical behavioral therapy, mindfulness-based therapy, and other group treatments. Studies including only medication management were excluded. It was found that within the 37 studies psychological studies showed a medium effect size with high levels of heterogeneity associated with CBT and Mindfulness-based therapies. This speaks to the volume of data regarding CBT and MBI and their benefits for addressing the needs of mentally ill offenders. Although, this still highlights the lack of implementation regardless of the information accessible.

Furthermore, Rotter, et al., (2011) sought to assess recidivism with evidence-based practice models for mentally ill offenders. Although some clinical needs may be met it is unclear that these interventions such as Assertive Community Treatment will address criminal recidivism. This research focused on the structured clinical interventions from the criminal justice system and psychiatric literature.

Cognitive Behavioral Therapy (CBT) is an accepted and validated evidence-based intervention for working to alleviate distressing feelings, disturbance in behaviors, and dysfunctional thought processes (Rotter, 2011). Although it is proven to be successful, its

original purpose was intra-personal with the goal of improving feelings and function. The recidivism related antisocial cognitions and maladaptive emotional reactions are interpersonal and may not be categorized as distressing. With, recidivism focused CBT interventions require more than a central focus on “feeling better”, the focus needs to shift towards interpersonal skills and acceptance towards community standards for appropriate behaviors. This alludes to the ability of incorporating criminogenic risk, needs, and responsivity. Typically, these are seen through problem solving skills within the program Thinking for a Change, Moral Recognition Therapy (MRT), Lifestyle Change, Options, and Reasoning and Rehabilitation (R and R).

Thinking for a Change as well as Lifestyle Change work with problem solving skills in a structured, self-reflective analysis of choices and consequences. This focuses on thinking styles that tend to support criminogenic needs. MRT works towards improving moral reasoning as well as R and R which targets cognitive processing associated with pro-criminal thought processes. The findings suggest with the use of a recidivism-based CBT framework is applicable to justice involved mentally ill offenders.

In the later study, Rotter, et al., (2013), assessed the factors for reducing recidivism with CBT using a Risk Needs Responsivity theoretical framework. Rotter, et al., (2013) identify that treatment interventions should avoid grouping individuals based solely on their offense rather to consider the intervention they would need to reduce criminal recidivism. These consist of antisocial behavior, personality, and cognitions as well as their antisocial associates. Additionally, family support, leisure activities, education/employment, and substance abuse should be considered. With the use of CBT to address distressing feelings, behaviors, and dysfunctional thoughts, recidivism centered CBT would be beneficial. As mentioned in the article (2011) several other programs have been implemented such as Thinking for a Change,

MRC, Interactive Journaling, R and R, and Options. Although all these programs have been noted as statistically significant for reducing criminal recidivism in non-mentally ill populations, minimal research has been related to those with mental illness. It is found that that these practices including RNR-based recidivism focused assessments and clinically sensitive community case management would be effective in reducing recidivism and improving quality of life outside of the correctional institutions.

Methods

Research Design and Setting

Although evidence-based interventions are vastly studied, the is limited research on the rationale behind the limited implementation of evidence-based mental health practices for mentally ill offenders while incarcerated. There is also a vast amount of information regarding the re-entry process and factors in decreasing rates of recidivism. While we correlate certain policies, theories, and interventions that are deemed effective, we cannot explore or develop a relevant understanding without diving deeper into the barriers providers, policymakers, and mentally ill offenders face while attempting to obtain appropriate treatment interventions.

Data that has been collected around this information is presented through systematic literature reviews, narratives of released incarcerated individuals, and clinical providers. While there is limited information on the experiences of the correctional officers supervising mentally ill offenders, in addition to ways of addressing the barriers identified in previous research. This research intends to re-shape how the social work profession, policy makers, and correctional staff can better facilitate evidence-based practice interventions for mentally ill offenders while incarcerated.

Creswell & Poth (2018) suggest qualitative researchers embrace the concept of diverse realities founded within the participants experiences within the study. This is an inductive and emerging methodology which allows for flexibility regarding the interpretation of findings. Additionally, qualitative research tends to be context dependent. This allows for a greater area of coverage, such as socially, politically, and historical factors that impact the increasing number of mentally ill offenders held in correction facilities (Creswell & Poth, 2018). This aligns with Penrose's Law/Transinstitutionalization and seeks to understand the impact of increasing mentally ill offenders held in inappropriate environments in addition to RNR and GLM which seek to address the risk, needs, responsivity of offenders and emphasizing their strengths to replace antisocial behavior with prosocial behavior. This alludes to skill development to healthily cope with distressing internal and external factors.

Data and Subjects

This research has utilized snowball sampling. Snowball sampling has been utilized until saturation has been met. According to Creswell and Poth (2018), saturation takes place when the researcher is analyzing the data and creating categories, during this time the categories are assessed for level of support and if the researcher no longer needs additional information to support the identified category (p.318). It is also suggested a minimum of 20 participants are used in Grounded Theory, there for this study sampled until saturation is met utilizing a saturated sample.

Inclusionary rather than exclusionary criteria are chosen because it helps the researcher to be explicit with their sample and allows for diversity. While the sample is focused on the barriers related to mentally ill incarcerated individuals receiving evidence-based practice services while incarcerated, it allowed for diversity while interviewing previously employed correctional

officers on their experiences and interactions with this population. The sample consisted of previously employed correctional officers who have been assigned to work or have worked with mentally ill offenders within private and state prisons, emphasizing their perceived needs, accessibility to their needs, and factors that could improve their general well-being.

Correctional officers are included in this study due to the limitations associated with interviewing currently and formerly incarcerated mentally ill offenders. They can speak to their experiences regarding level of training, collaborative care, accessibility, risks, needs, and current responsivity provided within the facilities. The correctional officers have worked in either California State and/or New York State private and/or state-run prisons.

When the sample has reached saturation, the researcher may begin to use *discriminant sampling*. This step is not necessary however utilizing Creswell and Pith (2018) grounded theory methods, it is recommended discriminant sampling be utilized to meet saturation. This also helps to provide evidence and support to the emerging factors of the study (Creswell & Poth, 2018). Constant comparison is suggested to be utilized throughout the data analysis in comparing patterns and attempts in aiding the researcher to further understand the events.

The sample has been recruited using networking systems such as LinkedIn, Social Media Platforms, flyers posted at community programs/groups for correctional employees, The California State Department of Corrections and Rehabilitation (assuming the application is approved if not then this population has been recruited through the same networking systems), as well as through word of mouth (snowball sampling). A preliminary questionary was sent via Qualtrics to assure inclusionary criteria are met. Inclusionary criteria include those previously working in NYS and/or California State private and/or state-run correctional facilities and have

experience with mentally ill offenders within the last 4 years. Exclusionary criteria included those who have no experience with mentally ill offenders.

