BRIDGING PROFESSIONAL GAPS IN THE DELIVERY OF MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

by

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ABSTRACT

In the recent past, the mental health system has responded to calls for deinstitutionalization and has had to deal with steadily decreasing flows of money. At the same time, a growing number of people who need treatment are finding themselves in the criminal justice system. The criminal justice system frequently finds it has to care for mentally ill individuals even though that is not their mission. In order to better address the needs of mentally ill individuals in both systems they have had to collaborate on behalf of those they serve.

This study set out to explore the possibility of inherent problems in the way mental health and criminal justice professionals viewed each other, perceived barriers to collaboration, and possible inroads to better collaboration.

Using a qualitative methodology based on the constructivist paradigm and systems theory, fourteen mental health and 15 criminal justice professionals were interviewed. Semistructured questionnaires in separate focus groups were used to explore their perceptions of each other, each other's systems, and barriers that individuals with mental illnesses in those systems face.

The results indicated that mental health and criminal justice professionals' views varied according to their education, experiences with each other, and proximity of working with each other. The results also indicated that funding problems, low cross system education, service gaps, and inconsistency in professionalism inhibited collaboration between the two systems. Participants felt education regarding each system's philosophies, appropriately shared responsibilities, and understanding the limits

both systems would help eliminate some barriers faced in collaboration. Participants said benefits of close collaboration would include higher success rates for mentally ill individuals, less recidivism in both systems, and increased professional satisfaction.

Implications of the study indicated the need for increased education in both systems regarding the purpose, function, and philosophies of both systems. Also, leaders and front line professionals should focus on making their interactions with each other more consistent, clear, and available. Further research should investigate quantitative verification of the results, policy implementation to promote collaborative efforts, and educational efforts to improve the perceptions of mental health and criminal justice professionals of each other.

To my father who never let me settle for anything less,
To my wife who gave endless encouragement and support,
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And to those professionals who put their lives and careers on the line to help those who suffer from mental illness.

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CHAPTER 1

INTRODUCTION

Recidivism, or the tendency of people with severe mental illness to return to jails, prisons, and hospitals, has remained high since the deinstitutionalization of psychiatric institutions in the 1960s (Sharp, 2007). Even though there are many systems to help care for people with severe mental illness when they are out of highly structured institutions, such as jails and hospitals, there continues to be a considerable lack of progress in the collaboration between the mental health system (MHS) and the criminal justice system (CJS) (Estey, 2008; Janofsky &Tamburello, 2006; Vogel, 2007). Since many people with severe mental illness cycle between the CJS and MHS, a systemic collaboration between the mental health and criminal justice systems would seem an essential step in the process of improving services and reducing recidivism (Haimowitz & Appelbaum, 2004).

Both systems serve important roles for individuals with mental illness (IMI). The MHS provides many levels of care for IMI such as outpatient treatment, residential treatment, hospitalization, clubhouse models, and case management. It is made up of many professionals, including social workers, psychologists, psychiatrists, nurses, case managers, licensed professional counselors, family and marriage counselors, and community advocates. The goal of all of these services is similar across professions: to

reduce and prevent crises for IMI and encourage them towards growth, independence and safety (Roskes, 2001).

The CJS utilizes many professional roles, including police forces, lawyers, probation officers, judges, and incarceration personnel. The CJS primarily focuses on the protection of society, the punishment of those who break laws, and ensuring that justice is served to victims of crimes. While not specifically geared towards helping IMI, research has shown that IMI are more represented in the CJS and tend to have long-term negative side effects when engaged in the CJS (Winstone, 2008).

Research has shown a general willingness for the MHS and CJS to collaborate, even though there are few places where systemic collaboration takes place (Sharp, 2007). Opinions on the best practices for such collaboration have been offered (Janofsky & Tamburello, 2006; McNiel & Binder, 2007; Roskes, 2001); however, there has been little evidence questioning the basic assumptions that might impede collaboration in the first place. Understanding those assumptions, should they be accurate, would also be beneficial in understanding what fundamental differences need to be addressed in both systems to improve collaboration. The current study explores qualitatively how professionals in the mental health and criminal justice fields view each other and the potential problems that might result from those points of view. The information gathered from these professionals should then inform policy as to the best ways to improve collaboration efforts.

Potential Benefits of the Study

This study aimed to achieve the following benefits for both systems: 1) increased mutual awareness of MHS and CJS professionals of their work together and what each system does; 2) increased awareness of the benefits of collaboration amongst MHS and CJS professionals; 3) informed policy and educational work that lays a supportive foundation for more effective collaboration between systems; and 4) reduced recidivism for IMI through greater collaboration between the systems.

A purposive sample of mental health and criminal justice professionals within the Salt Lake City, Utah area was invited to participate in focus groups that explored attitudes towards working with other professionals and how to improve collaboration efforts. Focus group participants were asked questions regarding themselves, their work lives, their roles, their experience working with mental illness, and how they view their respective system and each other's system.

Research Questions

In order to investigate systems of collaboration among the MHS and the CJS, four qualitative questions were posed:

- What perceptions do criminal justice and mental health professionals have of each other?
- What obstacles do these professionals believe inhibit collaboration?
- How could MHS and CJS professionals resolve those perceived problems through collaboration?

- What do mental health and criminal justice professionals view as potential outcomes of greater collaboration?

Organization of This Dissertation

This dissertation is divided into five distinct chapters. The first chapter introduces the problem and addresses the systemic differences between the MHS and CJS. The second chapter reviews relevant literature regarding mental health services, criminal justice services, collaboration attempts, systemic problems, and proposed approaches to collaboration. The third chapter details the research methodology, including the study design, theoretical review and perspective, sample characteristics, process of data collection, analysis methods, and the context of the data and researcher. The fourth chapter discusses the findings and theme overviews and triangulation methods to verify the trustworthiness of the data. Finally, the fifth chapter discusses the findings in terms of what can be surmised from the data, the limitations of the study, and what the practice, policy, and educational implications of the study are.

For the purposes of the study, members of the criminal justice system are defined as professional individuals who work primarily in one of the following capacities: police officers, probation officers, lawyers, judges, jailors, prison security, and educators of the criminal justice system. Mental health professionals are individuals who work with IMI in any of the following capacity: therapists, nurses, doctors, forensic social workers, psychologists, licensed professional counselors, licensed marriage and family therapists, and educators of any of those professionals. While it is understood that there are professionals from both systems who work in each other's systems—forensic social

workers or Crisis Intervention Team officers—those individuals will be classified by their profession and not the systems in which they work. IMI is used to denote individuals who would qualify for a diagnosis in the Diagnostic and Statistical Manual (DSM-IV-TR, 2000) that would lead to significant functional impairment as denoted by the Global Assessment of Functioning in the DSM.

The study uses several acronyms:

IMI- Individuals with Mental Illness, used both in singular and plural

MHP- Mental Health Professional

CJP- Criminal Justice Professional

MHS- Mental Health System

CJS- Criminal Justice System

CIT- Crisis Intervention Team, a police designation for a mental health trained officer

HIPAA- Health Insurance Portability and Accountability Act, a federal policy that defines the way private medical information may and may not be used.

PO- Probation or Parole Officer

CO- Correction Officer

ED- Emergency Department

LPC- Licensed Professional Counselor

CHAPTER 2

LITERATURE REVIEW

The purpose of this review is to summarize the history of the mental health and criminal justice systems and current approaches to treatment of individuals with mental illness (IMI), and to call for greater collaboration between the two systems. Treatment and recidivism prevention services available for IMI in both systems, where the systems bridge, current problems in those bridges, and current recommendations to address those problems will also be described. Finally, there will be a discussion of how and why the current study is going to contribute to the knowledge that is currently available.

Historical Perspective

The history of the mental health system helps explain the necessity for greater collaboration between mental health and criminal justice professionals. In the early days of the United States, IMI were typically cared for by family members or lived with other homeless individuals in alms houses (Dembling, 1995). Care for IMI was commonly accepted to be the responsibility of the communities in which they lived, and IMI were viewed as social and economic problems as opposed to people with medical problems. Due to a lack of understanding about mental illness at the time, treatment and care was commonly inhumane (Bell, 1989).

In the late 1700s, the writings of Philippe Pinel led to what came to be known as the Moral Treatment movement. This philosophy advocated for compassionate, humane, and psychologically oriented treatments for IMI. This movement was not originally intended to view mental illness in moralistic terms, but in the United States, the morality of IMI was considered (Rochefort, 1993). The belief was that bad habits and engaging in "sin" led to mental illness, and recent research indicates that this belief is not totally extinguished (Stanford, 2007).

One of the major contributions of Moral Treatment was the development of state-run psychiatric facilities designed as "asylums" or "retreats" where those admitted would receive compassionate medical treatment. In the United States, Dorothea Dix helped propagate this movement by advocating for the development of asylums for IMI where they would be better treated than in the communities in which they lived. Slowly, IMI in communities across the United States were admitted to these asylums for acute, year-long stays, or for longer periods of time in some cases, up to the rest of their lives (Grob, 1992).

At first, this movement was seen as economically sound because it kept "undesirables" away from communities and allowed IMI to live in a compassionate setting where they received the treatment they needed. This was important because community resources were not available at the time. However, by the 1890s states began taking on most of the financial burden of asylums and began efforts to improve the quality of care for the increasing IMI population by centralizing responsibility for their care. This policy move eventually led to a shift in focus for asylums, as their purpose became more custodial than treatment oriented. This led to overpopulated and

understaffed asylums where treatment deteriorated to the point of being no better or worse than the minimal services available in communities (Bloom, 1984).

Shortly following this movement, the psychotherapies of Freud and Skinner became popular as potential treatments for mental illnesses. While this Mental Hygiene movement did little to address the care of IMI in asylums other than note that it was woefully insufficient and inhumane, it did lead to a philosophical change in the way that IMI were viewed. Instead of being insane, people in asylums were considered people with mental illness who could potentially be treated. It also led to dropping terms such as "asylums," which were now referred to as "psychiatric hospitals." The Mental Hygiene movement then paved the way for advocating treatment within communities again as a more cost effective and humane way to deal with IMI (Grob, 1994; Tessler & Goldman, 1982).

In the 1940's, a new movement emerged. Costs for psychiatric hospitals were soaring and there was a greater consensus that a better way to treat IMI was now available. Medications that treated mental illnesses were also coming forth as a treatment that could restore function in many people once deemed unable to function in society (Rochefort, 1993). This movement, known as deinstitutionalization, brought people out of institutions and into the community, where they could receive mental health resources (Fellin, 1996).

This movement was based on the idea that individuals who were hospitalized were often experiencing acute psychiatric crises and that institutionalizing them would do more harm than good (Jenks, 1994). Deinstitutionalization was quickly defined as the process of preventing unnecessary admission and retention in psychiatric hospitals,

finding and developing alternative treatments in the community and improving care for those requiring institutional care (Fellin, 1996).

In order to account for the IMI who were leaving psychiatric facilities and making their way into communities, community resources were created to help IMI deal with life in society. Community mental health centers were designed to provide five essential services: inpatient care, outpatient care, emergency services, partial hospitalization, and consultation and education. There was also to be a continuity of care provided at each of these levels that would allow for any individual requiring one service to have access to other services as deemed necessary for their care (Bloom, 1984).

Deinstitutionalization actually resulted in the creation of a more complex set of systems that included state hospitals, emergency hospitals, residential treatment, nursing homes, and community support centers. The idea was to foster recovery and provide community living; however, a more complicated system emerged where IMI frequently found themselves interacting at different levels and requiring frequent re-hospitalization.

Assessments of the deinstitutionalization movement have met with controversy. Many experts have said that this movement is generally viewed positively, in part because of the reduced financial strain on states to care for IMI in psychiatric facilities (Fellin, 1996; Sharp, 2007; Wilmoth, 1987). Many psychiatric facilities closed or dropped in census dramatically, an indication that many IMI were now able to live productive lives in their communities. On the other hand, several researchers (Janocko & Lee, 1998; Rosenzweig, 1983; Shadish, 1984) have noted that while the ideals of de-institutionalization were sound, it turned out to be the status quo masquerading as reform. Many IMI were not discharged into communities but were transferred to nursing homes,

halfway houses, or residential facilities--a kind of trans-institutionalization as opposed to deinstitutionalization. Moreover, community mental health agencies frequently had insufficient resources to meet the needs of IMI in the communities, leaving IMI to interact with systems not designed to handle them, such as the criminal justice system. In the end though, the framework of de-institutionalization is the basis for understanding the current state of the mental health system and those who receive its services.

Criminal Justice System

When mental health services are insufficient to meet the needs of IMI in the community and antisocial behavior is identified, the IMI often enter the Criminal Justice System, leading IMI to interactions with courts, jails and prison.

Historically, the Criminal Justice System has taken a *laissez faire* attitude towards mental illness, not distinguishing IMI from the rest of the community and only interacting with them when they would break laws (Lee, 2007). This attitude changed little until recent developments came about in how mental illness is understood. De-institutionalization, for example, made the unique challenge of IMI in the CJS apparent (Winstone, 2008).

IMI have often been considered dangerous and violent even though, statistically speaking, they are generally no more violent than the rest of the population (Torrey, 1994). Of great concern then is that in the CJS, IMI are over-represented in jails and prisons, up to four times the percentage of what is commonly found in the general population (Peters, 2008). The CJS, due to long-term apathy towards mental illness, is woefully underprepared to manage and treat IMI. Typically, only a select few receive

any treatment services while incarcerated (Draine, 2007). When incarcerated, IMI are also frequently subject to more disciplinary action, longer stays, increased victimization by other inmates, and are more likely to return to jails and prisons after release (Carr, 2008).

Other factors that could theoretically contribute to this problem have more to do with how American society views those who end up in jails and prisons. Popular public opinion has vacillated between punishing people who commit crimes and rehabilitating them. Most commonly, the U.S. has preferred punishment over rehabilitation, leading to policies that reinforce this sentiment. The United States incarcerates more people than any other country—averaging 1 in 31 people—(Lambert, 2009), and the privatization of jails and prisons in the U.S. has become a big business, leading to stricter sentencing policies to keep the businesses growing (AFI, 2008). These data suggest that economics drives the support for incarceration over rehabilitation in the CJS.

Why these problems exist and to what extent they create problems in everyday life is still a matter of debate. IMI are portrayed as violent and dangerous in up to 72% of movies and TV shoes (Dubin & Fink, 1992). Perhaps it is because of this influence in the collective psyche of American culture that IMI might be singled out as criminally dangerous, and therefore more often arrested and placed in jails than their non-mentally ill peers. It could also be that many people are unaware of what behaviors are signs of mental illness, and therefore perceive any behavior that breaks social norms as something to be relegated to the police.

The CJS is generally underprepared to manage and treat IMI. Some (Wilson & Draine, 2006) make the argument that it is not necessarily the duty of the CJS to treat

IMI, but only to protect the innocent and punish the guilty. Jails and prisons, however, are required by law to provide basic medical treatment to their inmates. Considering the medicalization of mental illness over the last few decades, this mandate would logically apply. Apart from that, with social services always under scrutiny and subject to funding cuts by government agencies, many more IMI are ending up in jails and prisons, leading towards a trend that would make the CJS the *de facto* treatment for IMI (Wilson & Draine, 2006).