Procedures

Data collection was conducted in two parts: a demographic questionnaire (Appendix A) and an interview (Appendix B). The interview was offered through video technology via Zoom and consist of a 60-minute recorded interview. The participant and researcher coordinated a date, time, and circumstance for the interview to take place. The first contact was via email response to the potential participant, thanking them for their interest in addition to the Consent Form as well as the resource sheet. The email included the link to the Qualtrics questionnaire. After clicking on the link, the participant consented to participate prior to completion of the survey as outlined within the consent form. If the participants meet the inclusion criteria, they were contacted via telephone or email to schedule an interview time and method. The researcher applied to CDCR to access currently employed correctional officers, however, was unsuccessful. Due to NYSDOCCS not taking on new research due to COVID-19 restrictions and limited resources the population has shifted to previously employed correctional officers. The application for CA is still pending however, to provide additional accessibility researcher extended the population to previously employed correctional officers in CA. Once approved by WIRB researcher outreached to potential participants in both NYS and CA (Appendix C).

Each interview via Zoom was recorded, the participants may choose if they would like to have their camera turned on or off, however the researcher had her camera on. The zoom audio recordings were transcribed using *Transcribe by Wrealy*, an AI transcription service. All interview recordings are stored on the researcher's laptop with a password protected file, a backup file was kept on a password protected google drive which is affiliated with the

researchers University. All data that has been collected will be kept for three years. To assure confidentiality and a safe space, the researcher conducted all interviews in a private space (home office space or University empty space). The participant was able to choose the location which best suits their needs.

If at any point a participant is no longer comfortable or becomes upset by the interview questions or content, they may choose to withdrawal at any time, and their data and information will be destroyed at their request. The researcher offered a resource sheet to all participants to support them in their discomfort or distress.

Measurement

There are two main measurements within this study, the first is a demographic questionnaire sent via email through a Qualtrics links. The demographic measurement (Appendix A) asked if the individual consents to participation within this study as well as demographic information: age, race, gender, years of experience in corrections, and years of experience with mentally ill offenders, which is shown in a table (Appendix E). Inclusionary criteria for the study consisted of the following: correctional officers who previously worked in either New York or California, who have experience working with mentally ill offenders. Exclusionary criteria included those who have no experience with mentally ill offenders.

The second measurement instrument is the interview guide, which contains twelve questions that were used during the 60-minute interview. The data was collected and coded from these questions. This served to address the overall research question and discover a deeper understanding of: *"What factors are impeding the implementation of evidence-based practice for incarcerated mentally ill offenders?"*

Data Analysis

The data analysis methods mirrored Strauss and Corbin's Grounded Theory, which means the data analysis occurred alongside with data collection. This collaborative process can provide for more relevant or irrelevant concepts to be immediately identified and addressed (Corbin & Strauss, 1990). In grounded theory, the concepts are units of analysis, what arises from the data illustrates the action, event, or incident was utilized as the data unit. All concepts developed must be related and can be utilized later in the research to assist in investigating *what, how, before* and *after* each concept (Corbin & Strauss, 1990). The analysis also utilized constant comparison to help prevent researcher bias due to each concept being challenged and viewed with new data upon each new interview. The data analysis also included open, axial, and selective coding. This assisted in narrowing the data into core concepts or 'themes' that ultimately informed the factors and themes derived.

An additional essential component of the grounded theory data analysis is documenting ('memo-ing'). This is when the research takes note of the constant changes and re-grouping of categories and codes through the method of constant comparison. Throughout the coding process, memos were utilized to track the evolving factors as well as patterns. These patterns consist of changes in complexity, clarity, saturation, and accuracy (Creswell & Poth, 2018). A codebook was also utilized to further assist in ensuring rigor and usage of codes. Memos in this usage are not just the researchers' ideas, they aided in formulating a deeper understanding of the data collected. This begins with the first coding session and continues throughout the research process. This also included writing the results and employed to support the discussion of findings (Corbin & Strauss. 1990).

If the researcher and the researchers char/committee believe that the data collected is not saturated and needs additional supporting data, the researcher conducted a second round of interviews. This was done using *discriminant sampling* to create a second data set, sought to support the emerging themes. The codebook in addition to the themes emerged from the data as evidence is collected and analysis progresses. The researcher engaged in active memo writing and reflexivity to ensure all themes and theories that emerge are unbiased and based alone on the data provided by the participants. Demographic information on each participant and future participants from a discriminant sample was presented in a chart within the appendices to allow for transparency of the sample participants sample details.

To demonstrate rigor and reliability, several methods are described in this subsection to enhance this study. There have been on going arguments regarding validation within qualitative research has been working to establish a universal understanding and systematic procedure to identify and prove validation (Creswell & Poth, 2018). Authenticity was established by identifying the following methods in the proposed study: reflexivity, clarifying researcher bias, and generating a rich, thick, description. Reflexivity involves the researcher disclosing their understanding of any biases, values, and experiences with the subject of the study and population to create transparency and provide insight into their perspectives and ideas (Creswell & Poth, 2018). The researcher shares some level of identification with the population being studied, bracketing was used as a best reflective practice to reduce bias. With the understanding that the researcher has experience within their personal life with formally mentally ill and formally incarcerated individuals, it is essential to reflect on the subjective interpretation of the data being collected.

The researchers experience with this population is minimal, this may create a power dynamic among those she may interview. Within this power dynamic, all questions and ideas that may arise from participants that the researcher openly answered while limiting sharing of personal information that could skew the data collected. Participants were encouraged to wait until the end of the interview to engage in questions and voicing of concerns with the research, at that point they were given the opportunity to withdrawal from the study. The researcher also acknowledges that strong feelings and reactions to opinions she hears may be triggering. Themes related to social justice and equity within the interview may illicit challenging and informative conversations during the interviews. The researcher intends to only amplify the voice of the participants and the experiences voiced by them regarding the vulnerable population of the mentally ill incarcerated individuals. Additional questions and clarification from the participants were used to obtain the most understanding of the data as possible. This form of validation criteria is a detail account of the evidence for or against the formulated themes and factors. This provided by inclusion of details on the environment, atmosphere, physical descriptions, movement descriptions, and activity descriptions (Creswell & Poth, 2018). The readers will understand from the beginning through to the end within the data the *how* and the *why* based on the thick data description and evidence provided.

To address reliability coding systems Atlas.ti and employing higher-quality electrics to record and transcribe data was utilized (Creswell & Poth, 2018). The researcher proposes using peer debriefing and auditing methods as fit within the rigor and structure provided by Strauss & Corbin's (1990) grounded theory and data analysis methodology.

Results

Participant Characteristics

The study participants were interviewed from January through May 2023. A total of six (n=6) study participants met the study criteria and agreed to participant in the study. Open, axial, and selective coding were used to analyze using Atlas.ti. Most participants were male (83.33%), White (83.33%), and have an average of 13.3 years' experience.

Themes

The results below are organized by the participants perspective collected during the study which will discuss three major themes emerged: (1) care coordination, (2) participation, and (3) knowledge of the program.

Theme 1: Care Coordination

Care coordination and communication are essential in being able to treat, keep safe, and manage the overall well-being of an individual that you are responsible for. Correctional officers are the main staff that incarcerated individuals are under the care of, however given that the needs of mentally ill offenders differ from the general population the participants in this study discussed their experiences with coordinating care and the process of working together with mental health providers:

> Participant 4: *"I feel our screening process is excellent. And it's over and above. So even if an inmate, we feel a little antsy about something. Well make them a mental health inmate and have him watched more carefully. Because it happens a lot of times where you go through the interview and it will be found but when they get to the floor, the new admit floor, and then they hang themselves. You know, it happens, and there's nothing you*

> *can do, because if someone wants to hurt themselves, they've got to do it. I think all our track records department anyways, in screening and take care of the mental for those inmates. I think it's very good. In the news you'll hear deaths constantly, especially in my place with drugs, drug overdoses and guys that come in because they smuggle it in. You can only do so much when they first come in, and they get it, they take it, and they die. But as far as hang-ups and hurting themselves, those I think we're very good especially since 1999 when an inmate died and went to DOJ had stepped in and come to our facility. After that I think the trainings has gotten so much better, the old school mentality of what it used to be. It was hard for me because I came in on the old school mentality but with the new training and it was a wakeup call."*

Participant 5 perceived coordinating care for mental health a little differently than the expected treatment interviews and working with providers. Participant 5 discussed viewing other amenities as factors that improve care coordination as well as the downside to not being able to have a certain role that could make a significant call:

> *"If you have to be in court on a Thursday, on Wednesday you have the right to a haircut. I know it sounds something silly, but you have a right to that. So, from what I saw someone said I have a problem you know sometimes you call the captain immediately and from there on they would sometimes take them out of the house to the unit right away. They felt like it was a dangerous scenario I mean I was only an officer; I didn't have the autonomy to make those calls. I could make a call to the captain but then they would take the next steps on."*

Theme 2: Participation

As seen in the literature review there have been several programs developed and implemented within various correctional facilities throughout The Unites States. Although, none of the participants were able to identify a specific program that is available to mentally ill incarcerated individuals they were able to speak to the details of what is available to them.

> Participant 2: *"There is group which is a lot of collaboratives, unfortunately, a lot of the psychiatric classes' inmates are supposed to engage in they take their medication, and the other issues are when they pile up their medication or they don't take it. They have to be supervised if they had a scoop of ice while they administrated the medication it causes issues. They act on their own and that's where the problems lie. So usually when they are in transit or coming in from the street, we don't know how long or what medication they need to get you know settled, and that's the most dangerous part of dealing with that type of inmate. But for the most part once they're managed and they get a little bit, but everybody wants to be free as possible under the circumstances. So, they more they comply with their doctors and us the happier they are to feel, and it starts all over again. If they have a bad court case or if they have an issue with someone on the unit it starts all over again."*
>
> Participant 4: *"They call them down even if they don't want to go."*

When asked to speak a little further on treatment modalities participant 2 did not work within the mental observation unit but worked closed with them and finds:

> *"I do notice that they do get checked in on more often by psychology staff. They are also managed through security staff. We all respect the fact that they have*

> *those types of issues. Unfortunately, other inmates don't respect that so they kind of mock and try to push them. The pushed individuals over the edge and yeah it gets a little crazy at that point when you try to calm somebody down that's been triggered by somebody else that's doing it on purpose, unfair but unfortunately that's the environment."*

When asked to speak on the specific policies or protocol that takes place when de-escalation is needed participant 2 found:

> *"If you're in the unit or any area that has multiple issues it makes the same issues, I would try to separate them and help a lot of times it works and sometimes it's just everybody gets aggravated over circumstances and just we all also have for whatever reasons. So, they have their reasons but yeah protocol works. The system in place I think. We learn every day. So, all the days that we put into the system we have enough knowledge to try and help as best we can and everybody's different or unique individual."*

Theme 3: Knowledge of Programs

Although there is an emphasis on medication management and check ins there is also a barrier associated with the frequency that mental health staff are available. Given that staffing shortages have been acknowledged the hours in which mental health staff are available plays a large role in knowledge of programs and accessibility to them.

> Participant 2: *"Psych used to be 24 hours but not anymore. It was like extended hours; you have an early shift and a later shift. And they went home when they locked in around 10:30pm or 11:00pm. There's always a*

> *duty psychologist on call. Duty physician or PA so there's always a medical staff on board. There's always a nurse on board, then it depends on the situation. They're running around and were all trained to a degree, you know, CPR and but if there's any psychological issues I think they come in at 5:30am or 6:00am until about 11:00pm at night every day."*
>
> Participant 4: *"There's therapy involved, they see social workers and mental health professionals if they sign up for it. They get called down even if they don't want to go and know kind of especially close back then, but things changed now but especially close to discharge time. The social workers will want you and have a plan for them."*

When asked about which providers are typically sought out for assistance in times of emotional distress it was found that mainly just the officers are sought out and work towards adjusting to meet the mentally ill incarcerated individuals where they are at emotionally:

> Participant 4: *"...when you just know life if you know them for a while, whatever you everybody you know you see these people all the time so you get to have some sort of rapport with them and you start talking to them and something seems off you know as the officer you become the social worker, become the priest, you become the counselor so you're doing it and wearing different hats. That used to happen not too often but there is now the screening process when you come in first which helps."*

Many participants discussed their own lack of knowledge behind what programs are available to the mentally ill incarcerated individuals which if they are the main providers they have contact with it can be challenging to make a referral if you're unsure where to refer.

Additionally with the stigma behind mental health treatment when incarcerated individuals are called out they will defer due to fear or shame. This tells us that individuals are trying to figure out how to help themselves by at least talking to the officers they see more frequently however coping skills and evidence-based mental health practices need to be incorporated through either educating the correctional officers on CBT or to educate them further on what's available to the incarcerated individuals.

Discussion

This study has highlighted the provider barriers towards implementing evidence-based mental health interventions for currently incarcerated mentally ill individuals. The significant themes include care coordination, participation, and knowledge of the program. The findings have highlighted gaps in understanding barriers within accessibility, consistency, and knowledge in reference to services available to mentally ill incarcerated individuals. The participants within this study (formerly employed correctional officers) presents an opportunity for behavioral health providers and correctional officers to engage individuals who have mental health diagnoses while incarcerated. Increasing the knowledge of mental health crisis signs, services offered, providers names/departments, and support for providers is essential to tailor and implement interventions for this population further.