IMI typically spend more time, are subject to more disciplinary actions, are more frequently victimized by peers, and are subject to further incarcerations after release (Carr, 2008; Daniel, 2007; Fisher, 2006; Lamb & Weinberger, 2005; O'Keffe & Schnell, 2007). These issues can be explained by the difficulty IMI have when dealing with new environments, not receiving proper medication, and being easily influenced by peers. Add to that the fact that most security personnel are not trained to identify and deal with mental illness and the stage is set for a disaster for the incarcerated IMI. IMI may be less likely to understand why incarceration security might be giving them orders and therefore act out against them. Further disciplinary action frequently leads to longer stays in jails, coupled with the prospect of the mental illness impeding IMI' ability to advocate for themselves and understand system rules to ensure shorter stays. Other inmates will often take advantage of a conflict between IMI and incarceration security in order to create a false alliance with IMI when they are vulnerable, thus being more subject to victimization by a fellow inmate who would take advantage of their trust for personal gain. Additionally, and probably most importantly, when IMI enter the CJS system, they are frequently further institutionalized by the jails and prisons, making them more apt to

follow a criminal lifestyle, or become dependent on the care that they receive when incarcerated. Finally, once involved with the CJS, IMI will have criminal histories--a factor that will influence officers to direct IMI to the CJS instead of treatment options (Lamb & Weinberger, 2005).

Several studies have investigated the use of community mental health services upon discharge from penal institutions as a way to reduce this trend of reincarceration (Chandler & Spicer, 2006; Fisher, 2006; Hylton, 1995). These studies indicate that appropriate coupling between the CJS and MHS might be an important step to preventing re-incarceration, but that it might not be a complete solution since reincarceration among IMI remains around 70% (Lovell, 2002). There are also problems related to limited resources available to those who are discharged. Most IMI when discharged from jails in Salt Lake City are discharged after midnight and with little more than the clothes on their back. A select few will be discharged with a month's worth of medications, but without the structure of the jail to support their use, many are simply abandoned to the streets (Bills, 2009). Budgets are not set up to create step down programs that would be necessary to address the problems of discharge, or are grossly inadequate, even though such a program would seem necessary and prudent (Haimowitz & Appelbaum, 2004).

Other studies have explored factors that might lead to less incarceration. One in particular looked at a way to reduce reincarceration by ensuring inmates were discharged with Medicaid benefits. The program studied qualified IMI for benefits and theorized that having those benefits might lead to increased access to community mental health services. This had limited success in that it reduced reincarceration by 16%, but did not

affect the severity of the crimes that led to reincarceration of those that did recidivate (Morrissey, 2007).

Substance abuse was found to be a significant risk factor leading to re-incarceration, and treatment compliance in the community was found to be a protective factor (Sullivan, 2007). Another study looked at treatment engagement and compliance as a protective factor and found that up to 73% of recently released IMI either never received clinically significant services or received only minimal services, making treatment engagement's usefulness as a predictive factor limited (Lovell, 2002). Finally, social support was found to be predictive of higher quality of life, but had little influence on re-incarceration (Jacoby & Kozie-Peak, 1997).

In summary, most efforts to reduce recidivism have had a limited effect. The current consensus is that incarceration prevention is the best way to reduce re-incarceration (Daniel, 2007). A variety of programs has been employed to redirect IMI to hospitals when a symptom of mental illness may have been responsible for criminal behavior. For example, in the state of Maryland, a law allows for any citizen to petition that an individual be subject to a medical examination against his or her will. While this policy was not aimed to divert IMI from jails into hospitals, it did lead to an increase in psychiatric care for IMI when a criminal charge could have been filed. This report concludes that official involvement from mental health and criminal justice professionals at every level could potentially lead to a more comprehensive diversion program (Janofsky & Tamburello, 2006).

Since their populations have a high overlap and the etiology of their clients' problems also overlap, it may make sense to include more mental health services in the

CJS, and perhaps more criminal justice services in the MHS. In the end though, in order for effective diversion and recidivism prevention programs to work, the mental health and criminal justice systems must work together towards such an end.

Current Collaborations

There are several ways in which the two systems are currently working together on behalf of IMI, and each is being met with significant success, as well as its own challenges.

One of the more recent and well-known programs is mental health court (Redlich, 2006), where IMI who enter the CJ system are identified early and given reduced sentences for treatment engagement and compliance. Studies indicate that participation in mental health court results in a more than 90% reduction of reincarceration, reoffense, and violence (McNiel &Binder, 2007). Despite mental health courts' remarkable success in reducing recidivism, arguments have been raised against them, centered on systemic flaws in both the MH and CJ systems. Some argue that mental health courts present violations of civil rights and signal the acceptance of IMI in the CJ system. Critics also point out that mental health courts can reduce the political power needed to address inadequate diversion services and treatment options (Seltzer, 2005).

The CJ and MH systems also interact through the use of forensic MH professionals within the CJ system. These MH professionals often provide treatment, stabilization, or assessments that can affect the outcome of CJ trials of IMI. Their presence in the CJ system is fairly longstanding and indicative not only of the pervasive

presence of IMI in the CJ system, but also of the need for MH and CJ professionals to collaborate. (Brennan, 1986).

There have also been recent efforts to specially train police officers in IMI crisis stabilization and redirection from the CJ system to the MH system instead (Hanafi, 2008). These Crisis Intervention Team (CIT) officers help prevent unnecessary involvement of IMI in the CJ system. This specialization is rare, however, and one study indicated that education about IMI does not equal change in attitudes or behaviors towards IMI (Godschalx, 1984).

Another area where MH and CJ professionals work together occurs when probation officers work with MH professionals on the same cases. While this effort is to be lauded as a place where both systems connect (Cohen, 1999), communication between the systems in practice is often minimal and reserved solely in times of crisis when one may ask the other which of the CJ or MH services is really best option for the shared IMI client at the moment.

Finally, there has been a movement to create treatment programs in jails and prisons. These programs often consist of group education for GED's, group counseling for addictions and mental health issues, and a regimen of medication, which tends to be minimalistic (Daniel, 2007; Estey, 2008). These programs also show some promise for reducing re-incarceration; however, they are subject to the same criticism as the MH courts.

There is consensus in the literature of the need for more effective collaboration between the MH and CJ systems. Some have suggested an expanded CIT program across police specialties (Laing, 2009), while others a more integrated system of collaboration

between MH, CJ, health care, and other social services (Lamberti, 2001). Similarly, strategic planning for following up with IMI upon discharge and addressing problems they face when discharged to the community has support (Vogel, 2007), and initial results indicate it could work, but such approaches have not caught on popularly. What programs do exist have been created out of necessity in order to help manage IMI in penal institutions, as well as in the community, but strained relationships between MH and CJ professionals often develop (Haimowitz & Appelbaum, 2004), creating new barriers to collaboration.

Problems and Gaps

The MH and CJ systems have very different philosophies, values, and goals; these differences can be problematic when it comes to collaboration, creating conflict that has a detrimental effect on IMI. Roskes (2001) describes several areas where barriers can be seen between the two systems: differing missions, stereotypes of each other, stigmas, communication and language (definitions of mental illness, each other), confidentiality, fraternity, and mass media messages. The following section summarizes these experiences and assessments.

Most mental health programs share a few common goals, both implicit and explicit. Primarily, the mental health system seeks to minimize the risks that IMI pose to themselves or others, to encourage treatment and medication compliance, to alleviate symptoms, and to promote deinstitutionalization and resocialization of IMI within communities over custodial care. The CJS on the other hand, has the primary goals of ensuring public safety, often by creating and enforcing laws. The system also has the

primary mission of punishing those who break those laws through measures such as incarceration, fines, or mandated public service. Both the MH and CJ systems see personal and public safety as primary, but they tend to diverge from there in terms of methods and overall treatment of any individual.

Stereotypes that the mental health and criminal justice systems have of each other often impede the collaborative processes between MH and CJ professionals. For example, in the mental health system, CJ professionals such as police are often stereotyped as cruel, unfeeling Gestapo whose primary goal is to lock up criminals without regard to circumstances or feelings of those involved. On the other hand, therapists in the mental health system are often stereotyped as “bleeding hearts” who want to empower criminals and claim that the criminals themselves are the victims, therefore minimizing the impact that the crime may have had on society and taking away the responsibility of the person who committed the crime.

The stigmas often associated with mental illness also may tend to become areas of conflict between MH and CJ professionals. This is most commonly seen when CJ or MH professionals have clients that they, for one reason or another, find distasteful and would rather that the other system deal with them. Words like “crazy” might be used to describe a particularly disruptive inmate, who then might be shipped off to the MH system for treatment so that the CJ system does not have to deal with them. On the other hand, words like “sociopath” might be used to describe IMI who have resisted treatment and are otherwise unpleasant or deemed dangerous, and therefore need to be taken care of by the CJS.

Like most other professions, the CJ and MH systems develop their own languages to describe their work and processes. For example, MH professionals tend to speak about clients in diagnostic terms set forth by the current Diagnostic and Statistical Manual of Mental Disorders, which can be disorienting to others if they are unfamiliar with the book. CJ professionals on the other hand deal with legal terms such as "detainer" or "probable cause," which many MH professionals will view as meaningless.

Confidentiality is an issue that can frequently become problematic between MH and CJ professionals. MH professionals, across disciplines, have a basic value of maintaining client confidentiality, or professional secrets, under most circumstances. In fact, state and federal laws dictate that client confidentiality can be broken only in cases where suspected child or elder abuse may be present, if clients disclose intent to harm themselves or someone else, or if the client gives specific written consent to have the information shared. This can be frustrating for CJ professionals, who may need to gather information about a client for the sake of prosecution or defense. CJ professionals often view this as a way that MH professionals prevent a sharing of responsibility between the systems.

Many CJ professionals share a sense of fraternity. Many CJ workers see themselves as brothers and sisters who support each other and stand together against chaos. While this attitude may be helpful in feeling supported and fostering trust amongst CJ professionals, this very attitude tends to shut others out; as a result, many MH professionals may never be able to feel like they are an integral part of the overarching system.

Finally, as mentioned above, misleading messages can come from the media about MH and CJ professionals. Most Hollywood depictions of MH and CJ professionals are grossly inaccurate, yet they influence large portions of the general public, including CJ and MH professionals. This is especially true when MH and CJ professionals have little or no previous experiences with each other and have little else to base their information on.

According to Roskes (2001), there are barriers that are presented to IMI that make their ongoing treatment and interactions with each system more problematic. He divides them into three categories: client based barriers, system based barriers, and clinician based barriers.

Client based barriers include a dual stigma that IMI are both crazy and "bad" for having committed a crime. Frequently, IMI who commit crimes also lose their social support networks, thus leaving them without important resources. IMI who commit crimes often will have other comorbidities, such as multiple diagnoses or addictions and a myriad of other health issues complicating their lives. Finally, IMI who have dealt with the CJ system often grow distrustful of it, therefore making positive interactions difficult. This becomes a barrier to treatment too, as MH professionals will often be associated with "the system" as well.

System based barriers that clients in both systems will face include problems with the flow of information between the systems, with confidentiality a major barrier to timely interactions between the systems on behalf of IMI. Power struggles between the two systems over who is in charge of what parts of IMI treatment can also slow the

process of treatment and punishment. These conflicts are often compounded by professional struggles to obtain funding for services in an effort to establish “turf.”

Finally, Roskes, Landsberg, et al. (2001) discuss a set of clinical barriers faced when working with IMI in the CJ system. Clinicians often fear IMI clients in the CJ system, due perhaps to the social stigma attached to being in a penal institution mixed with the stigma of being mentally ill--perhaps another relic of misinformation perpetuated by the media. Also, clinicians involved in working with the CJ system are more likely to be scrutinized by the CJ system, giving them a higher risk of liability (Roskes, Landsberg et al. 2001).

Roskes (2001) suggests ways to improve cooperation between the systems. First, he suggests that the benefits of collaboration be brought into greater awareness in both systems. In support of collaboration, Sharp (2007) suggested that the likelihood of collaboration was most predicted by perception of benefits of collaboration. Roskes et al. recommend integrating MH and CJ professionals in combined training programs so that greater mutual understanding can develop. Second, they encourage clinical flexibility so that MH professionals become willing to consider CJ professionals as part of the same team, working towards the same goal. Finally, they suggest that professionals from both systems learn as much as they can about each other’s systems, missions, and common ground. This last idea is not as well supported in the literature, with one study indicating that CJ professionals’ attitudes may not change, even with increased knowledge of IMI (Godschalx, 1984).

It should be noted here that Roskes et al. represent professional opinions in the CJS in Maryland. Their discussion of the two systems and their barriers working

together are based on professional recommendations, but are not based on any formal research.

Policies

Policy actions in the MH and CJ fields have affected each system in many ways. First, the MH system does not have a clear set of unifying policies or directives, despite efforts of the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration to develop such policies. There is not even a consensus by a simple majority of mental health professionals about what the mental health system's mission and policies should be (Marshall, 1992).

Given this fragmentation, the MH system frequently struggles to define itspurpose and make quick, national decisions. As a result, such decisions are often relegated to the states, which have widely varying priorities regarding mental health and mental illness. Political forces within each state will often deal with a "stop-and-go" style of developing policy towards mental illness, depending on the changing local political atmosphere and the public's feelings about responsibility for IMI. Finally, these impediments lead to a further confusing of lines of authority between different branches of government at all levels, making decisions regarding this population particularly difficult (Dorwart & Epstein, 1993).

Some mental health policies evolve from criminal cases and judges' rulings, for example, *Tarasoff vs.the California Board of Regents* of 1974. This is the case in which an individual confided to a psychologist his plans to kill his estranged girlfriend. The psychologist recommended that the client be detained—and he was—but no further

action was taken. Several months later, the client did murder his estranged girlfriend in the manner he described to the psychologist. The psychologist and university where he worked were then sued by the family of the girl, resulting in the policy that state's mental health professionals, when informed of intent to harm another person, have the duty to warn the person and notify the proper authorities. This policy has since been adopted by the majority of states (Tarasoff v. The Regents of the University of California, 1976).

Another example of an MH policy evolving from the CJ system is Kendra's Law (New York Office of Mental Health, 2006), named after the victim of a murder by an individual with mental illness. This law was passed in New York as a means of committing certain members of the community to treatment if they meet certain criteria, potential for harm to self and others being primary. The law, created in reaction to this case and passed by the State of New York in 1999 and later renewed in 2005, was a temporary reaction and was set to expire in 2010. It was renewed for 5 more years, but not made permanent. There is a movement to make it permanent, as research has shown the law helps reduce violence and increase treatment for IMI (New York Treatment Advocacy Coalition, 2009), but it is also facing opposition based on the idea that the law scares IMI away from treatment and that the policy is socially and racially biased (New York Civil Liberties Union, 2005).

There are many other such cases where MH policies were influenced by court cases (Frederick, Mrad, & DeMier, 2007). While these policies serve a vital purpose, it is not a productive way to create and sustain systems of policy and collaboration. The process is reactionary, not proactive, and only creates basic pathways of collaboration

rather than working towards systemic collaboration aimed at public safety and preventative treatment.

Need for Current Study

Compared to the wealth of literature on system problems and recommendations, there is little research that analyzes the perceptions of those who deal these problems at the ground level. Policies and political movements towards building greater systemic collaborations are slow moving, but the needs of IMI in the CJ system are immediate.

In order to make the most of the current state of affairs within the United States, an understanding of the perceptions of MH and CJ professionals of each other is necessary. Such knowledge will make the problems MH and CJ professionals are experiencing within and across their systems more explicit. This information, in turn, can be used to address barriers to collaboration, both on a practical level between professionals and on a systemic level for policy purposes (Lurigio, 2004).

A qualitative investigation offers an especially rich way to gather this kind of data for practical uses. Qualitative designs are best for building theories and producing more questions that can then be used for further study and evaluations. The underlying purposes of this study are (1) to better understand the needs and perceptions of individuals serving in both systems, (2) to develop a theory of interaction between the two systems, (3) to gain insight into what basic changes can be made in both systems for improved interactions, and (4) to influence the political process so that policies can be put in place to address the concerns of MH and CJ professionals.