Theme 1: Care Coordination

The first theme to emerge from the data collected identified that many of the participants in the study feel care coordination across departments could be improved. Many participants mentioned that they are aware of the mental health department but do not have a relationship with the providers, resulting in lack of knowledge regarding the risk and needs of the incarcerated individual they are responsible for overseeing. Additionally, a similar finding

highlighted that due to security being the top priority there is always a correctional officer present during sessions with mental health providers resulting in difficulties maintaining confidentiality. However, this is a double edge sword due to valuing confidentiality the officers are unaware of the needs of certain offenders while infringing on confidentiality could further prevent incarcerated individuals from feeling comfortable with their mental health provider. This makes it very challenging for mental health providers to be willing to work in the environment due to the agencies policies conflicting with the professional and personal values the provider holds.

Additionally, it is the responsibility of the correctional officer ending their shift to debrief the replacement, this is a positive policy as it is essential for all the officers to be aware of any difficulties they may be walking into. Although, the process for an officer to seek out a mental health provider on behalf of an incarcerated individual becomes challenging, as it is the incarcerated individual's responsibility to request services on a form, it is unclear if the officer can complete it as a referral without the consent of the incarcerated individual. The process for having someone evaluated after the process of intake has barriers especially regarding timing, given they have 72 hours to respond to the request. There is room for improvement in the process for obtaining services.

Theme 2: Participation

The second theme derived from this study through the collected data by the participants is the level of participation in services provided. Many participants discussed that medication management is the umbrella intervention utilized for most mentally ill incarcerated individuals. This is due to the high volume of mentally ill offenders needing medication management as well as somewhat of a supplement for the lack of behavioral and cognitive interventions available.

Many participants find issues with participation and consistency with medication management due to security issues that could prolong the dispensing of medication in a timely fashion, the individual potentially hording their medication, and the possibility of certain incarcerated individuals allegedly manipulating the system for substance abuse purposes or other purposes outside of taking it as prescribed. Due to the issues regarding medication management, short staff, and lack of programing available this impedes the opportunity for cognitive and behavioral interventions that are consistent and align with evidence-based interventions.

Theme 3: Knowledge of Programs

The third theme that arose from the data that was collected from the participants the knowledge of the services offered are limited. It was reported by the study participants that they are aware of medication management, screenings taking place among the intake process, and that mental health providers can be accessed by completing a form on behalf of the incarcerated individual. However, when asked about specific programs such as individual or group therapy they were unaware. This can create a stressor and barrier to providing referrals should an incarcerated individual inquire about what is available to them. Given that the correctional officers are at the forefront of care for incarcerated individuals their knowledge of programs and interventions available should an incarcerated individual ask is essential to improving the participation, knowledge, and engagement in evidence-based interventions.

Implications

Implications for Social Work Practice, Policy, and Education

Social workers are sensitive to vulnerable populations and cultures with the goal of improving well-being and end stigma and discriminatory practices. Historically the expectations

of correctional facilities to be a place to separate those deemed to be in violation of social norms from society have shifted. The issue of mentally ill offenders being placed into correctional facilities alongside with the general population is a disservice to the individual, the general population, as well as the outside community. There are several barriers, legally, ethically, and geographically to appropriately implement mental health services in correctional facilities. The shift from punitive to rehabilitative and heading back to punitive is ongoing without a solution to break this destructive pattern.

To resolve this issue, there must be a higher standard set if facilities are housing mentally ill incarcerated individuals. Some mentally ill incarcerated individuals will spend months on the mental health roster to still go unseen. As part of social work, the core value of social justice is being utilized to provide reform within the criminal justice system. The criminal justice system is aware of the need for mental health services and has held correctional departments accountable but there is minimal follow up. This creates unconstitutional interventions within the facility.

The lack of mental health services provided and the minimal access to the services that are available is unethical. Everyone is entitled to mental health care services while incarcerated or within society. The stigma behind mental health in general causes many people to be undiagnosed, which is why it is so important for those who committed a crime to understand why they offended and receive rehabilitative services to do so. If a mentally ill incarcerated individuals is diagnosed for the first time upon arrival the feelings, they feel is surreal. During this time of their life which should include self-reflection, and this should not be done while they are alone. The new lifestyle they are attempting to adjust to is hard enough without being mentally ill.

The United States criminal justice system is in desperate need of reform. The public is becoming more aware of this with the media coverage but that is not enough. There are incarcerated individuals attempting and succeeding with suicide while incarcerated, and sometimes when they are released. Mentally ill incarcerated individuals need to be seen on a semi-regular basis by a mental health professional to help them adapt to their new environment in addition to transitioning out of the facility. It is unethical to assume that a mentally ill incarcerated individual could be rehabilitated or able to transition to society the way an incarcerated individuals without a diagnosis could. The implementation of evidence based mental health practices within correctional facilities could address the rates of recidivism, suicidality, and proper transition back into society.

Implications for Research

Future research should continue to explore the role of the correctional officer as almost a mental health provider as well and their impact on differential treatment and trainings that could improve their abilities to assist those in need. Little research has been conducted on the perspective of the mentally ill incarcerated individuals and their relationship dynamics with correctional officers. Therefore, further investigation is needed to explore if this seems one sides or if there are things correctional officers could improve on to improve overall well-being and quality of life while incarcerated.