CHAPTER 3

METHODOLOGY

The purpose of the study is to understand the perceptions of criminal justice and mental health professionals towards each other, the obstacles these professionals identify when it comes to collaboration, what suggestions these professionals make for increased collaboration, and the extent to which these professionals view greater collaboration as a potential solution to IMI recidivism. The purpose of this chapter is to describe the methods and sampling for the current study and explain why the methods are best suited to answer the research questions.

Paradigm and Theory

The current study is based in part on the philosophy of constructivism. Constructivism is a philosophy of knowledge that adopts a relativistic point of view of knowledge and seeks to create knowledge out of reconstructed understandings of the social world (Lincoln & Guba, 2005). Accordingly, accumulation of stories for the sake of knowledge creation is achieved through dialogue and co-created transactional findings with a focus on what is practical.

In other words, this philosophy indicates that the nature of reality is subjective and can only be solicited through subjective dialogue with careful documentation and

analysis. The reason for using this paradigm is that it lends itself to the understanding of individuals and their experiences which are not accounted for in the literature.

The theoretical point of view that guided the gathering and interpretation of data was based primarily on systems theory. Systems theory is an interdisciplinary theory that suggests that in order for tasks to continually be achieved, systems of interactions that support these tasks need to be developed to create and maintain homeostasis (Bateson, 1972). Systems theory describes "characteristics of organizational behavior for example individual needs, rewards, expectations, and attributes of the people interacting with the systems are considered in the process in order to create an effective system" (Behrmann, 1984, p. 212). Systems theory was particularly important in this study as the participants were parts of large systems seeking to understand the interactions of each and how they work on task together and maintain homeostasis.

The foundations of systems theory and Constructivism are particularly useful in this study. The study is primarily exploratory and seeks to provide an initial, in-depth description of the experiences of professionals and their interactions on behalf of IMI and their interactions within and between their respective systems.

Context

The context of the study is based on the current political and financial situation of the United States and Utah. The country is currently experiencing a recession and budgets are subject to cuts at the federal, state and county levels, as well as in private systems. Thus, participants' responses are expected to be influenced by the fear of cut programs, increased risk to IMI and society's safety.

The study's interpretation is also influenced by my own environment like current events in society, as well as the context of my own professional life and development. The study was completed as a dissertation, which is necessary for the completion of my PhD, so I put pressure on myself to finish the dissertation quickly and perfectly. I am also a MH professional who has a passion for advocacy for IMI, which is the impetus for this study. Such a background possibly influenced the interviews with other MH professionals as it may lead to collusion with their statements. It is also possible that my limited professional experience may have led to emotional or biased reactions to what is said.

Finally, the study context and justification was brought about through a pilot study that was conducted during 2009. The methods described here were used in the pilot study. The pilot results suggested that data gathered were relevant to those who participated in the study and well received by professionals in the field. Many similar themes emerged after analysis of the small pilot samples. It was thus initially theorized that a sample of 15 (five times as many as the pilot study) from each group of professionals would achieve data saturation.

Participation

Participants recruited for this study had to be either a current or former mental health or criminal justice professional, which requires active certification, credentialing, and work in their respective fields. Each participant had to have at least 6 months working within their position, unless they had extensive previous experience in their respective system. Mental health professionals (n=14) recruited for this study included

one psychologist, nine social workers, one licensed professional counselor (LPC), and one recreational therapist. The pilot study included three social workers. Participants from the criminal justice system (*n*=15) included one district attorney, one federal prosecutor, three probation officers, three corrections officers, and four police officers. The pilot study included one corrections sergeant, one legal defender, and one professor of criminal justice. Classification of participants was based primarily on their training/education first, and then by their occupation. No exclusionary criteria were used based on demographic characteristics such as gender, religion, and ethnicity.

Recruitment in qualitative studies, as opposed to quantitative studies, focuses on being purposeful and specific rather than random and representative. A snowball technique was used in order to purposefully sample populations within each system. Participants were recruited through social and professional networks. Once they were interviewed, participants were asked to recommend names of other professionals known to them who might be willing to participate as well.

Snowball sampling carries both potential benefits and risks. On one hand, snowball sampling is cost efficient and simple and allows for easy access to populations that are often more difficult to reach with other sampling techniques. On the other hand, snowball sampling leaves much to chance in terms of who is recruited; those who are sampled are dependent on those who were sampled before. There is no guarantee that the sampling was representative of the populations studied and the data may only represent a small portion of the population. Contacts might tend to hold similar perspective with the researcher. Finally, there is no way to verify the extent to which the data gathered were truly characteristic of the systems the participants represent (Castillo, 2009).

Snowball sampling, however, is appropriate for this study. As noted above, this technique is commonly used to recruit from populations that might otherwise be more difficult to reach. Many MH and CJ professionals do not allow public access to the personal information that would be necessary for recruitment because of safety protocols (not allowing for former clients or inmates to be able to find the professional in their homes). Thus, this particular method allows for access to participants who would otherwise not be open to outside contact.

As already stated, representativeness is not as much a factor in sampling in qualitative studies as it is in quantitative studies. However, to best account for potential bias that may arise in the sampling process, each participant was asked to not only recruit other professionals who might agree with the concepts brought forth in the data collection, but also to invite those who might not. Finally, an effort was made to reach as many different professional points of view as possible, i.e., recruiting from as many different kinds of professionals and from as many different agencies within each system as was feasible.

The final sample included 15 participants from the criminal justice system and 14 from the mental health system, for a total of 29 participants. This number is based on two principles: common qualitative studies and the concept of data saturation. Many qualitative studies are based on sample sizes much smaller than quantitative studies as representativeness is not as important; rather, the data must be credible, original, resonant, and useful (Denzin & Lincoln, 2005). As such, qualitative studies seek to find data saturation, or the idea that the data have become repetitive enough that the patterns and themes are readily apparent and little to no new knowledge would be gathered by

further sampling. The 2009 pilot study had a total sample size of six, and within that dataset, patterns became readily and quickly apparent. It seemed reasonable that a sample size that is five times as large would lead to data saturation to the point that not only would the themes be apparent, but that little new information could be gathered from further sampling.

Demographics

The MHPs who were recruited included 11 social workers, one licensed professional counselor (LPC), 1 psychologist, and 1 music therapist. Their jobs ranged from working in outpatient mental health, residential substance abuse, mental health hospitals, emergency departments, jail and corrections settings, and homeless outreach clinics. Of the 14 MHPs, 8 were male and 6 were female. 3 were considered as having administrative positions or experience.

Of the 15 CJPs recruited, 3 were judicial workers (attorneys or those working with adjudication), 3 were probation officers, 4 were corrections officers, 4 were active police officers, and 1 was a retired police officer who also worked as a criminal justice professor. 11 were male and 4 were female. 4 were recognized as having an administrative role.

Data Collection

Participants were invited to participate in focused discussions. Focused discussions were used because they allow for the collection of data relatively quickly. Focused discussions with small groups were used because large focus groups tend to

emphasize breadth and lose depth. To find a balance between breadth and depth, the focused discussions were limited to 1-4 participants, which allowed for greater personal depth of information from each participant.

Groups have a tendency to take on “lives of their own” as group dynamics come into play during the course of discussion. In order to account for group dynamics, an interview schedule was used to focus conversation and guide the interviews towards gathering pertinent information. The interview schedule is available in Appendix A.

Groups took place in a relatively neutral and quiet location away from work pressures and time constraints, typically on Saturdays or Thursday evenings. Participants were compensated with meals for their time. Each group lasted between 1 and 1.5 hours, as it did in the pilot study. Also, each discussion group was homogenous in terms of participants, i.e., each group consisted solely of either MHS or CJS professionals. This was done to ensure that participants could discuss their feelings and perceptions of the other system without feeling the need to censor themselves for the sake of others present.

In order to maintain ethical boundaries in the discussion groups, each participant was given a list of the risks of the study, benefits and resources available to ensure their ethical treatment by the researcher. Participants were also asked to give written consent to participate. The University of Utah Institutional Review Board (IRB) approved the study on October 15th, 2009, indicating that ethical treatment of participants was sufficiently accounted for in the study protocol.

The interview guide consisted of four sections with general questions that were used in each. The first section dealt with building relationships of trust with the participants to help them relax and feel at ease so they could share their experiences

about their respective systems. The first section helped give some context to the answers that participants provided and led to more in-depth information on the experiences of professionals in their positions. The second set of questions dealt primarily with their work, job satisfaction, and roles in dealing with IMI. This section gave context to their experiences as well as served as a path to improving relationships between the researcher and the participants. The third section of questions dealt primarily with the roles of the participants and their experiences with and attitudes towards IMI. The fourth and final section dealt primarily with participants' perspectives on both systems and where they saw gaps in services. It also identified areas where interdisciplinary work could be expanded to bridge the gaps they identified.

Given the nature of the group interactions, many of the questions were answered before a chance to ask them was given. The questions served as a general guide for the discussion, and additional probing questions were occasionally asked to gather more specific information from participants' about their experiences.

Each focus group was digitally recorded using an iPhone digital recording application. This device has been shown to be sensitive enough for the collection of data which can then be transferred electronically to a computer for transcription.

In order to control for bias and to provide a "paper trail," the researcher provided oral documentation of his experiences of the interviews and their process to serve as a reflection journal. These were collected immediately following the interviews and served to focus on the specific thoughts of the interview. The reflective recordings, which were also transcribed, allowed the researcher to air his own biases and to reference them as necessary during the analysis process. A reflexive journal, documenting the general

process of the researcher at each stage of the dissertation was also used to crosscheck researcher bias.

Data Analysis

After the data were gathered from the participants, the discussions were transcribed word-for-word and read several times over while listening to the recordings of the data. This process of data immersion was done until I was sufficiently familiar with the data and was able to question the meaning of the findings.

Analysis of the data used a grounded theory approach (Charmaz, 2006). Once immersed in the data, I began coding the data. Data immersion consisted of a line-by-line summary of the data in the study that described the content and process of what was said in each line. These initial codes stayed close to the data, describing what was said in each sentence. Each code was also simple, precise, and descriptive of each line using gerunds. The purpose of this process was to break up the data into component parts or properties, define the process of each part, discover tacit assumptions, and explicate implicit actions and meanings of the data.

Once the line-by-line description was finished, the codes then underwent an immersive reading process where they were read until I understood them well enough to begin the next process of memoing. Upon immersion into the descriptions, I wrote questions about the process and meaning of the information. Each transcript went through this process of progressive memoing, leading to the identification of 10 themes that arose from both discussion groups. These themes were cross referenced with each other in order to establish dependence, independence, and interdependence. To maintain

a sense of objectivity, my journals were periodically referenced to counter check for bias.

Once the analysis was complete, representative statements that illustrated each theme were selected and the resulting stories woven into the results of the study. Those themes were used to induce the answer to the research questions posed for the study.

In order to triangulate the data for trustworthiness and authenticity, the results were cross checked with participants and professional opinions to see if they confirmed or contradicted the findings. The results were also disseminated to professionals, including participants, to test if the conclusions resonated with their own professional experiences. Few responded, but those who did responded positively and noted that the findings seemed accurate and reflected the current state of professional perceptions in Utah.

Limitations of the Study

This study was done carefully and methodically, with every attempt made to treat all information equally and to gather all information uniformly. The study does, however, suffer from some limitations that could be addressed in future research.

The environment and backdrop of the study may make the general utilization of the theory created by this research limited in its applicability. This study was done during an economic crisis, which may have influenced the response patterns. Also, responses in this study may have been influenced by the fact that this study was done in the State of Utah, where religion permeates the belief systems of many individuals and has a strong influence on policy. Responses were also tempered by the reports of many

participants who noted that many of the policies in place in Utah on collaboration between the systems are among the most progressive in the country. Considering these factors, it may be useful to further verify the results by conducting similar studies in better economic times and in different states.

Probably the most glaring problem with this study was its sheer scope. Unfortunately, d many details as to how to improve interactions between the MH and CJ systems were likely left out. Using a qualitative study to understand two very large and complicated systems, and to try to find solutions on making them work together, was perhaps overly ambitious. To achieve greater understanding and build a better theory of systemic interactions, studies based on specific levels of interventions could be done, e.g., an ethnography or a similar study focusing only on corrections and their interactions with the MHS.

The next limitation of the study deals with the populations sampled. Mental health professionals, in my own experience, do not like to engage in scientific studies, but they do have an appreciation for them and will participate if conditions are favorable. It seemed that for CJPs this was not the case, and recruitment for them at times was extremely difficult. Some identified themselves as exceptions to the system that they represented, saying that the rest were “hard headed” and “wouldn’t care” about research or giving their opinions. Those CJPs who did participate also faced the public more often than MHPs did, and so often had to choose carefully their responses in order to protect themselves from a possible public backlash. They were, of course, informed that they would be de-identified, and most of them did open up, but there seemed to be hesitancy with this population in their responses. This hesitancy possibly skewed the results and it

is possible that, despite member checking, their perceptions are not entirely representative.

The final limitation of the study relates to who not was interviewed. I would like to think that the population of MHPs interviewed was broad enough to encompass at least a sample of each level of the MHS, but there were some whom I feel could have contributed to the study significantly who did not participate. For the MHS, no advocates for IMI agreed to participate in the study, which is unfortunate because they often directly help IMI in their everyday lives, perhaps more than other MHPs or CJPs. It also would have been valuable to interview more physicians or psychiatrists. For the CJPs, it probably would have been beneficial to include more lawyers and judges in the study. Also, it did not occur to me at the beginning of the study to include firefighters as part of the CJS, but since they were often first responders, their perspectives on IMI would also have been a valuable contribution.

With these techniques, methods, and limitations in mind, the themes can be approached with a healthy appreciation for what they do mean and what they do not. The themes presented are intended to serve the systems that serve IMI, in anticipation of greater collaboration and less recidivism for the mental health community. It is this hope that inspired the study and kept it going.

CHAPTER 4

RESULTS

The purposes of this chapter are to overview the results of the data collection and explore the themes that emerged from the analysis. The results will be presented by discussing the overall themes relating to IMI, the mental health system (MHS), and the criminal justice system (CJS). Finally, a discussion of my own processes in the data collection is provided to verify the trustworthiness of the data.

The themes presented in the data include descriptions of the professionals' experiences with IMI, stigmas understood to be associated with mental illness, the professionals' reflections on their own systems, reflections on levels of interactions they had with each other, professional inconsistencies they noticed, the question of who takes responsibility for IMI, the impact of education on collaboration, resource issues preventing collaboration, and gaps and barriers to services in the systems. Each is presented and described from the point of view of those who participated. Themes were selected by frequency of ideas or concepts mentioned by participants, as well as saliency of the ideas across groups.

One thing to note in particular about the way participants responded is the way MHPs and CJPs referred to IMI, themselves, and each other, as groups or departments, but not as individuals. For example, police officers often referred to other police officers

by the department they worked for, such as "DV (domestic violence) units," or "fire." This trend was similar in both systems. This may be because each group was generally homogenous and the questions were based on a systems theory approach, focusing more on getting general rather than specific information. This trend is reflected in the data presentation as many of the themes were colored by the perspectives of the different groups involved. Each theme is shown from the points of view of therapists, emergency department (ED) workers, judiciary workers, probation officers (POs), corrections officers, and police officers. As mentioned previously in this study, the population sampled was designed to get a broad selection of professionals from different subfields in each system. This broad array is also represented in the data presentation.

The frequency of themes was roughly equal across systems and professionals. Most of the themes were discussed by all participants, but there were a few salient themes that were brought up to varying degrees by participants. For example, problems with resources were brought up by all MHPs, but only about 70% of CJPs. Also, the impact of education on collaboration was mentioned by about half of the MHPs but about 75% of CJPs. Otherwise, the themes arose in frequency roughly equally. The issue of responsibility sharing was brought up by 60% of participants from both systems and previous interactions were brought up by about 75% of participants from both systems. All other themes were brought up by most or all participants.

These themes were developed through the analysis of primary data, which included line by line analysis and describing the information in short sentences. Ideas that seemed to get a great deal of attention from participants or were common across participants and systems were selected as themes.

Professional's Experiences with IMI

Both groups had many experiences with IMI. How MHPs and CJPs viewed IMI set the stage for how they view each other, and so this theme is presented first to provide context to the rest of the themes presented.

MHPs noted that they dealt with IMI's on a regular basis. Many of them said their primary duty was to help them. Therapists noted their role was to help clients improve their symptoms and provide systems of support to promote resiliency and recovery. They also saw their role as a teacher of life skills and socialization techniques. When describing IMI, they stuck closely to terminology from the DSM-IV. What they reported seeing most was depression, bipolar disorder, schizophrenia, delirium, and anxiety disorders. One thing that stood out for therapists was that most of them not only had professional experience with IMI, they also had personal experiences with mental illness in their families or friends. Some of their stories included family members committing suicide, overdosing on drugs, and seeing family members become homeless.

In EDs, MHPs reported seeing IMI at their worst, typically drunk, high, actively psychotic or seeing IMI right after a suicide attempt. They also noted sometimes they were attacked or witnessed IMI attempt suicide in the EDs. "I saw a guy light himself on fire in an emergency room once," reported one ED worker.

Judicial workers on the other hand saw IMI as both clients and individuals who were worthy of both compassion and punishment if they committed a crime; but they did see rehabilitation as the best way to deal with IMI. One lawyer said this about his role in dealing with IMI in the CJS: "The other thing is, that my role has been, it's been interesting because they [IMI] are very suspicious of the criminal justice system because

through their experiences they've seen how the criminal justice system has failed the people that they've dealt with on a human level. We've dealt with them more as a statistical level, right?" He notes here that his work occurred on a numbers level, i.e., number of clients served, as opposed to a human level where people dealt with "real bodies and persons." Judicial workers also saw their role as screening those with mental illnesses to try to get them to the right services and the right place in or out of the CJS. This screening process was also used to catch malingerers, but they mentioned this screening let some IMI fall through the cracks and not get the services they needed.

POs mentioned that they worked with IMI frequently and would collaborate with local mental health authorities to help them meet their parole or probation requirements. They saw their role as defenders of the public and enforcers of the rules placed on parolees by the board of pardons. An interesting fact they shared was that they also saw their role as a protective one for their clients, saying if they thought a client might be a danger to his or herself and was lacking proper treatment, they would arrest the client and put him or her in jail so he or she could be safe and get some basic services.

Corrections officers saw IMI routinely. They said they saw them so frequently that they became jaded to mental illness, despite seeing new odd behaviors frequently. They noted one of the most difficult things in dealing with IMI is identifying them when they are admitted to jail. They also noted that recognizing IMI is often difficult because drugs made people seem like IMI, and they would have to wait a few days for the drugs to wear off to see if it was really mental illness or just the effects of drugs. CJPs differentiated IMI through observing their behaviors, saying IMI would act out in a general fashion, as opposed to people who would act out against an officer for the

purpose of revenge or “acting stupid.” “There is a difference between someone who is cutting themselves for attention and someone who really wants to die,” said one corrections officer. Corrections officers also saw IMI at their worst when admitted to jails. They tended to categorize IMI by their behaviors as opposed to diagnoses “I’ve seen it all: poo players, self mutilators, delusional, people obsessed with local religion. I’ve even seen a debate between Jesus, Satan, and Joseph Smith!” remarked one corrections officer on his experiences. CJPs described IMI by their behaviors, compared to MHPs who described IMI in technical terms as outlined by the DSM-IV.

Most of the police officers interviewed were Crisis Intervention Team (CIT) trained. These police noted that they worked with IMI regularly and working with them made them grateful for what they had. One officer related the following story;

> One situation I went to, a young juvenile girl and prior to my arrival to see her, her parents didn’t want me to talk to her, fire [department] didn’t want me to talk to her, but I said I’m a CIT officer, let me talk to her. I went in there, noted things we had in common, and instantly we had a good relationship and the situation was deescalated. Fire later said, wow, you really knew how to talk to her!

Police described their work with IMI as everything from crisis de-escalation to arresting them if they committed a crime. Each officer also reported that before they had CIT training, dealing with IMI was very different and many did not know how to properly interact with them. The interviewed officers admitted there were some officers still not CIT trained and that these untrained officers often treated IMI differently and perhaps more harshly than offers that were trained. Utah is fortunate because the CIT program offered here was recently supported and encouraged by the state legislature, and in many police departments most of the officers were already CIT trained.

All participants agreed that dual diagnosis (with a substance abuse disorder) was extremely common and that the drugs, combined with the mental illness would create ongoing problems and recidivism. One ED worker said that "it is arbitrary to separate mental illness and substance abuse disorders. I'm not sure I've ever known anyone who abused substances who did not also have a mental health disorder." Another participant, a lawyer, said the following;

> When I have someone that is mentally ill, they are often a person that is self medicating themselves because 9 out of 10 times or 8 out of 10 times the infrastructure of family support and social support is already deteriorated to a point that they are just basically out on their own. Often as a result of that, because of their mental illness and they don't have access to adequate medication, they are self medicating often with illicit drugs and alcohol.

The contrast of the ways each system saw and worked with IMI is worth discussing briefly. MHPs viewed themselves as healers and protectors of IMI in whatever situation they came across them professionally. CJPs on the other hand did not see their roles as healers, but as protectors and interveners with them. MHPs described IMI in terms of diagnostic criteria whereas CJPs tended to refer to them more by behaviors.

Stigma Related to Mental Illness

Both sides acknowledged that the stigma of mental illness made work with IMI difficult. They also said that this same stigma made it difficult for them to work with each other and made the lives of IMI difficult. As one therapist put it, "The criminal justice system is hard enough as it is for people without mental illness. To deal with both is unimaginable to me."

Participants from both systems said IMI in the community who had been in the CJS had additional challenges because their interaction with the CJS disqualified them from certain programs and benefits such as mental health court. This dual stigma therefore made life even more difficult for IMI and less likely to seek services, let alone receive them. Participants also saw that the disqualification of IMI due to involvement in the CJS was largely due to fear and a sense that they should "just get over it." "They [the community] think that they [IMI] should 'just get over it.' Remarked one therapist on the attitudes the community had of IMI in the CJS: 'Why are you using up so many resources? Just get over it.' And then they lock them up in a room with the expectation that it will give them the ability to get better."

Stigma held by society at large of IMI became problematic for both systems when it came to collaboration. Stereotypes of what IMI were and the role that CJPs and MHPs had with them made for unrealistic expectations of each other, such as believing that a PO could arrest an unruly IMI at any time, and that MHPs were miracle workers that would leave IMI "cured" in a short amount of time. Assumptions about what IMI are like would then led to assumptions about both MHPs and CJPs and their roles with IMI, and those assumptions were often not based on facts.

"We dehumanize them when we use our labels: Criminals, Anti-social, Borderline," one therapist remarked. Therapists also acknowledged occasional bias against IMI, such as difficulty working with someone who is "only half there." Even those whose job it is to help IMI struggled with the idea of healing them and fell victim to the prejudices of society at large.

CJPs noted IMI in their systems were often taken advantage of by other inmates, treated more poorly than other inmates by guards, and often given stigmatizing labels without fully understanding what the IMI' background was. One jail administrator noted his goal was to identify IMI early to minimize the negative effects of incarceration on them. He noticed that because of limited resources and the influence of drugs on those admitted to jails, the process of distinguishing between the effects of drugs and mental illness was often difficult, lengthy, and would leave many incarcerated IMI waiting for appropriate treatment.

Contrasting Philosophies

Professionals from both systems were quick to point out the basic differences in working models of each other's systems. MHPs and CJPs readily acknowledged that the CJS worked with an adversarial model, or the idea that one group in a way is pitted against the ones that they work with primarily to establish and maintain dominance. On the other hand, MHPs took a collaborative approach to their work, finding unity amongst themselves and feeling like their primary focus was to improve the lives of IMI with their help.

MHPs reported feeling like their roles with IMI were to help them become more independent through creating therapeutic relationships with them and teaching them effective life skills. They saw this as a largely collaborative process where, for the most part, two equal partners worked together for a common goal. They saw that this approach was necessary for achieving results in therapy. One therapist described his role as follows: "To work as a professional in helping to guide them [IMI] in taking them

from where they are [to] where they need to be. There is no magic in psychology or psycho therapy; there's people and there's problems and there are solutions to those problems."

MHPs saw themselves interacting with CJPs coming from this similar, collaborative standpoint. They noted there were obvious differences in the way they approached each other, and that these differences caused some friction between them. MHPs felt like while they viewed themselves as different from those they collaborated with, they noted that the CJPs more adversarial stance was completely contradictory to what they viewed as important or necessary. One therapist who had worked in a prison said that CJPs suffered from a "foxhole mentality" where they saw there were so many forces that could act against them, that they were forced to take an adversarial stance to protect themselves first, then to protect the public, then to protect those who might be consumers of the CJS. He said this specifically when describing his experiences working with corrections officers and their attitudes:

> Cover your own ass. I called it the foxhole mentality. I'm standing in the foxhole, I've got my rifle trained on you, if you give me any shit I'm taking you out. Now I'll listen to what you have to say and maybe I'll put my gun down later but not right now because I don't know what he has. And I think that's true in law enforcement or a lot of law enforcement. And it's true for mental health workers too, you know they don't engage. Protect yourself first.

Noting that this starkly contrasting view of those they served was so prevalent is perhaps why some MHPs described their collaboration with CJPs as "breaking the rules."

CJPs for the most part were quick to acknowledge they did come from an adversarial standpoint. One lawyer said that the CJS is set up so that two people go into a courtroom, fight out their arguments, and the truth was supposed to "magically emerge"

from the process. While this same lawyer said that in systemic collaboration, such as in mental health court, this idea was stood on its head and a collaborative approach was used to help out IMI:

> …We're [MHPs and CJPs] working for a common purpose which is really incomprehensible to what we look at [in the] traditional criminal justice model which is an adversarial fight. Our theory is two people fight and truth somehow emerges magically out of that. That's the notion of our criminal justice system. This model [mental health court] stands this theory on its head.

He also said the idea of being adversarial was not entirely removed from the equation. He reported the adversarial model would then at times be used against MHPs in Mental health court who were advocating for the idea of clients reaching "Maximum Treatment Benefit" (the idea that a client has been helped as much as he can be helped and that further therapy would offer very little, despite ongoing problems).

Corrections officers were also quick to point out their use of the adversarial model, but said that it was a necessary thing for them, not something that came from spite. Their primary role was to ensure the safety of all people in jails and prisons, and the adversarial stance gave them the power to enforce safety when it might be threatened. "We're hard headed. It's not because we're assholes, it's because when you've been assaulted enough times, we have to put up a hard front to protect ourselves," remarked one corrections officer about his adversarial role in working with IMI.

One corrections officer noted in particular that the jail was not set up to be a therapeutic setting; rather, it was set up to be punitive. He also mentioned the roles that MHPs and CJPs take are very different and cannot truly coexist in the same individual, but said both were necessary for the well being of IMI in the CJS. He summed it up thus, "I think that it's largely cultural with the negative and positive interactions between the

MHS and CJS. There is a clash in the CJS culture and MHS cultures which are on [a] totally different spectrum, but both are needed."

Their Self-Reflections

While representatives of both systems were quick to point out the differences they had in philosophies, participants were also quick to point out the weaknesses they each had within their own systems. MHPs noted they had limitations within their own system that CJPs should be aware of and vice versa.

Most MHPs acknowledged that the MHS was often fragmented and many IMI "fell through the cracks." They criticized the system as being too reactive instead of proactive, pointing out, for example, that in order for many IMI to get the treatment they need, they have to threaten to kill themselves or someone else. Then when IMI would need help but were not willing to make those kinds of threats, the IMI would often isolate and be ignored by society at large, including the MHS. This is coupled with often fragmented communication between mental health agencies, follow up outside of the office becoming virtually nonexistent, and having to wait for the next crisis for the IMI to come back in the revolving door of the MHS to get services.

Most MHPs acknowledged the front door of the MHS was the Emergency Department; when they came to counseling voluntarily, clients often had to go through long, tedious paperwork before getting started. They noted this was challenging for both the therapists and the clients, who typically had to swallow a lot of pride just to admit they needed help, only to have to go through a lengthy paperwork process. They described it as follows:

> Mitch: You know, what's coming to my mind in addition to the whole psychotherapeutic process, there's this whole administrative process, so first they've got to call up and get an appointment. And then when they come in they've got to spend a good hour with our support staff filling out paperwork, checking insurance, signing these forms, and then we have everyone [fill out] what's called an outcome questionnaire, and they've got to fill that out.
>
> Ruby: It's pretty long.
>
> Dan: 45 questions.

Some therapists noted that this was enough to turn some IMI off to counseling. If the IMI never return to counseling, the therapist is unable to help them.

Therapists noted that when they worked in communities or jails, the providers would at times fall for the charm or manipulation of inmates. They said that they had to pay careful attention to themselves in order to make sure the client was not manipulating them. One therapist said her best clue was to pay attention to how she felt after meeting the client. She said, "If I felt really strongly that I liked or disliked the client at the end of a session then there was probably some manipulation going on that I did not catch on to while meeting with the client."

When comparing themselves to CJPs, some MHPs were quick to complain, but they also acknowledged things were getting better and they had seen CJPs respond very appropriately to IMI. They also realized MHPs come from a very humanistic point of view, and saw that many CJPs would probably not have much use for such a philosophy because it would not help them accomplish their goals of public safety in the face of danger.

Judicial workers saw a few challenges they had in their own system that limited availability of services to IMI. One lawyer pointed out the challenge of deadlines. He

said that if certain paperwork deadlines were not met, cases had to be closed and services were not provided. Secondly, judicial workers noted certain programs, such as mental health court, were limited to certain individuals, and the limitations set were politically driven. For example, in Utah's mental health court, violent criminals do not qualify for the service, but neither do IMI charged with driving under the influence of drugs or alcohol (DUIs), because if an IMI were to get into a vehicle drunk and kill somebody as a result, it would reflect poorly on the mental health court and could lead to its closure.

Judicial workers also noted being impersonal and ignorant of mental illness were frequently barriers within their own system. One lawyer said that he dealt with IMI in the CJS at a statistical level, trying to best prevent recidivism through mental health court, but expressed appreciation for MHPs who dealt with IMI at the human level and whose job it was to create hope and trust in the CJS, which had failed many IMI in the years past. Another judicial worker noted that some judges would be completely ignorant of the concept of mental illness and would throw out cases based on sayings such as "he doesn't look crazy to me." This judicial worker noted this was happening on a less frequent basis, but said it still existed in some courtrooms.

Probation officers (POs) noted that while they wanted more communication with MHPs, those same POs were not always complete in their communication with MHPs and would fail to let them know when a shared client would be incarcerated. They also noted that because of their huge caseloads, they would often have miscommunication amongst themselves about the needs of their clients, leading some to miss getting essential services. Quipped one PO: "Yeah, we always want them to provide us with good reports that are always on time, but there are times when we don't communicate

with them too, like if we arrest someone and don't tell the therapist. Later it becomes a situation where it's like 'Oh sorry, Jimmy won't be coming in to counseling for a while.'"

Corrections officers offered insight into their own system and how it dealt with IMI and collaboration. First, they saw that their own stance in prisons and jails had to be aggressive in order to protect themselves. They said this was because they often had to manage units of 64 prisoners by themselves. They also saw they were under a constant stress of budget cuts and salary freezes, minimizing any motivation to do more than maintain safety.