Conclusion

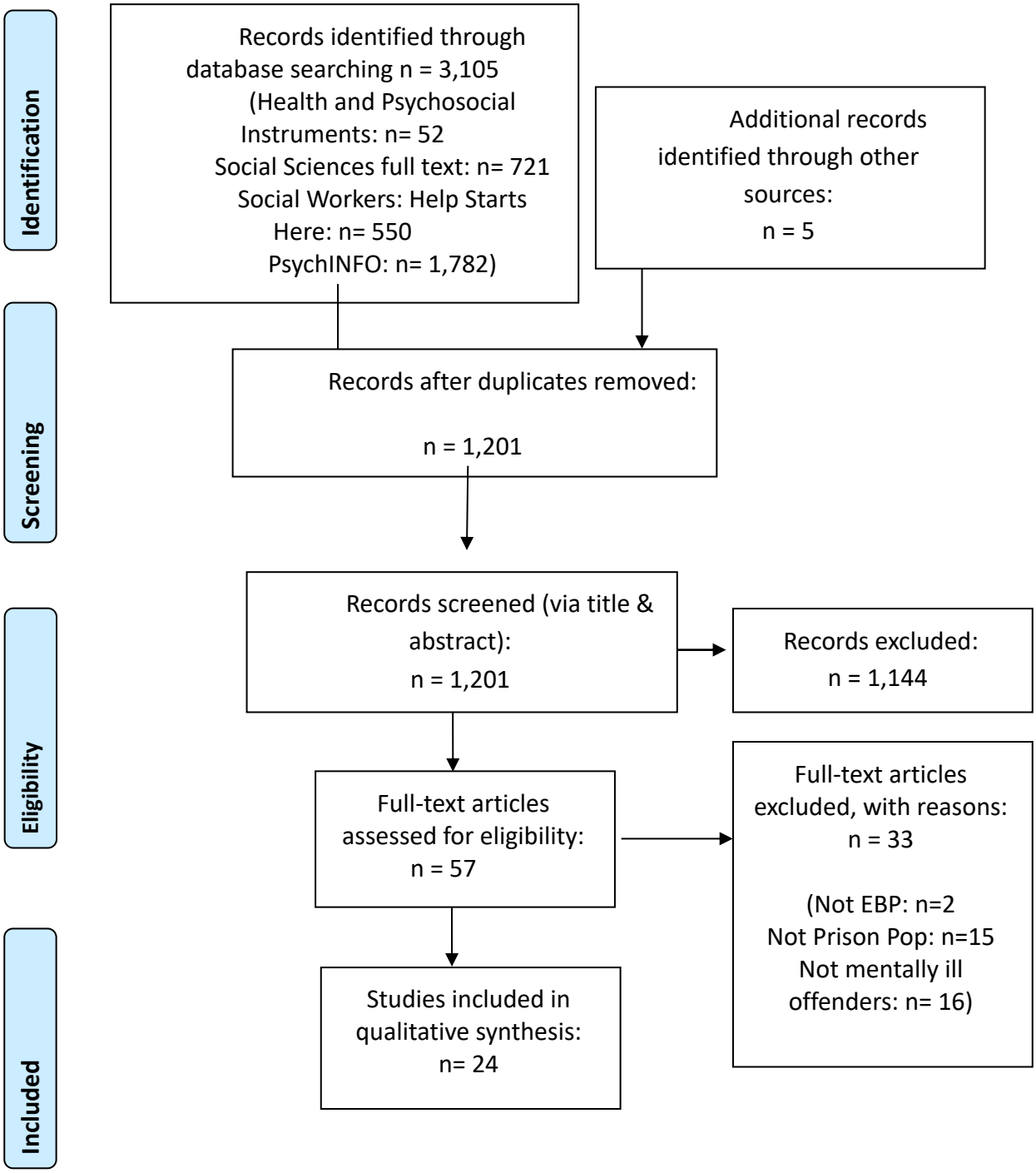
This qualitative study sough to examine the provider barriers that take place when mentally ill incarcerated individuals need treatment while incarcerated. Findings from this study align with the previous literature that spoke to staffing shortages, lack of knowledge, lack of participation, and stigma behind attending. Additionally, it highlighted the antisocial behaviors

that are discussed within RNR theory, in which the avoidance of treatment is seen as antisocial behaviors however the goal is to engage and develop prosocial behaviors to improve success of transitioning back into society.

Table 1: Demographic Table

Characteristic	n	%
Age	6	44.66
Gender		
Male	5	83.33%
Female	1	16.67%
Race/Ethnicity		
White	5	83.33%
Hispanic/Latino	1	16.67%
Years of Employment	6	13.3
Experience with Mentally Ill Offenders	6	100%
New York State Employment	6	100%

Figure 3. Flow chart depicting inclusion and exclusion process



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Yoon, I. A., et al,. (2017). Outcomes of psychological therapies for prisoners with mental health problems: A systematic review and meta-analysis. *Journal of consulting and clinical psychology*, *85*(8), 783.

Dissertation Conclusion and Implications

This three-paper dissertation highlights the lived experiences and themes from formerly employed correctional officers regarding factors that imped the implementation of evidence-based mental health practices for mentally ill incarcerated individuals while incarcerated. There is limited knowledge of the state policies, department policies, and provider barriers and the role they plan in introducing evidence-based practices into the facilities. The three-paper dissertation provides knowledge surrounding the participants experiences and knowledge of policies at both state and department levels, procedures, accessibility, and interventions available. The study's findings and implications for social work practice, social work education, and policy are summarized in this chapter.

State Policies

The first dissertation paper explores the state policies and the knowledge the participants have regarding the potential factors that imped the implementation of evidence-based mental health practices. The study's findings indicate that the participating correctional officers engaged in a variety of procedures and protocols addressed by the state to provide the best care with what they have available. Specifically, correctional officers who have worked in New York State facilities report emphasis on the importance of security which leads to an underlying tone of a punitive rather than rehabilitative environment within the facilities. The process of mental health screenings at a state level efficacy is dependent upon self-reports from the inmate rather than providers who are well informed in mental health screenings which further highlights that it may not be appropriate for most of the mentally ill offenders to be placed into their facilities. There are no specific state policies for that will not allow for evidence-based interventions to be implemented at this time, more so provider barriers which are explored further in paper three.

Department Policies

The second dissertation paper discussed the study's participants knowledge of the department policies and barriers towards engaging or accessing appropriate and consistent treatment interventions. Findings from the study indicate that the participants have a minimal knowledge of what modalities are offered in addition to other potential interventions aside from medication management. More specifically, if an incarcerated individual is interested in engaging in services it is up to the individual to inform an officer of their interest to be followed by the completion of a request via paperwork. This process becomes challenging as the correctional officers are unaware of what is offered resulting in challenges with providing the incarcerated individual with the most well-rounded options available. Given that the correctional officers are at the forefront of working with incarcerated individuals their lack of insight into the programs available becomes a barrier. It was mentioned that this could also infringe upon HIPAA if a mental health or physical health provider share too much information with them regarding an incarcerated individual. The policies regarding security and confidently are a catch 22 for coordinating care. The findings also highlight that most of the diagnosing of placement of the incarcerated individuals is based on their presentation upon intake not much follow up there after unless expressed by the incarcerated individuals. Due to the stigma behind mental health, there are situations in which others will not be honest upon entry and will take time to build rapport to potentially disclose emotional distress. Conversely, it is unknown if all the participants obtained the same specific set of trainings to work with mentally ill incarcerated individuals diagnosed or not, hence an additional implication for future research.

Provider Barriers

The third dissertation paper explored the provider barriers such as accessibility, staffing issues, program evaluations, and engagement. The main findings of this study reported that collaborative care is challenging as well as the revolving door of mental health providers making development of rapport for both the incarcerated individual and the officer to develop a relationship. The adoption of evidence-based mental health practices is limited due to lack of available providers and due to the limited time of employment a long-standing program is challenging to implement. Organizational and provider level factors need to be incorporated into the state and department policies as well as within practice. Increasing the use of evidence-based mental health practices is essential for creating an overall improvement in the well-being of mentally ill offenders, however given the lack of communication, knowledge of programs, and implementation of programs this highlights the low success level of transitioning out of the department back into society resulting in the return of these individuals back into the facility. Findings of the study highlight that programs have been integrated however are not always utilized, whether it's due to the incarcerated individuals being unaware of what is offered or if stigma plays a role, future research is implicated. Additionally, it was found that there are issues with consistency regarding medication management whether by the provider or the mentally ill incarcerated individuals abusing their medication resulting in unsafe spaces for staff, the individual, and others on the floor.