Corrections officers noted there were two camps of corrections officers, the "old school," which trended towards machismo and focused more on jail as a punishment, and the younger officers, who wanted to make jail more rehabilitative and more proactive towards addressing mental illness. They said that while the momentum was moving in a positive direction, the "old school" officers typically had seniority over the younger ones, which meant they were first to be promoted and keep the same punishment mentality in place. One officer said that if there were ever anything to change in the way the system works, "something's got to give at the administrative level. On the other hand, correctional officers are worried about safety and security, period." He added that even younger officers are subject to the mentality of the "old school": "[We] officers are hard headed and never wrong in our own opinion. Our environment breeds that because what we say goes."

Police officers for the most part offered less self-reflection on their own weaknesses. They did acknowledge that before CIT training came along for them, they

would never know what the role of therapists was, how to interact with them, or how to even address policy issues that become barriers for their interactions.

Levels of Interaction with Each Other

CJPs and MHPs interacted with each other on two different levels: an individual level and a systemic level. Interactions on an individual level focused more on direct practice experiences with each other, and systemic interactions focused more on professional interactions supported by the administrations of their systems. Here both are explored.

Individual

Most MHPs expressed attitudes towards CJPs that could only be described as stereotypical. They said that they based how they saw CJPs on a few experiences, and then generalized those views to others in the system. Most saw CJPs as uncaring, depersonalized power mongers whose only concern was immediate safety as opposed to long term results. One therapist related the following story:

> George: I remember a situation at [a homeless medical clinic] once where we had an actively psychotic mentally ill guy in the room. And the medical director felt threatened. I was there with her, and it's not my call to make. If she feels threatened, she feels threatened and that's that. I didn't notice anything too untoward, he was pacing and anxious and nervous. She had called the police to come for some help. They showed up with like 10 officers. They huddled outside, got the game plan, go in, and we're going, no, no, no! Not really necessary! You don't need to do this! And they were like, get out of the way. And they just, it was like rushing a jail cell man. They just surrounded and blocked off that little hallway…

> Interviewer: Which I sure made that person even more paranoid. I can just imagine someone with psychosis who is all of the sudden surrounded by police officers…
>
> George: Police officers ready to take you down. And then three days later he was back in the lobby. And it's like golly man! What, with the same problem- no meds. The exact same problem. And I was like, this sucks.

This same MHP later reiterated that he did not feel that even if he worked more closely with police officers, he would not be able to trust them or work with them because of a "machismo" they exuded. Others mentioned that CJPs were only interested in locking people up and had little empathy for IMI they encountered. One MHP quoted, "They [CJPs] like to arrest people and put them back in jail."

Another social worker said the following based on his experiences with CJPs: "I think they [CJPs] really downplay the role of mental illness in their system. It's getting better, but I don't think they understand us or our clients." This same therapist also mentioned that CJPs who did not have any training on IMI were more likely to be problematic for IMI, being more likely to mistreat them or resort to violence. Other MHPs also saw unfair treatment of particular categories of IMI, noting that ones with sex offense crimes would get harsher treatment or older IMI would get much less treatment than the general population.

While many MHPs responded in a similar fashion, there were a few who noted the CJS and certain CJPs had made great inroads towards dealing better with IMI. In particular, they mentioned the Crisis Intervention Team (CIT) training that was given to police officers, Mental health court, and the Drug Offender Recover Act (DORA, a law that allows for people charged with drug offenses a chance to get out of jail or prison early provided they attend intensive treatment with close collaboration between POs).

These were areas where MHPs expressed less stereotypical views of CJPs and generally felt better about their roles in working with IMI.

MHPs expressed gratitude for officers who would protect them when they were attacked or threatened in EDs. "They've saved my butt a few times," quipped one ED worker. They also reported that some officers showed unacceptable attitudes towards IMI and would publicly mock the IMI or use excessive force on them. Another simply put it, "Some of them do a really good job, and some of them do a really poor job, usually when they see a big power differential or are on some sort of power trip." One ED worker discussed his distaste for "jail dumps," where the jail would simply send an IMI who was incarcerated because the jail was too full. This would usually result in resentment towards CJPs because of the shifted responsibility and lack of communication.

Lawyers frequently collaborated with MHPs and said that, for the most part, the collaboration was helpful and necessary. One lawyer described MHPs as "the Mother Teresas" of society because they would work with the real human and the problem, typically for low pay. Judicial workers noted at times that their relationship with MHPs was adversarial because it was the nature of their work in the courts. In mental health court, lawyers saw MHPs as integral to the way mental health court worked and stated that the close collaboration in the mental health court created MHPs and CJPs who were experts in each other's systems.

POs said they frequently experienced gaps in what they knew about MHPs and what their roles were. They requested more communication with them, as well as cross education about what MHPs can and cannot do. They reported imagining that MHPs

with multiple credentials resented getting orders from POs, who had nothing more than a high school diploma, on what to do with their clients. POs feared at times that IMI would not get the services they needed from MHPs who were just trying to get them out the door. They saw that MHPs did not like to share necessary information in a timely manner because they did not like to see IMI get arrested. "They don't want to see the incarceration process. They want to see everything as rosy and not recognize when arresting them might be the appropriate response," was the description given by one PO on how MHPs reacted to working together with shared clients and why he thought they did not share information as readily and quickly as they could.

Correctional officers said their interactions with MHPs typically were with the mental health workers in the jail. They noted most of their interactions with MHPs would be in crisis mode, therefore not allowing for collegial relationships to occur. They noted that despite efforts to be proactive in taking care of IMI in the jail, there are simply not enough MHPs to go around. While some noted that MHPs were easy to work with generally, there were instances in which they were not helpful. "I don't know if the jail hires the cheapest mental health help they can get, but our officers often joke about how loony mental health is," joked one corrections officer. Corrections officers described times when there were new MHPs in the jail and training them all was difficult. Sometimes, MHPs would make decisions that would make corrections officers scratch their heads. For example, one corrections officer said MHPs would sometimes let IMI stay in the general population when their clear behavioral problems made it a danger to the IMI to be anywhere but the MH section of the jail.

Police officers said they worked with MHPs occasionally and that before CIT, they had no idea what the roles of MHPs were and what they could do. One said at first he had animosity towards them, but eventually saw them as working together on the same goals, just in different ways. After CIT training, they disclosed they were much more willing to collaborate with MHPs.

All participants were well aware the CJS treated and cared for more IMI than the MHS did. In general MHPs saw CJPs as overworked and sometimes on a power trip; some CJPs acknowledged this and agreed. CJPs, on the other hand, saw MHPs as useful and important partners, but felt they were sometimes inconsistent and "soft," which led to difficulties trusting them in general.

Systemic

There were three ways in which the CJS and the MHS would interact. There were (1) programs that worked closely together and worked well, (2) programs that had loose collaboration with mixed results, and (3) programs with little to no collaboration where MHPs and CJPs were mostly estranged from each other.

Participants identified three programs that were consistently spoken highly of and identified as examples of how MHPs and CJPs could work together for greater benefit for IMI: Mental health court, the CIT program, and the DORA program. Participants noted these programs involved systemic collaboration showing significant benefits to clients. The relationships between MHPs and CJPs here were typically good and collaboration was natural. One MHP noted how all of her DORA clients graduated their counseling programs due to close collaboration with POs. She said, "All these probation officers

from DORA, they had this close connection with us. They come to our staff meetings every month, all the probation officers, and we would discuss cases…. It would make things very clear. That program was very successful. Nobody dropped out; I don't even think anyone relapsed." Most MHPs and CJPs noted mental health court was hugely successful and were aware that studies backed up its effectiveness. Any MHP that had worked with a CIT officer noted it was a good experience. Most MHPs contributed the CIT program for the positive changes they saw in the CJS and CJPs' improved ability to work with and protect IMI.

There were three areas where MHPs and CJPs collaborated loosely, resulting in mixed benefits to IMI and each other. These were the interactions between therapists and POs, between corrections officers and therapists, and between state hospital forensics and the courts. Therapists and POs observed that when good collaboration happened between them, clients got better more quickly. But they noted there were particular problems because communication was often inconsistent, vague, or had limited use. When both parties felt overwhelmed with their work and clients, the collaboration seemed almost like it was just "one more thing to do," and the collaboration seemed "more symbolic than personal."

In the jails and prisons, it seemed as though the MHS and CJS were simply two different systems housed in the same building and the only interaction that took place was in crisis modes. This crisis mentality coupled with a lack of understanding of the needs and goals of each other led to strained relationships and frustration. One corrections officer said, "There are some [CJPs] who feel like the mental health staff really don't

help much when dealing with a crisis or on a routine basis because they don't see what they do."

Forensic hospitalization and the courts also seemed to have little interest in doing little more than making IMI in their system able to be held accountable for their crimes and would only work towards that goal. While this may seem to be an effective way to collaborate, due to the narrow focus of their efforts, many clients were simply discharged without appropriate services to prevent them from recidivating. One therapist said this about the way forensic units at the state hospital work:

> I have a problem with that. They have this idea like in the forensic unit they might say: "Ok we are going to treat you, we are going to help you, and then we are going to put you in jail as if you had been mentally sane when you committed the crime." I think to myself "Well if they were mentally ill when they committed a crime, should that not be taken into account? And yet no, they are saying, "We will treat you and help you with your mental illness, then we will convict you as if you had been mentally sane the whole time. I have a big problem with that, and unfortunately it is just the state of our current system.

Where there was little or no collaboration was in noncourt mandated counseling and in EDs with the police and corrections. In EDs, the collaboration between the MHS and the CJS seemed to be little more than a delivery service for clients or security for the hospital. There seemed to be little direct communication or collaboration for the sake of IMI, leaving one system to deal with an IMI until they could be passed along to the next system. In cases where IMI were in the MHS without the intervention at any point of the CJS, MHPs were completely cut off from CJPs, tended to avoid them, and were more distrusting of what their roles might be with their clients. In both cases, isolation and shifting responsibilities led to misunderstandings and distrust with no direct benefit to IMI other than what each system could offer them independently.

Chronological and Professional Inconsistencies

The biggest frustration expressed by participants was that working with each other was usually inconsistent, both in terms of time and quality, which made good collaboration difficult. Both MHPs and CJPs also noted working with each other was difficult because of variations in experience, education, and general openness to collaboration.

MHPs expressed that when there was little or no two way communication with the CJS, they felt cut off and had a poorer point of view about CJPs. This point of view may be due to the fact that limited interactions did not allow for personal relationships to be created, something mentioned by MHPs to be highly important in their work environment. On the other hand, some MHPs noted when there was consistent, systemic interaction, they worked well together. “Communication. Like I said if we work on many cases, having a meeting like we had before with DORA, [where the POs and therapists would meet regularly] that worked so well,” stated a therapist about what would make working together easier. Some also expressed frustration about how slow some CJPs, like POs, were in responding to requests.

MHPs in EDs alleged that some security personnel and police officers were great, but that some were on a power trip and did not help IMI much. For example, two separate ED workers expressed gratitude for security and police at hospitals who would keep them safe from dangerous people or who would quickly intervene if attacked. But they also said some police use excessive force to bring violent IMI down, frequently causing more injury to the IMI than necessary to control them.

Judicial workers shared frustration about the ethical inconsistency of some MHPs. One lawyer said that some MHPs would do a great job assessing IMI and others were more interested in pleasing the lawyers. When they did work with good MHPs, lawyers reported enjoying it and made a point to continue working with them.

POs noted inconsistency with some therapists as well. They said some were very good and provided detailed reports, while some would give few and often vague reports. “One of the biggest problems I had in Salt Lake was not getting reports on time, not getting quarterly reports.” Another said, “Probably what happens most commonly with me is I’ll have to make that first contact with whoever the provider is, and I don’t usually do that unless I need something. [laughter]… I find that a lot of providers don’t know exactly what we do, and they sort of expect us to be miracle workers.” POs requested MHPs spend more time face-to-face with them to improve their relationships, communication, and clarify expectations.

Corrections noted more inconsistencies amongst themselves, stating every officer was different, where some were very strict and some were very lenient. They said the ones who did best were the ones that got to know the inmates. One corrections officer who worked in juvenile care complained that mental health services were not even present in many cases: “The corrections center I work at doesn’t even have any [mental health services]. You have to go to secure care to get any kind of mental health service.”

Police noted they created long-term relationships with MHPs whom they trusted to do good work for them. They noted some, mainly private MHPs, were less trusting of police and would not collaborate well with them, often hiding behind the Health Insurance Portability and Accountability Act (HIPAA), which is used to protect people’s

health information. This frustrated police officers who are CIT certified because "HIPAA, the way it is written, is not designed to hide information, it was designed to share information. But unfortunately most mental health providers interpret HIPAA where it says that information 'may' be shared, but does not say 'shall' be shared; they interpret it as 'won't' be shared."

Who Takes What Responsibility?

"Society doesn't care, as long as it's not my problem," said one therapist summarizing the responsibility people take for IMI in the community. There were multiple instances where responsibility for the care of IMI in both systems was passed off to the other for a number of reasons. This "dumping" of responsibility tended to create tension between the systems, and understanding how and why this happens is important step to overcoming obstacles to collaboration.

Tensions due to "dumping" were seen frequently between therapists and probation officers. When a client had both a probation officer and a therapist working together due to a crime committed by the IMI, the MHP and CJP would frequently defer to each other whenever there was a behavioral problem. The probation officers, for example, would have clients experiencing difficulty keeping the terms of their probation and would refer them to therapists to "fix the problem." One therapist said: "They [POs] give us clients, ask us to fix them and give them consequences, when that is not our role." Similarly, therapists noted that when they worked with probation officers and their clients would have a behavioral problem, they would be quick to push the problem back to the probation officer, again saying "He's not compliant. Arrest him." The most frustrating

aspect of this interaction was that neither MHPs nor CJPs were aware of the processes each other had to go through in order to sanction or address behavioral problems. Therapists and POs requested further education about each other in this regard so they could communicate more effectively and share their responsibilities more fairly.

MHPs in EDs were especially quick to point out their distaste for having the care of an IMI "dumped" on them from the CJS. MHPs who worked in EDs noted especially that they would get what they referred to as "jail dumps," when the jails were overcrowded and someone was having a mental health problem. They then noted that once IMI were in the ERs, they would go through a "shell game" where they would be transferred from one place to another, shifting responsibility on to someone else after they had done their part. They noted this was frustrating for MHPs and clients. One therapist stated his perspective on shifting responsibilities: "Well I think mostly it comes down to shifting responsibilities. I think sometimes we as humans do not like to do anything that we do not have to do. I think if we came to be more centered on the needs of the patients other than ourselves… we might get somewhere."

On the other hand, CJPs, especially corrections officers, discussed their reasoning behind "jail dumps" and their dependence on MHPs in the jails. They said they always took the safe road with IMI in the jails, because if they hurt or killed themselves, the CJPs could be held criminally and civilly liable for damages. One correction officer put it this way: "Our job is to keep them safe. When we have a prisoner that has filleted his arm open and needs to go to [the] mental health [unit], we want him there to keep him and us safe. It's frustrating when that happens and Mental Health [professionals] clears them to stay [on the original unit]."

Other corrections officers noted their number one priority was always safety and that all other programs, be it mental health or education, had to be subject to that priority. This caused frustration when corrections officers dealt with MHPs or volunteers, who came in with good intentions but prioritizing healing over the safety of the inmates, which would leave the corrections officers liable for damages. An example of this was volunteers allowing certain inmates to have a pencil, which could then be used as a weapon.

Finally, regarding “jail dumps,” corrections officers said it was true that they had limited space in the jail and they would sometimes have to send people out of jail early, especially if they had an influx of inmates with more serious charges than those who were already in the jail. They noted that when IMI were out of jail, the jail had no duty to follow up with them, and so it was better to send IMI who did not have any other resource to EDs where they would at least get referrals to appropriate treatment. “Even when the economy is good, there is no way we can increase mental health on our units. I don’t know what the solution to that is,” remarked one corrections officer on how difficult it can be to manage all the IMI in the jail.

Where there was more intensive and systemic collaboration, this theme of who takes responsibility did not emerge. For example, judicial workers who were instrumental in mental health court saw that IMI who were in the CJS and MHS were worthy of both compassionate treatment and justice if they had committed a crime. Participants who worked closely across systems saw a shared responsibility for IMI between the CJS and MHS. MHPs and CJPs said they worked closely together, whicn

helped them to understand each other's language and roles, and led to effective collaboration and positive results for IMI.

The Impact of Education

In general, education played an important role, not only in the way that MHPs viewed CJPs, but also in terms of how they viewed the CJS. Those with more formal education and experience were more forgiving of each other and accepted that variation in professional skill was a normal thing. Those with less education and experience were quicker to point out stereotypes or to resent those with more education than themselves. Both sides consistently requested more education about what each other does so they could communicate more effectively.

Some MHPs noted there were still many unknowns about the duties and abilities of CJPs. "It's like, we just don't know what each other can do because we're not communicating," said one therapist. Particularly, MHPs wanted to know who had what powers and how long it would take to apply those powers on behalf of IMI in the CJS. Other MHPs wanted CJPs to better understand the roles MHPs had and show more respect to the IMI with whom they worked. They were particularly fond of the CIT program and wanted to see more CJPs trained in it.

Lawyers, as noted before, were able to view many of the intricacies of both the CJS and MHS where other professionals from both systems did not. This view was likely due to their education and experience in working with both systems. Judicial workers noted close collaborations with MHPs and the experiences of working with MHPs left

them feeling highly educated about the MHS and the roles of MHPs. Regarding mental health court, one lawyer said:

> So the therapists play a very integrated role, because they play a co-equal complementary role at least in the model that we have… and the irony is, I have them talk to me about taking this person to jail while I as a prosecutor am talking about treatment compliance issues, so the rules are starting to meld as we become experts in each other's concerns and we're looking at the client or the defendant as a whole person and coming up with therapeutic options that we can step into the others person's shoes and have this conversation when the other person forgets to have that conversation.

POs noted that education beyond a high school diploma was not necessary for them and education only benefited them because it helped them do better paperwork. One PO described the way education was approached by the CJS: "There is no economic benefit to an education, and so eventually you'll lose that in your workforce." This same probation officer noted, "The biggest problem that I've run into is if there's not a lot of education, or if that person [MHP] doesn't have a lot of experience with [probation] and tends to view us with negativity or hostility or as part of the law enforcement brigade who is just trying to take their client down; they'll view themselves as a kind of prophylactic between 'their client' and 'my offender,' and won't share information with me until it is too late and I have to arrest [the IMI]."

Corrections noted as well that those with more education worked more effectively with inmates, especially IMI, but they said education was not necessary to advance in rank. Both said they lacked education on the roles of MHPs and wanted to learn more about them. "It would be very beneficial to educate us, to have greater maturity and better education in our staff, so that being in jail is more than just punishment," remarked one corrections officer.

Police noted those who received CIT training made better police officers and safer streets. They also noted that better education of therapists about what police officers could and could not do would make collaboration easier, mainly because it would allow for better communication and expectations of roles.

Resource Issues

Limited resources provided the backdrop for the entire study because it was on everyone's mind. The current study took place during the "Great Recession" that began in late 2008. Across the board, MHPs noted that a lack of resources inhibited the creation of good collaborative systems. Additionally, each group interviewed expressed some anxiety at the risk of budget cuts, further limiting their security in their own jobs and their ability to provide services to those in need.

Therapists in particular noted the biggest problem they saw with their own system was that at the core it was designed to make money more than to help people. One therapist, an administrator, noted that if the mental health system was ever to provide adequate care there would need to be a cultural shift in perception of mental health, including overcoming fears for public safety and providing appropriate resources for those who cannot take care of themselves. What funding is available to help is always limited, making access to services difficult. When IMI were admitted to EDs, decisions regarding their treatment were largely based on their ability to pay or their insurance, leaving the more severely mentally ill individuals who did not have funding to get only basic services, be turned away, or dumped on another system.

One therapist summed it up as follows; "There are never enough resources. That has always been the case throughout my career." Most MHPs agreed that where there was good systemic collaboration, money was saved (by reducing recidivism) and clients were helped in extraordinary ways. One therapist who worked with DORA noted the success she had when she had this collaboration, claiming 100% of her clients successfully finished their treatment. Many of the MHPs interviewed shared their frustration with the fact that although there is good work being done with each other and money was being saved through that collaboration, there was never enough time or money to invest in collaborative programs.

Judicial workers noted a different side of the funding issue and how it affected their work with IMI and MHPs. They said limited mental health resources created large waiting lists for clients, delaying their treatment and putting their judicial cases at risk due to unmet deadlines. They also noted consulting with MHPs for their cases was costly and would typically burden either the CJS or the IMI, depending on who was paying for the treatment.

POs simply noted they were so frequently overworked with large case loads that they rarely had the time to put in the appropriate effort to collaborate. Funding affected them too because there were never enough POs to handle each case effectively.

"Even when the economy is good, there is no way we can increase mental health on our units. I don't know what the solution to that is," said one jail administrator. He noted that despite efforts to increase awareness of IMI in the system and providing classes to help them out, it was never enough, the classes were always full, and they could not reach everyone they needed to.

Police noted that lack of funding created more of a problem for MHPs than it did for them. They saw the difficulties faced by MHPs in providing funding leading MHPs to decisions that would shift the responsibility of a client from the MHS to the CJS. For example, if an ED worker was faced with two patients who posed a threat to themselves or others due to a mental illness, and one of them had insurance and the other did not, the one with insurance would be treated and the one without would likely be left to the CJS. A police officer summed up this situation:

> Funding comes down to the bottom line. I mean when you start talking about that you have such a large unfunded population, I mean, what are you going to do with this? So, now you start getting into the situation that nobody really wants to pick them up because they are not funded. So, all of the sudden, you have a limited amount of bed space, and you have a lot of people rolling in, and you have to start making decisions on who is going to get a bed. And then from there, you've got two people that need a bed-- this one has money, this one does not. Who's going to get that bed?

Gaps and Barriers in Services

Participants were quick to point out the problems that existed between the two systems and brought up how these problems affected IMI. For example, MHPs and CJPs noted that due to an IMI's involvement with the CJS, he or she would not qualify for certain MHS benefits, including mental health court if he or she had a driving under the influence of drugs or alcohol (DUI) conviction as mentioned previously. They also saw barriers in terms of how IMI were seen (drug abusers or mentally ill or both) and the fact that many come from poverty, which makes them less likely to be able to take care of themselves before going into the CJS, and much less likely when they get out.

MHPs saw problems in their own systems and said getting IMI into treatment was only half of the battle. They would then have to contend with keeping them motivated to

stay in treatment and follow through with it. Said one therapist "And then in terms of big overall process I think – I don't know if this is just me thinking out of the top of my head—but I think we have a certain percent of people that come in and they're just not going to take, and they only come maybe once or twice and then they drop out." This interpersonal barrier made it difficult for MHPs to provide care that maximized IMIs' ability to be independent. MHPs also expressed frustration at access to care, noting insurance companies made getting mental health services difficult, and the process of working with insurance was tedious at best.

Two therapists related stories of IMI discharged from jail, after midnight, out on to the street with little more than the clothes on their backs and a week's worth of medication. They said this was a perfect recipe for recidivism, where the IMI, now without a home, structure, or means of transportation, is left to fend for himself or herself on the streets, leading in turn to treatment noncompliance, drug use, and, eventually, crimes or odd enough behavior to get them "locked up" or hospitalized again. These therapists said a good step down program would help bridge this gap.

MHPs also noted there was a real problem with IMI who isolate. One group of therapists said there were many IMI who never came back for services and the MHPs could only hope that the individual actually got better. Usually it just meant that the IMI learned to hide really well through isolation, meaning MHPs would have to wait for IMI to have another crisis before they will be helped again. Therapists who worked at the state hospital said that this effect was mostly driven by the stigma of mental illness and the desire of those who have it to be left alone, or out of the belief that they are unworthy of help.

Judicial workers on the other hand complained that the biggest barrier they see in collaborating with MHPs is the strict rigidity of the CJS, especially at the federal level. While state and county level courts could actually develop creative procedures to improve collaboration, this collaboration was still limited by the adversarial roles that were frequently played out in the courts themselves.

Another judicial worker noticed a gap in services for people with traumatic brain injuries, stating that there simply were no services for them:

> One of biggest gaps right now, on a small intimate level, is traumatic brain injury (TBI) offenders. …Especially now that we're getting some [veterans] now that are coming back with some TBI, that are documented with PET scans and brain scans and their brainwaves are different, and there are no services. And do you put someone like that who is very impulsive, not necessarily criminal, but impulsive in their reactions to the things going on around them in prison? Is that going to teach them to be less impulsive because their brain is now changed? It's not likely. That's a huge missing piece. There is nothing out there for TBI.

POs simply noted the biggest barriers they came across were everyday life and policy. They said they typically would have between 80-120 cases they would have to take care of and that left little time to talk to MHPs about their cases. Even when communication was warranted, MHPs and CJPs said the process was often tedious and time consuming. POs also complained that when releases of information were not in place, information exchange between therapists and POs could not happen.

Corrections saw lots of gaps in services for IMI, from the moment they walked in the door, to the moment they left the correctional setting. One of the first things they noted was frustration at obtaining knowledge about IMI when admitted to jails or prisons. They said many IMI would follow a similar pattern when they were incarcerated. First, the IMI would go off of their meds, then commit a crime, and then be incarcerated. Once

incarcerated, there was no way to independently verify if they were on medications, let alone find out which one they were using. This created a continuity of care issue that was prevalent throughout the corrections system.

Once admitted to jails, administrators took proactive steps to identify and care for IMI. However, this was subject to limited resources. A jail services coordinator said this about the services offered in jail: "We need more. We need more services. Right now we're limited to about a quarter of the jail's population that we can reach with the various [programs]… and that mostly has to do with security levels. We focus mostly on minimum security prisoners and again it's because we have civilians teaching most of these classes." This, too, was always subject to cuts in services and funds. Perhaps because of this, corrections officers also expressed frustration with the mental health services they did have. Corrections officers said that when there was a crisis on their unit, they would sometimes have to wait a long time for the MHPs to intervene. This delay was described as possibly being due to both systems in the jail being overwhelmed and underfunded.

Corrections officers also reported they were frustrated by the fact that MHPs in the jails and CJPs do not understand each other's needs very well. The officers requested they be better educated as to the needs of IMI and to the duties of MHPs. They also requested MHPs take into consideration that corrections officers, above all, are always interested in safety first, and all other things in the jail have to be subject to that. "Something's got to give at the administrative level [to make a change], remarked one corrections officer regarding how he thought collaborative efforts could move forward: "On the other hand, correctional officers are worried about safety and security, period."

Corrections officers said this change in structure at the administrative level would be necessary because jails and prisons are set up to be punitive, not therapeutic.

Finally, corrections officers noted that when IMI were discharged from jails and prisons, there needed to be a better continuum of care that would follow them. A corrections programmer noted that while some IMI would receive treatment in jails, the treatment they received out of jail was just as, if not more, important. He noted that his own research showed that if they received treatment outside of jail, IMI were less likely to recidivate, but there was no quick or easy way to get them to follow up with treatment. He also noted those who did not receive follow up would frequently come back to jail, often for the same reasons that brought them there originally.

Police officers expressed their greatest frustration was in dealing with EDs. They said the EDs were the front doors to the MHS, but they rarely coordinated with each other, which left the front door system fragmented. One police officer, identified as an administrator, noted he knew of a client who had been committed to three EDs in 24 hours due to this lack of coordination. Police officers suggested the creation of a receiving center managed by the local mental health authorities to serve as a kind of psychiatric ED, from which IMI could be sent into coordinated systems of care.

Police also noted the way the Health Information Portability and Accountability Act (HIPAA) (US Department of Health and Human Services, 1996) was interpreted by many MHPs was a barrier to collaboration. One police officer shared the story of a situation he was involved in where an IMI was barricaded in his house and was surrounded by SWAT officers with multiple guns trained on the house and the IMI. This officer tried to communicate with a local hospital in order to get information on the IMI

in order to de-escalate the situation. The hospital, however, citing the lack of a release of information, said they could not confirm or deny any affiliation with the IMI. The officer then had to explain to the hospital worker the law did permit the sharing of information in this case because there was a potentially deadly crisis going on with this IMI. Eventually, through this education, the information was shared.

In conclusion the data analysis based on the focused discussions yielded these 10 themes: experiences with IMI, stigmas associated with mental illness, contrasting professional philosophies, the professionals' reflections on their own systems, levels of interactions they had with each other, professional inconsistencies they noticed, the question of who takes responsibility, the impact of education, resource issues, and gaps and barriers in the systems. Each of these themes has important micro, mezzo, and macro implications which will be explored in the next chapter.

Triangulation

In order to preserve my own ability to ensure the trustworthiness and authenticity of the data presented, I kept detailed logs of my processes in the creation of this study. I also pursued member checking to see if those who participated agreed with the findings of my study. Here, reflections of my own process and the feedback of participants are explored to show the quality of the data and findings. My own history of work with IMI is also presented to give context to the motivation of the study and close the framework of the research.

Self Reflection

In the process of collecting data, researching, and writing this study, I experienced the full range of emotions from sadness, to rage, to joy. There were times when researching this topic caused a sense of sadness due to the plight of IMI in the CJS, but mostly it came from a sense the topic was so large that I was afraid I would never finish my research analysis. I felt fear at times that the study would not yield results worth reporting on, and also felt joy every time I coordinated a new focused discussion. Every step towards completing this study was filled with some emotion about the potential of the study and as it ends, I am filled with a sense of relief and curiosity as to its potential.

My points of view of MHPs interviewed seemed to vary little. For the most part, I identified with them, had an intuitive sense of where they were coming from, and was able to enjoy camaraderie with them through a shared language. Perhaps the biggest threat of this connection was I felt that my intuitive understanding may have led me to impose my own experiences on the data. I think that this would be natural, but in order to counter this, the results were revised several times to identify where I was putting my own words into the results, and not the words of the participants.

On the other hand, my reactions to CJPs varied a great deal. My reactions to them were mostly positive, never dull, and always educational. I shared no common frame of reference with them, so I had no other choice but to report on what they had to say versus my own experience. I think what surprised me most about meeting some of them was just how strong and positive a reaction I had towards them, given that I was subject to much of the same bias my peers in the MHS demonstrated. One corrections officer and I seemed to just "hit it off" as if we were long lost brothers. One of the lawyers left me

star struck by his eloquence, education, and mature perspective. Ironically, I tried to take this into account when analyzing their data and found that I wanted to pay a little less attention to their reports than those I did not have such a strong reaction to. I'm not sure why this turnabout was the case. I took this into consideration when analyzing their data and found my extreme caution about my strong emotional reactions to them required me to analyze their reports more than the others. Otherwise I would have ignored a lot of details as to what they had to say.

There was one instance where I had an epiphany about the work of corrections officers and how it correlated to the MHS. As I listened to several corrections officers describe their jobs, I found I could relate because of my past experience as a psychiatric technician. The descriptions of their jobs sounded eerily similar to my own work experience maintaining the safety of IMI in psychiatric hospital units.