Social Work Implications

Research regarding the barriers to implementing evidence-based mental health interventions within correctional facilities is exhaustive. However, few researchers sought to explore and understand the voices of the workers and their perception of the needs and their

ability to meet them to develop a theory as to *why* and *how* this can be altered. In trying to understand and provide a comprehensive description of mental health services within correctional facilities, this study hopes to discover an effective solution to this challenge. This study seeks to identify the factors and themes that can be explored and further tested. This study will work to further the social work profession in several aspects.

Social Work Practice

This study highlighted factors, personal, organizational, and policies that contribute to the implementation of evidence-based mental health practice in correctional facilities. As well as the benefits associated with implementing more collaborative, consistent, and well-rounded interventions in correctional facilities for mentally ill offenders. The implications of this study could influence how the social work field perceives working and providing within the confines of a correctional facility. The person-in-environment perspective seeks to address the psychosocial needs of those who are mentally ill and incarcerated. For example, the study's finding will help inform social work practitioners about the needs of correctional staff and mentally ill offenders about interventions that work best for addressing this populations needs.

Implications for Policy

Social Workers can be fully prepared to address mental health needs of incarcerated individuals. From a macro perspective, the rates of mentally ill offenders have been impacted due to deinstitutionalization and systematic oppression. Social workers must consider how the concept of institutionalization plays a role in the revolving door of mentally ill offenders being incarcerated. It has been shown in previous program evaluations that there are successful interventions implemented among select facilities and states however this varies from each facility to the next. Therefore, the proposed study may inform new policy, program, and funding

development that addresses the needs for evidence-based interventions for mentally ill offenders in correctional facilities. The results from this study will hopefully inform social determinates of mental health, staff training programs, funding, and program initiatives to address the challenges within this population to alleviate the number of mentally ill individuals being incarcerated.

Implications for Research

The data collected on the experiences of the most frequently seen correctional staff and they ability/inability to provide adequate care, services, and interventions for mentally ill offenders is limited. Although there is information on the perceived unmet needs of the mentally ill incarcerated individual and provider barriers, this research seeks to look at the barriers for implementation. Additionally, the efficacy of services and interventions currently in place which is underdeveloped. The proposed study will add to the body of knowledge that examines the experiences of correctional staff with the goal of developing themes and factors to understand the *why* and *how*. Thus, the proposed study will work to contribute new and relevant information to assist in future research.

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Appendix A

Demographic Questions:

1. What is your age? (open ended)
2. What is your gender? (categorical)
    a. Male
    b. Female
    c. Non-binary/third gender
    d. Transgender
    e. Prefer not to say
    f. Other ____
3. What is your race and ethnicity? (categorical)
    a. American Indian, Native, First Nations, or Alaska Native
    b. Asian
    c. Black or African American
    d. Hispanic or Latino or Latina or Latinx
    e. Indigenous people of Mexico, Central and/or South American
    f. White
    g. Don't know/Not sure
    h. Other _____
    i. Two or more races
4. Are you currently employed as a correctional officer?
    a. Yes
    b. No
5. How many years of experience do you have as a correctional officer? (open ended)
6. What state/states do you have experience working as a correctional officer in? (open ended)
7. Have you worked with mentally ill offenders?
    a. Yes
    b. No

https://www.surveymonkey.com/r/MFBCXB2

Appendix B: Semi-Structured Open-Ended Interview Questions & Connection to the Study

Each interview will begin with several ice-breaker questions related to the participants unique demographics to enable rapport to develop. The following questions are the central focus of the interview and are grounded in this study's literature, theory, and methodology.

1. Tell me about your experience working a correctional officer
2. Tell me about your experience thus far as a correctional officer working with mentally ill offenders
3. Tell me about your level of training to work with mentally ill offenders
4. When you think about mentally ill offenders what needs do you think differ from general population?
5. When you think about the differences, in your experience are the varying needs being met?
6. How much collaborative care have you experienced with mental health providers?
7. When identifying the needs of mentally ill offenders how often do you see the needs being met?
8. Has collaborative care been an option, if so how often do you participate in it?
9. What messages have mentally ill offenders shared with you about their needs and if they're being met?
10. What is your process for attempting to meet their needs?
11. Tell me what you think about the mental health services currently offered at the facility
12. When you think of mental health needs, what does it mean to you?

Appendix C: IRB Exemption Approval

September 21, 2022

Lauren Hoffman
Yeshiva University
2495 Amsterdam Ave
Belfer Hall
New York, New York 10033

Dear Lauren Hoffman:

SUBJECT: IRB EXEMPTION—REGULATORY OPINION
Investigator: Lauren Hoffman
Protocol Title: A Qualitative Study on the Factors Impeding the Implementation of Evidence-Based Mental Health Practices in Correctional Facilities

This is in response to your request for an exempt status determination for the above-referenced protocol. WCG IRB's IRB Affairs Department reviewed the study under the Common Rule and applicable guidance.

We believe the study is exempt under 45 CFR § 46.104(d)(2), because the research only includes interactions involving educational tests, survey procedures, interview procedures, or observations of public behavior; and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

This exemption determination can apply to multiple sites, but it does not apply to any institution that has an institutional policy of requiring an entity other than WCG IRB (such as an internal IRB) to make exemption determinations. WCG IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions. You are responsible for ensuring that each site to which this exemption applies can and will accept WCG IRB's exemption decision.

WCG IRB's determination of an Exemption only applies to US regulations; it does not apply to regulations or determinations for research conducted outside of the US. Please discuss with the local IRB authorities in the country where this activity is taking place to determine if local IRB review is required.

Please note that any future changes to the project may affect its exempt status, and you may want to contact WCG IRB about the effect these changes may have on the exemption status before implementing them. WCG IRB does not impose an expiration date on its IRB exemption determinations.

If you have any questions, or if we can be of further assistance, please contact Olga I. Balderas, JD, at (360) 570-1302, or e-mail RegulatoryAffairs@wirb.com.