Another epiphany I had when interviewing police officers was the way HIPAA influences practice. As a clinician myself, and having worked in the MHS for several years, I know HIPAA means that private health information is shared only under some extreme circumstances such as when clients threaten to kill themselves or someone else. As a clinician, I always saw this as a one way street where I could share this information with a police officer if I saw an emergency, but not the other way around. I realized that if a police officer was dealing with an emergency situation with a client instead of the MHP, the officer would still qualify under HIPAA as able to receive information about the client. This thought had never occurred to me and it broadened my understanding of when client information could be shared.

The last epiphany I had about the study came from a focused discussion with an ER worker and a therapist. They spoke of times of close collaboration and the ability of therapists to provide positive reinforcement for IMI and the CJPs were able to provide corrective actions for IMI, when they "messed up." I realized having both sides working together made compliance with treatment so much more effective because clients had incentives to go to treatment and work on getting better and disincentives to let themselves slide or relapse. I came to the conclusion that this is likely why collaborative processes in the two systems resulted in higher success rates.

Finally, in analyzing the data, I saw a wide range of attitudes and experiences of MHPs and CJPs towards each other. I met therapists and CJPs who wanted nothing to do with each other and saw that they could never peacefully coexist. I noticed others who saw collaboration as a basic, integral part of their work. Three factors seemed to emerge as being predictive of whether or not MHPs and CJPs would be able to see each other positively: education, experience, and proximity of collaboration. Those with higher education, more education on the roles of the other system, more experience in their own fields, more experience collaborating, and who were closest to the other system tended to be more forgiving of faults, and would think more highly of the other system. Early in the study this seemed to be an artifact of those in administrative positions, but further analysis showed that three factors accounted more for the differences in perspective than administrative positions did.

My Own Experiences with IMI

I have been a mental health professional for 10 years at the time of writing this dissertation. I began working at a phone crisis center where IMI would call regularly asking for help finding treatment, quitting smoking, or handling a crisis. At first this job thrilled me as a student interested in the human mind, but I eventually burned out as the people on the other end of the line became nothing more than disembodied voices calling to bother and dump their emotional baggage on me.

In my next job, I was privileged to work as a psychiatric technician at a local psychiatric hospital. When starting there, I immediately had an eye opening experience where I learned that all those disembodied voices with diagnostic labels were actually real people! Not only were they real, but most of them were genuinely good people with the same kinds of hopes and dreams as any other person. This realization made me care more for their plight and gave me the belief that they could also live full, healthy lives.

After about a year of working at the psychiatric hospital, I noticed that some of the IMI who came to the hospital previously had committed suicide, while some were incarcerated. If neither of those things happened, they frequently came back to the hospital. Many times, this was a bittersweet experience. On the one hand, I enjoyed the company of many of those individuals, but on the other I was sad to see them coming back through the "revolving door." It was also difficult to see how some of them changed after being exposed to the CJS. Many became more paranoid, many lost what little support they already had, and many more simply would not trust anyone anymore.

The changes that IMI went through in the MHS and CJS with the revolving doors saddened me and made me want to do something more. I heard of programs such as CIT

and mental health court and saw that these kinds of collaborative services set up between the MHS and CJS were hugely successful. I began this study hoping to see if there was more that could be done, and hoping the results would eventually lead to a better life for IMI everywhere.

CHAPTER 5

DISCUSSION

The purpose of this chapter is to review the results of the data briefly, discuss implications for theory and practice, and discuss respective recommendations for micro, mezzo, and macro practice. The inquiries of the study are also overviewed briefly as well as directions for future research.

The 10 themes that emerged from the research were:

1. The mental health professionals (MHPs) and criminal justice professionals (CJPs) experiences with individuals with mental illness (IMI)
2. The stigma related to mental illness
3. The contrasting philosophies between the two systems
4. The self-reflections of professionals from both systems
5. The different levels of interactions between the MHS and the CJS
6. Chronological and professional inconsistencies between the two systems
7. The question of who takes responsibility for whom in each system
8. The impact of education with MHPs and CJPs
9. Resource issues experienced by both systems
10. Gaps and barriers in services for IMI

Each of these themes brings forward relevant information and suggests recommendations for micro, mezzo, and macro practice. For the sake of simplicity, micro practice can be defined as levels of service that include everyday work done by professionals in their corresponding fields. Mezzo practice is defined, for the purposes of this study, as education provided by universities, academies, and other areas of learning. Macro practice is here defined as policy and administrative work, aimed at changing systems.

There were three overarching themes that stood out as being the most relevant factors predicting the perceptions of MHPs and CJPs of each other:

1. *Education*, which comes out of the themes of educational impact, contrasting philosophies, and self-reflections.
2. *Experience*, which comes out of the themes of experiences with IMI, stigma of mental illness, and levels of interaction.
3. *Proximity of work*, which comes out of the themes gaps and barriers, questions of responsibility, inconsistency, and resource issues.

It seemed those who perceived the other professionals best, or most maturely, were those professionals with higher education levels, more experience, and proximity to working with the other's system. Where education was lower, professionals were less experienced, or only had few interactions with each other; the perceptions were poorer, less forgiving, and more steeped in stereotypes.

The common thread or singular variable that emerges from these three factors is that of knowledge, whether gained formally, personally, or passively. The more MHPs and CJPs knew about each other, the more likely they were to be more open to collaborating. The idea that knowledge is the key factor in making change is

encouraging because knowledge can be shared, taught, and built upon. In the following section the recommendations for ways to impart this knowledge will be presented.

Implications for Change from the Themes

Each theme has a variety of potential implications for change on micro, mezzo, and macro practice. Each theme is briefly reviewed with recommendations. Figure 1 describes which levels of practice have potential areas of growth by theme. They are organized by importance, following the thematic order in Chapter 4.

Experiences with IMI

Professionals from both systems had interacted with IMI at some point in their careers. This topic held high importance for all professionals interviewed, and participants from every group mentioned this theme. For MHPs, this interaction defined their work and, as professionals, they would use technical terms to describe IMI. On the other hand, CJPs would have varying interactions with IMI and would describe them by their behaviors. This tendency to describe IMI by behavior was likely due to the fact that CJPs professional careers were not based on having technical education about IMI. MHPs related both personal and professional experiences with IMI, and CJPs focused more on professional experiences. Finally, MHPs saw their roles with IMI as healers and advocates, whereas CJPs viewed themselves as protectors and interveners with IMI. This concept has micro and mezzo implications for improvements.

Table 1. Thematic Implications

Themes	*Micro*	*Mezzo*	*Macro*
Experiences with IMI	*X*	*X*	
Stigma of Mental Illness	*X*	*X*	
Contrasting Philosophies	*X*	*X*	*X*
Self Reflections		*X*	*X*
Levels of Interaction	*X*	*X*	*X*
Inconsistency	*X*	*X*	*X*
Question of Responsibility	*X*	*X*	
Impact of Education		*X*	*X*
Resource Issues			*X*
Gaps and Barriers	*X*	*X*	*X*

The recommendations for micro practice begin with MHPs and CJPs recognizing the differences in language they will both have when describing IMI. MHPs are naturally going to describe and refer to IMI by professional standards due to the way they are trained. CJPs, on the other hand, are likely to describe IMI by their behaviors unless they are trained otherwise. This difference in communication might upset MHPs, especially if they related to or have friends who are IMI because such descriptions are often viewed by MHPs as dehumanizing. It is important to recognize that the roles MHPs and CJPs have

with IMI are very similar and appreciating those similarities might make collaboration between each other easier. If these ideas are kept in mind when MHPs and CJPs interact, perhaps the friction between them could be lessened. This kind of change could be easily implemented by individual practitioners from both systems preparing to account for differences in communication before initiating or engaging with each other, e.g., thinking to themselves that "this person from the other system will describe the IMI in question differently than I; that is okay, normal, and a part of their training and function."

Mezzo practice should include teaching the different perspectives MHPs and CJPs have. The more MHPs and CJPs know about how the other is going to view IMI, the more forgiving they might be towards each other. If MHPs and CJPs are trained to recognize these differences early on, collaboration in the long run would likely have fewer hurdles to overcome. Therefore, educational practices in the MHS should include frank discussions of the CJS and vice versa. This kind of education could be done by making collaboration sections part of standard training classes for both systems, creating specialized classes to cover the topic, and including guest speakers from each other's systems in classes. This education could also be reinforced in professional forums and ongoing education in their respective fields.

I give no macro level recommendations due to the fact that interaction with IMI already seems to be prevalent with both systems, and roles for both professionals are already well defined. Forcing each other to understand each other's language by policy is also overly restrictive in terms of personal liberty; however, incentives could be provided for those who voluntarily engage in education seeking to bridge the gaps in communication between the two systems.

Stigma Related to Mental Illness

Professionals from both systems recognized that the stigma associated with having a mental illness created significant barriers to providing good services for IMI. This topic was brought up by all the participants in the study. MHPs and CJPs both saw how IMI were verbally demeaned, denied certain services because of their status, and generally greeted with fear in the community. The fact that they both recognized this as an issue leads to recommendations for micro and mezzo practice improvements.

Micro and mezzo practice improvements should focus on recognizing that professionals in both systems all see the difficulty faced by IMI and understand that the treatment of IMI in society as sub-par. This idea alone should be taught extensively in schools and reinforced in ongoing professional education so each group will recognize there is a shared concern that both systems can work on together. This idea might dispel the myth that some MHPs have about CJPs not caring about the plight of the mentally ill, and the more this idea is spread, the more MHPs and CJPs will be able to focus on reducing stigma together. This idea could be discussed in public forums, collaborative meetings between professionals, and taught in initial and ongoing trainings.

Macro level interventions on reducing the stigma of mental illness are already largely in place. IMI are protected under the Americans with Disabilities Act, and funds are made available for financing public education on reducing stigma. In essence, macro level interventions at this level are already available, and even though they could certainly benefit from further financing, real progress has to be made at the micro and mezzo levels on reducing stigma associated with mental illness. Reducing stigma is best

done by embracing the ideas already available through anti-stigma programs and adopting a less patronizing or demeaning language to describe IMI.

Contrasting Philosophies

The most fundamental difference the CJS and MHS have is their philosophies regarding their purpose and methods of work. This item was seen by roughly 90% of all participants, equally across groups. MHPs view themselves as helpers of IMI who work to assist them collaboratively. CJPs view their role as protectors of themselves, society, and IMI; in order to accomplish their goals, they would take on adversarial stances. These starkly different philosophies were the source of significant conflicts and should be recognized at the micro, mezzo, and macro levels.

At the micro level of practice, practitioners should recognize the basic differences in each other's philosophies and appreciate where those philosophies come from. MHPs need to understand and take into account when working with CJPs that the adversarial stance CJPs take is not necessarily based on malice, but is a stance that frequently comes out of obligation. CJPs would also do well to recognize that even though the collaborative stance MHPs take may make them look like overly sympathetic enablers of criminals, it is a necessary aspect to their methods of work with their clients. Overcoming the barrier of contrasting philosophies might best be accomplished by considering the need of each philosophy before engaging each other.

On the mezzo and macro level, education should be provided in schools and to system administrators about the differences in philosophies that each system might present and why those differences are important to recognize and work with. The macro

level of practice has already shown that the two philosophies, while starkly different, are not incompatible and can be married successfully through collaborative programs such as mental health court. Further action such as funding programs and policy recognition for the strength of collaborative agencies is encouraged to support such efforts in the future.

Self-Reflections

Professionals from both systems had many opinions about each other, but each group was also quick to point out the weaknesses already present within their own systems. Self-reflection was expressed by all participants from both groups. MHPs recognized their own systems were fragmented and agencies rarely shared information with each other, because it was not a priority. They also recognized they were susceptible to the charms of the criminal mentality and that the basic set up of their delivery systems created disconnects between the MHPs and their clients. CJPs also recognized that rigidity, communication failures, and being overworked left them significantly handicapped in their own ability to provide appropriate services for IMI. This self-reflection gives rise to recommendations for improved practice on the mezzo and macro levels.

Mezzo level practice would do well to recognize the weaknesses each system will have. If MHPs and CJPs can educate each other about their own shortfalls, it may also help each other recognize where potential problems may come up when collaborating, and would reflect certain humility from both systems. Understanding these shortcomings, especially at the outset of collaboration, could help each other know what to expect when working together. In order to achieve such aims, cross-system training

given by practitioners and administrators from both systems should be provided, going over what each other can and cannot do. Education efforts should include open forum discussions where questions can be fielded about the strengths and weaknesses of each other's systems.

On a macro level, administrators and politicians would do well to listen to the feedback given by those providing services to IMI. Recognizing shortfalls is an invitation to re-engineer service delivery systems in a way that would serve IMI better. Allowing for the status quo in current delivery systems is giving a blessing to the very barriers impeding the care of IMI in both systems. Administrators and politicians must listen and act on the feedback they get from MHPs and CJPs to make the kind of sweeping changes necessary to break down those barriers to service. Such changes can be made first by administrators and politicians surveying those they represent on what they see as weaknesses in their systems, compiling the data gathered, and then enacting policy based on what is discovered.

No micro level recommendations are given in that learning at a mezzo level would improve interactions, and knowledge about the weaknesses of one's own system already seems prevalent.

Levels of Interactions

CJPs' and MHPs' previous experiences with each other, whether or not those views were positive, were significant factors in how they viewed each other. This idea

was discussed by roughly 75% of MHPs and 70% of CJPs. Those views were often tempered by the manner of those interactions, whether they were impersonal meetings, or whether the interactions were frequent, systemic, and integrated into everyday work. This theme of interaction being on different levels brings out recommendations for micro, mezzo, and macro practice.

On a micro practice level, MHPs and CJPs should try to raise their consciousness about their own behaviors, especially when around each other. The behaviors professionals observe of each other can lead to stereotypes about others in that system. In order to improve future collaboration, MHPs and CJPs should do their best to leave behind stereotypes and represent their own systems professionally. MHPs and CJPs should also approach each other with an open mind, letting go of previously conceived notions about each other. Professionals from both sides should recognize that their behaviors need to reflect their professional ethics, both in and out of their professional roles.

On the mezzo level of practice, educators should make strong efforts to include cross systemic education as part of standard training. MHPs in training should be exposed to lawyers, police officers, probation officers, and corrections officers as guest educators. This training should focus on teaching MHPs the basics of what CJPs do, their philosophy, their roles, their terminology, and where they might collaborate with each other. Any CJP who is an officer would do well to become Crisis Intervention Team (CIT) certified because it informs them of the best practices for collaboration and how to respond to the needs of IMI. These kinds of courses could also be made available as part of ongoing trainings for professionals from both systems.

Macro level practice should focus on encouraging cross education of the systems and providing forums for MHPs and CJPs to meet and try to understand one another. Policies should also be put in place to encourage all sworn officers to become CIT certified and provide incentives to promote the program more. These policy driven interventions might engender more positive perspectives regarding the roles that each system plays in society.

Inconsistencies

MHPs and CJPs frequently complained about the inconsistencies of their interactions. This issue was noted by all participants from both systems. Participants from both systems complained that most of the time collaborating was difficult to maintain, and communication with each other was often of varying frequency and quality. They also observed that when working with each other, professionals were not consistently ethical or thorough. This challenging problem points to recommendations for micro, mezzo, and macro practice.

On a micro level of practice, practitioners from both systems would do well to inventory their own work and see where their interactions with each other could be improved. MHPs and CJPs already involved in a collaborative process should be assessing themselves for consistency of their work, taking into account how their work will reflect on themselves to organizations outside of their system. Such efforts could also be reinforced by field supervisors.

On a mezzo level of practice, those in training to become MHPs and CJPs should be educated on the importance of professional and collaborative consistency. In an

educational setting, an emphasis on maintaining good ethical and professional consistency would likely help improve images across systems. This kind of education can be given in formal classrooms, in the training process, or as part of ongoing field education.

Macro practice should emphasize consistency of work and collaboration as basic parts of each system's mission statement and philosophy. Since the collaborative process depends greatly on the consistency of agencies and individual professionals, efforts should be made to adjust policy towards making consistency a priority. Professional ethics should also be reinterpreted across professions in a way that reflects the importance of collaboration.

Question of Responsibility

A major complaint participants from both systems had was the frustration of dealing with "dumps," or the shifting of responsibilities from one program to another. This theme was prevalent in about 60% of MHPs and CJPs. Professionals from both systems also wanted to better understand what they can and cannot do for each other when it comes to working together on behalf of IMI. This theme brings out several recommendations for micro and mezzo practice.

Improved communication is essential on the micro level. When a client is transferred from one system to another, simple explanations as to why might relieve some of the frustrations related to dumps. These explanations should not only cover why the IMI is in need of the other system's service, but what is going on within the IMI's original services that created the need for a transfer or share of responsibility. This can

be accomplished by simple calls or emails to each other regarding the nature of transfers, why they are happening, and then leaving the door open for further communication.

On a mezzo level, there needs to be serious education provided for both systems that reflects what agencies, systems, and programs can expect from each other. Many agencies are well aware of what is within their power to do, but few focus on the limitations of their services. Perhaps the best way to approach this is to create some kind of open forum where professionals can go and discuss their services and field questions about what they cannot do. This would allow not only for better communication, but also for better networking and marketing for agencies.

No policy recommendations are given here due to the dynamic nature of mental illness. It is impossible to say that any given IMI should be only in the care of the CJS or MHS, and broad strokes of policy would probably just end up causing more confusion. IMI should continue to be taken care of on a case by case basis to determine what system should be responsible for whom.

Impact of Education

The role of education in the collaborative process is vital when creating working relationships between systems. This concept was prevalent in 50% of MHPs and 75% of CJPs. Education levels are inconsistent across systems, and whatever education professionals do have, it is primarily aimed at understanding one's own system. Professionals from both systems repeatedly asked for more information about each other. This theme indicates recommendations for the mezzo and macro levels of practice.

On a mezzo level, as noted earlier, education about each other's systems needs to be explained during the course of preparations to become professionals. This basic information should also be repeated several times throughout the course of the professionals' ongoing trainings within their own systems.

On a macro level, policies should be created to encourage higher education across disciplines. Professionals with higher education levels invariably were more forgiving and easygoing about difficulties in collaborating with others. The majority of MHPs had at least a master's degree or higher, whereas CJPs' education levels varied greatly. For example, in some agencies, "There is no economic benefit to a [higher] education," as one CJP put it. With this in mind, it would be important for the CJS to provide incentives for higher education such as increased pay or seniority because higher education levels will likely lead to easier collaboration.

No micro level intervention is given because the choice about how much education one gets is squarely an individual decision. It is hoped that the attitude of most individuals will favor more education over less, but understandably this is not always the case, and good education only comes from good motivation to obtain it.

Resource Issues

The MHS and CJS are always hampered by limited resources to support their programs and provide services to people in the community. This problem was discussed by 100% of MHPs and 70% of CJPs. Limited resources also affect IMI, as money is often required to get mental health services, and when those cannot be engaged proactively, the CJS often has to step in. In the CJS, many professionals are overworked

and unable to provide efficient services to the clients in their care. The greatest potential for change comes primarily at the macro level.

As one MHP put it, "If society was ever going to invest money in a way that really takes care of people and doesn't focus on punishing them, we would need a serious shift in culture." It is well established in the research that investing in prevention saves more money than spending that money on punishment. That being the case, it has always been difficult to raise money, public awareness, and political capital in such a way to invest in programs designed for better collaboration. Currently there is a unique opportunity in the United States, where politics have become highly focused on austerity. Perhaps this momentum could be used to make political arguments for the sake of investing in collaborative programs aimed at providing better services for IMI, because they would probably save money by reducing recidivism.

This problem is primarily a macro level problem. In schools and individually, people can support causes and vote for policies that will increase funding for collaborative efforts between the two systems, but change will only come about through policy reform and general support for it.

Gaps and Barriers

Professionals from both systems noted the way their systems are set up has created significant gaps in services for IMI. This was noted by 100% of professionals from both systems. MHPs noted there were barriers inherent in the paperwork IMI must deal with when seeking services. IMI are often discharged from forensic units or jails with no step down help. The system is not set up to be proactive in taking care of IMI,

leaving it to be reactionary to crises and negligent of those who isolate. CJPs noted that their system is rigid and slow to change. There are no services for individuals with traumatic brain injuries. Everyday life and being overworked does not allow for sufficient follow through in many cases. Limited resources allowed for only certain people to get services. Communication between the two systems was often insufficient. These barriers have implications and recommendations for change at every level.

On a micro level, professionals from both systems should seek ways to improve their communication with each other. The best place for this to start is to look at the HIPAA guidelines again. It would be beneficial for MHPs to know HIPAA does allow for sufficient communication between CJPs to provide better services for IMI. CJPs might also do well to educate themselves on the consequences of sharing private health information without proper consent so they would understand why so many MHPs are reluctant to share information about their clients. Finally, intake procedures for IMI in both systems should be made as simple and reasonable as possible. Unnecessary paperwork should be eliminated or simplified for the sake of those served.

At the mezzo level, education should be provided to both professionals in training and current professionals about the lack of services available for IMI. Enterprising MHPs and CJPs could then use that information to start agencies to meet the missing needs, such as jail services for those with traumatic brain injury, or step-down programs for inmates as they are released from jails and prisons. These programs, if jointly created, might have a better chance at succeeding and bridging the kinds of gaps present in the two systems.

On the macro level, services, especially in the CJS, need to be expanded. One jail administrator related he has a program in the jail that provides education and basic therapy that reduces the recidivism of his inmates by one half. That service is only available to one quarter of all the inmates though, leaving three quarters to continue recidivating. Most CJPs felt overworked and many MHPs acknowledged this was the case as well. If the MHS and CJS are to work together and create less of a need for services, they first need to have the resources and time to work out collaborative relationships. CJPs might also benefit by recognizing MHPs are there to help too. As long as the time is made and administrative support is given to collaborate, safety can be maintained and IMI can be treated so that they do not keep going back to jails, prisons, or psychiatric hospitals.

Implications for Social Work Education

If social workers are to be sufficiently trained for effective, evidence based practice in the field, then greater emphasis needs to be put on the importance of collaboration. This training could be done by offering classes on collaboration or making it an integral part of core coursework. Such education would probably be most effectively delivered using the following education strategy and model of interaction.

Social workers need to first begin by understanding the nature of the clients that they serve. Under current conditions, many IMI will cycle through the CJS and MHS throughout their lives. If the final purpose of treatment is to leave IMI better able to care for themselves, then social workers must begin with the premise that they cannot complete this task on their own.

Next, social workers need to educate themselves about the services that IMI will receive in the CJS. They must understand that sometimes IMI will be arrested, they will deal with police officers, and they will spend time in jail. Social workers need to be taught what the interactions IMI will have with police and correction officers will likely be. They will need to learn the process of adjudication, what defense and prosecution lawyers will ask of the IMI, and then understand the role that probation and parole officers will have with IMI. By learning these processes, social workers will be better prepared to help IMI who have been through the CJS.

Next, social workers need to be taught the philosophies of the CJS and understand that the adversarial stance is heavily prevalent and largely necessary. They must be taught not to fear this, but to accept it as something that is viewed as necessary by the CJPs. They must be taught the differences in the way they communicate about IMI and learn not to take offense at descriptions of IMI by symptoms, instead of as people with illnesses. They must then recognize that collaboration is likely to be short for each case due to constrained resources, but longer term in mezzo and macro work.

When it comes to interacting with CJPs, if social work students are familiar with the philosophies and language of the CJPs, they are then more likely to succeed in collaborating effectively with them. Interaction can be through face-to-face communication (always best), phone calls, faxes, and emails. Each of these methods has advantages and disadvantages and should be chosen according to the shared need.

Face-to-face interaction will always create the best collaborative relationship and should be encouraged whenever possible. When the two professionals are present, they are better able to communicate through verbal and nonverbal cues. Face-to-face

communication allows for meaningful interpersonal relationships to develop, which will improve long term collaboration, business partnerships, and general well being for the IMI being served by both systems. One must also be prepared for interactions and act consistently in line with professional ethics, so that risk of being perceived as flighty, unreliable, or unethical is reduced, because this can lead to less effective collaboration in the future.

Phone conversations can be helpful for sharing short amounts of data, but will only be effective collaboration if the two professionals already have a relationship. Otherwise the calls will likely only be useful for sharing information. Since time is always short for both systems, the nature of these calls must be efficient, sharing enough information as to be useful, and leaving out unnecessary details. It is also important to note that hiding behind HIPPA and leaving out unnecessary details is a poor excuse to not share vital changes going on in a client.

Faxes between MPHs and CJPs are often very formal and do little to engender ongoing professional relationships, but they are often a staple of collaboration between professionals. Here, social workers need to understand that they must be able to communicate professionally, clearly, and correctly. Faxed documents should be free of grammatical errors and reflect accurate facts about the case in question. Anything short of this will likely leave a poor reflection of them in the eyes of the CJP.

Emails likewise must be professional in nature. This form of communication is often the most convenient as it can be used to build relationships, share information in formal and informal ways, and create a nice paper trail of communication. These emails too must be clear, concise, and comply with HIPAA regulations.

Truly effective collaboration will likely involve all of the previously described elements combined. In bringing the elements of systemic knowledge and effective communication together, social workers can be more effective in collaborating with CJPs and will more likely provide more comprehensive services to the IMI in their care.

Social workers have a duty and ethical obligation to care for those who are unable to care for themselves. Social workers are also uniquely positioned as micro, mezzo, and macro practitioners and can take the lead in moving towards collaborative systems to improve the lives for IMI. If social workers can be effectively educated from the beginning to work across systems for the good of their clients, the ethical obligation of the profession can be better fulfilled through their practice.

Implications for Future Research

Further research on the topic of this dissertation should focus on verifying the validity of the over arching variables of education, experience, and proximity as factors leading to positive perceptions between MHPs and CJPs. Validating these ideas could be easily done through surveys and statistical analyses of the variables. Other quantitative studies could be done to verify the concept of increased collaboration leading to more effective outcomes for IMI by using comparative analyses of programs that have high collaboration levels compared to those that do not. Such studies could be used to guide curriculum aimed at increasing motivation for greater collaboration.

Further qualitative studies could also be undertaken to explore some of the finer details of systemic interaction by focusing similar methods employed in this study on smaller subsystems, such as MHPs and corrections officers or MHPs and probation

officers and in specific areas, such as jail and prison systems. Ethnographic studies in jails focusing on the interactions between MHPs and CJPs would also likely bring out important details on how these two systems, in the same location, could collaborate more effectively.

Conclusions

The central premise of this study was to understand how CJPs and MHPs viewed each other and how those perceptions helped or impeded the collaborative process. My interest in this topic was much more than an academic curiosity. Behind all of the study and analysis, I was seeking to understand if collaboration would be an effective tool to reduce recidivism. In order to address this concern I asked four research questions:

- What perceptions do CJPs and MHPs have of each other?
- What obstacles do these professionals believe inhibit collaboration?
- How could MHS and CJS professionals resolve those perceived problems with collaboration?
- What effects do MHPs and CJPs view as potential outcomes of greater collaboration?

To better research these questions, I provided an overview of the history of the MHS and the CJS in an effort to understand how we came to the current situation. The MHS seemed to go back and forth through history from being compassionate to being outright neglectful towards IMI. The CJS, on the other hand, changed very little, only slowly adding groups of people to whom “justice” applied and changing its views towards IMI through high court decisions. With the historical context in place and an

understanding of other studies and opinions on collaboration between the systems, I decided to move forward with the study using qualitative methods.

The methods I used included using a constructivist paradigm and systems theory to frame the study. From there, I went about recruiting MHPs and CJPs to participate in small, focused discussions aimed at understanding their perceptions of the systems they worked in and with. Once the data were collected, they were analyzed using a grounded theory approach, seeking to understand, in the most objective way possible in a qualitative study, what MHPs and CJPs really thought about each other.

The analysis yielded 10 themes about the perceptions of MHPs and CJPs. Study participants talked frequently about their experiences and opinions about IMI, as well as the stigma IMI faced. They talked about how each system thought differently, what professionals from each system thought about themselves, and the different places they interact. Finally, they discussed how inconsistency, education, resources, responsibility, and the inherent gaps between their systems affected the way they collaborate with each other.

In conclusion, it would be useful to review the research questions and proposed answers. The first question is, "How do MHPs and CJPs perceive each other?" The answer depends on the three overarching themes that came out of the study: education, experience, and proximity of work. The more of each variable present in individuals from both systems the better or more flexible the perceptions of each other were. These variables are important to keep in mind as they could be useful not only for future research, but also predicting the likelihood of success of educational programs designed to improve collaboration.

The second question was, "What perceived obstacles inhibit collaboration between the systems?" The answers given by the participants, as manifest in the themes of the study, were professional inconsistency, lack of communication between the systems, differences in basic philosophies, a lack of sufficient resources, and mixed responsibilities.

The third question was, "How can MHPs and CJPs overcome the perceived obstacles?" The answer, as indicated by the themes and recommendations is to increase general knowledge about each other, to implement policies that support collaboration and collaborative programs, and to recognize the opportunities presented to both systems to grow by working together.

The final question was, "What do CJPs and MHPs view as the benefits of increased collaboration?" The best answer given by a participant was simply, "People would suffer less." In the end, this is the goal of social work, and in an indirect way, the CJS. There is a certain sense of professional satisfaction that accompanies successful work, and this could also be shared through increased collaboration.

Finally, both the MHS and CJS have more similar goals than perhaps is readily obvious. Both work towards the safety of society and the benefit of mankind. Both systems are compromised of people with ideals, dreams, passions, and weaknesses. Perhaps it is the different ways in which CJPs and MHPs work that separates them and keeps them from seeing each other's value. I believe that should these two systems cooperate, recognizing the strengths and differences each brings to the table, greater progress can be made on behalf of both systems, and especially those IMI they serve.

APPENDIX

SEMISTRUCTURED INTERVIEW SCHEDULE

Questionnaire Guide

I: Building relationships

A. Collect basic demographics such as name, age, sex, ethnicity, etc.
B. Discuss life history, where they are from, what they do for fun, interests, etc.
C. Discuss interests in career choice, the population they work with, etc.
D. Thank them for their time, interest and willingness to share

II. Discussion of roles

A. What is your job description?
B. Why did you choose the career that you did?
C. What is your job like/your typical day like?
D. What is your favorite part of the job?
E. What is your least favorite part of the job?
F. What are your colleagues like?
G. What other kind of professionals do you work with regularly?
H. What kind of clientele do you serve mostly?

III. Perspectives on people with mental illness

A. What kind of experiences have you had with people with mental illness?
B. How do you recognize when you are working with someone with a mental illness?
C. What do you see most of when working with people with mental illness?
D. How do you deal with people with mental illness when you come across them?
E. Do you think there is a better way to deal with them? If so, what?
F. What do you see as your role in dealing with people with mental illness?

IV. System perspectives

A. What do you see as the process that people with mental illness go through when working with your system (CJ/MH)?
B. What do you see as the process that people with mental illness go through in the other (CJ/MH) system?
C. How do you see your system interacting with the other system?
D. What aspects of the other system do you deal with the most?
E. Do you see gaps in services for people with mental illness between your systems? If so, what?
F. If you could improve the interactions from your system with the other system, what would you do?

G. What aspects of the other system would you like to have greater cooperation with?
H. What improvements to your system might there be if there were greater cooperation between systems?
I. What do you see as the greatest benefits that could come from improved cooperation between the systems?
J. Where do you see potential areas to improve inter-system cooperation?

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