OIB:hp
D2-Exemption-Hoffman (09-21-2022)
cc: Edward Berliner, Yeshiva University
Monica Summers, California State University, Fresno Department of Criminology
Hanni Flaherty, Yeshiva University
Christine Vyshedsky, Yeshiva University
WCG IRB Accounting
WCG IRB Work Order #1-1587375-1

Appendix D: IRB Addendum Approval

January 13, 2023

Lauren Hoffman
Yeshiva University
2495 Amsterdam Ave
Belfer Hall
New York, New York 10033

Dear Lauren Hoffman:

SUBJECT: CONTINUATION OF IRB EXEMPTION STATUS
Investigator: Lauren Hoffman
Protocol Title: A Qualitative Study on the Factors Impeding the Implementation of Evidence-Based Mental Health Practices in Correctional Facilities

This letter is in regard to your request for review of the **Solicitation Letter with Consent and Confidentiality Agreements** and to continue the exemption status of the above referenced study.

The **Solicitation Letter with Consent and Confidentiality Agreements** do not change the exempt status of the study. **The main change in the study at this time is the change in population being studied. Formerly, currently-employed correctional officers were the target population. However, now, the target population is previously-employed correctional officers.**

If you have any questions, or if we can be of further assistance, please contact Olga I. Balderas, JD, at (360) 570-1302, or e-mail RegulatoryAffairs@wirb.com.

OIB:hp
D2-Exemption-Hoffman-Continuation (01-13-2023)
cc: Edward Berliner, Yeshiva University
Monica Summers, California State University, Fresno Department of Criminology
Hanni Flaherty, Yeshiva University
Christine Vyshedsky, Yeshiva University
WCG IRB Accounting
WCG IRB Work Order #1-1622029-1

Appendix E: Consent Form and Solicitation Letter

Research Study Title: A Qualitative Study on the Factors Impeding the Implementation of Evidence-Based Mental Health Practices in Correctional Facilities

Researcher(s): Lauren Hoffman, Wurzweiler School of Social Work, Yeshiva University – Wilf Campus, New York

Why am I being asked to participate in this study?

You are being asked to participate in this study because you have self-identified as a previously employed correctional officer in NYS and/or CA. You have also identified that you have current or experience(s) with mentally ill offenders. You have also identified that you have access to the internet and a computer and the ability to read, write and converse in English.

What is this study about?

The purpose of this study is to examine how policy and provider barriers impact the implementation of evidence-based mental health practice for mentally ill incarcerated offenders and if there is a theory that comes from this discovery that can later be tested. The research is also aimed to fill in the gaps of the limited literature on this topic and contribute to the overall social work profession.

How long will I be in this study?

If you agree to this study, you will be asked to fill out a demographic's questionnaire via email (a 5–7-minute process and be contacted to participate in a virtual or in-person interview for a maximum of 60 minutes, answering several open-ended questions related to the topic.

What happens if I say yes to participating in this study?

You will be asked to sign this consent form, complete a demographic questionnaire, and, if selected, go on to participate in an individual interview that will last for at most 60 mins. It is

your choice to participate in this study; should you have no interest, you do not need to respond to the consent form email, or questionnaire and you will not be considered. Your decision does not affect your relationship with the researcher.

What happens if I agree to be in this study but change my mind later?

You can change your mind and stop at any time during this study. Please follow the below steps to withdraw entirely: Contact the researcher directly via phone or email and inform her that you would no longer like to continue participating in this study. Any information that has already been collected from your participation will be withdrawn and destroyed.

Are there any possible risks to me?

There is minimal to no risk in participating in this study, however, should you feel emotionally affected by the discussion that comes from the individual interview, the research findings, you will be provided a sheet with resource information to utilize to support you. All identifying information will be removed, however, demographic data from your demographic questionnaire will be shared. Should anyone ask the researcher about your participation in the study, there will be no communication with anyone about your participation, except for with you.

Will I be paid for this research, or will it cost me anything?

You will not be compensated for this study. However, a token of appreciation will be given to those who participate in the form of a $10 Amazon gift card. It will not cost you anything to be in this study.

Who can see or use the information collected in this study?

Your name will not be collected with your interview, you may use a pseudonym of your own choice. The voice recordings of your virtual zoom or in person interview will be destroyed at the conclusion of this research, only a paper copy of your transcribed interview will be saved,

and password protected on the researchers University Google Drive. The information will be kept for up to three years (as required by Federal guidelines) or until it is no longer required and then be destroyed. Your email address may be required for contact purposes to schedule your individual interview, the purpose of having the email is strictly for professional use and is protected by the researcher by a password-protected file on the researchers google drive account. If information from this study is published or presented at social science research events/ meetings, your name and email will not be used. This researcher will do her due diligence to ensure that your information is not used improperly or maliciously; she will make sure that no one else knows of your participation in the research. While it is unlikely, there are times when others may need to see the information this researcher collects about you; these persons will only include individuals at the Wurzweiler School of Social Work who oversee research to make sure it is conducted properly.

Will I benefit from this study?

Participation in this study may benefit you by highlighting the experience you the participant has had as a correctional officer and lead to a call for action to change, develop, and demolish policies that continue to create a barrier from implementing evidence-based practices for mentally ill incarcerated offenders. In general, policies surrounding the implementation of evidence-based mental health practice and theories about how to implement it may arise from this study that directly impacts the social work profession by finding positive ways to support its vulnerable populations.

Who can answer further questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researcher, Lauren Hoffman, at lhoffma1@mail.yu.edu.

Statement of Consent

By clicking on the provided link, you agree to take part in this research

https://www.surveymonkey.com/r/MFBCXB2

Appendix F: Demographic Table

Characteristic	n	%
Age	6	44.66
Gender		
Male	5	83.33%
Female	1	16.67%
Race/Ethnicity		
White	5	83.33%
Hispanic/Latino	1	16.67%
Years of Employment	6	13.3
Experience with Mentally Ill Offenders	6	100%
New York State Employment	6	100%

Figure 1. Flow chart depicting inclusion and exclusion process

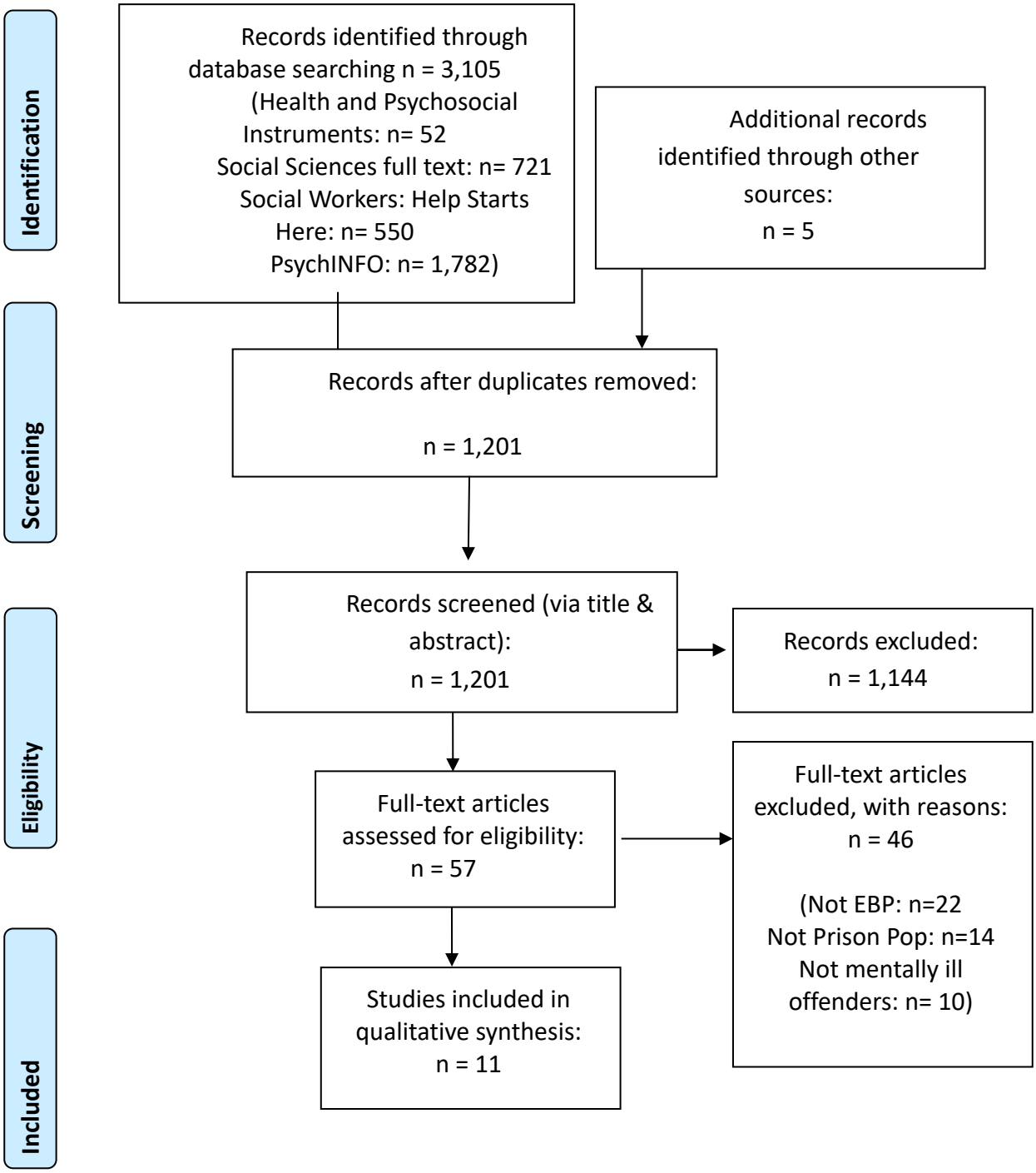

Figure 2. Flow chart depicting inclusion and exclusion process

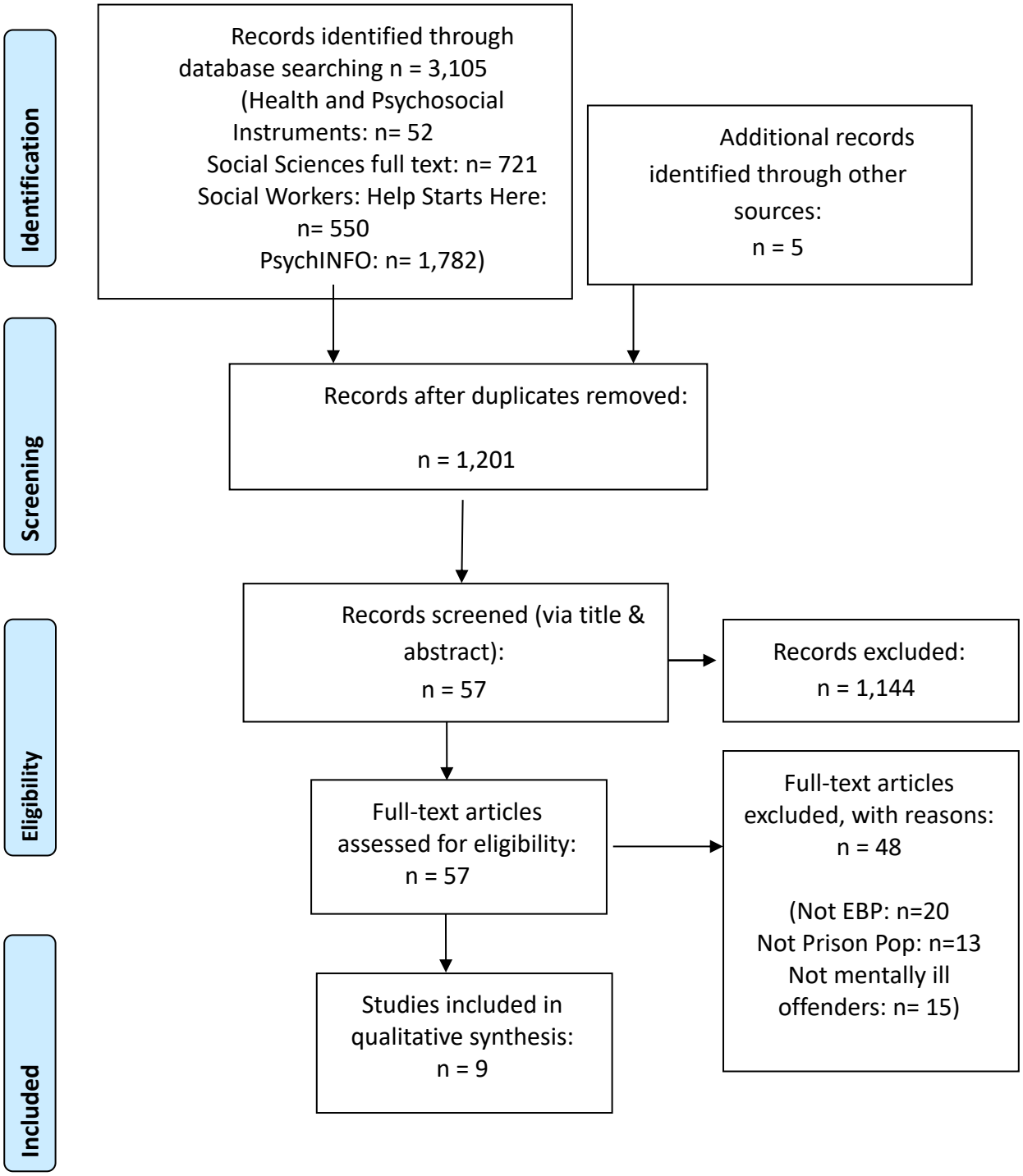

Figure 3. Flow chart depicting inclusion and exclusion process