Mental Health Provider Experiences in Rural and Suburban California Jails

By

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Abstract

There are a disproportionate number of seriously mentally ill inmates in California jails. Rural and suburban communities incarcerate many inmates with significant mental health needs yet struggle to maintain sufficient mental health providers to treat this vulnerable population. Jail mental health providers have long faced staffing, treatment space and other resource obstacles in providing constitutionally appropriate care to mentally ill inmates, which were exacerbated by COVID-19. At the time of this study, many of California's counties were undergoing new litigation and consent decrees to investigate and potentially improve jail safety conditions, including those related directly to mental health services. Guided by the Socio Ecological Model, this study aimed to explore the individual, interpersonal and organizational factors that support jail mental health providers in delivering mental health care services to inmates in rural and suburban California jails. Qualitative data were collected through individual telephone interviews with 14 rural and suburban jail mental health providers, which were recorded, transcribed and thematically analyzed. Themes were identified within 5 domains of the Socio Ecological Model (individual, interpersonal, organizational, community, and public policy levels). Two key findings emerged. First, the study identified needs for exposure to the jail environment as part of basic clinical education, and identified specific needs for mental health provider training, mentoring and clinical supervision that are both internal and external to the jail setting. Second, the study identified strengths of jail mental health providers and their networks to build upon including resiliency, collaboration and the support needed to navigate difficult experiences within the jail setting. Study findings highlight opportunities for educational institutions, county behavioral health and jail administrators, contracting agencies and correctional health care organizations to more fully understand how to train, mentor, recruit and retain jail mental health providers—especially for California's rural and suburban counties.

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Chapter 1: Mental Health Care in Correctional Settings

Americans with mental illness are disproportionately represented in populations incarcerated in US prisons and jails in comparison to the community (World Health Organization, n.d.). In comparison to psychiatric hospitals, there are three times more Americans with serious mental illness (SMI), defined as mental, behavioral or emotional disorders resulting in serious functional impairment severely impacting activities of daily living (NIMH, 2021), in prisons and jails (Abransky & Fellner, 2003 | James & Glaze, 2006 | Lovell & Jemelka, 1998 | Manderscheid, Gravesande, & Goldstrom, 2004). Of jail and prison inmates, 20% are diagnosed with SMI (American Psychiatric Association, 2000) whereas one in 20 or 6.3% Americans in communities are diagnosed with SMI (or 13.1 million adults (Kessler et al., 2005). Importantly, individuals with serious mental illness are more likely to develop physical health issues (heart disease, diabetes and HIV) and on average die 25 years prematurely due to treatable physical health conditions (CDC, 2018). Accordingly, inmates in prisons and jails typically present with multiple complex mental and physical health needs (Semenza & Grosholz, 2019).

Multiple factors contribute to the development of mental illness (i.e., mental health diagnoses that range from no impairment to serious impairment including SMI | NIMH, 2020) including adverse childhood experiences (ACEs), chronic medical conditions, biological factors, use of alcohol and drugs, limited social connections and feelings of isolation (CDC, 2018). These issues are more commonly experienced by incarcerated adults who report four times as many ACEs as compared to non-incarcerated adults (Reavis et al., 2013) as well as concomitant mental health diagnoses and substance use disorders (US Department of Justice, 2006). Additionally, suicide rates continue to increase in state prison settings (U.S. Department of Justice, 2020), in part, due to the high prevalence of mental health disorders in the population (Abransky & Fellner, 2003).

Mental health providers deliver, coordinate and advocate for the ongoing mental health care of inmates assigned to their caseloads in correctional settings. These providers have a variety of mental

health clinical classifications—including but not limited to Psychiatrists, Psychologists, Social Workers, Recreational Therapists and Psychiatric Technicians (California Correctional Health Care Services, 2020). While these mental health clinicians are members of multidisciplinary clinical care teams, their primary responsibility is the mental health care of the growing population of inmates with serious and persistent mental health issues and care to address the rising inmate suicide rates in jails and state prisons. Given the importance of these tasks from a public health perspective and the oversight by class action litigants and federal receivership related to mental health/Constitutional violations—for example, the 1995 ruling of Coleman v. Newsom (CDCR, 2021)—it is imperative that the correctional mental health clinical workforce has adequate preparation and support to address the complex mental health needs of the incarcerated population.

The current body of literature suggests three main themes that set correctional settings apart from other areas of mental health practice. The first theme is the frequency of ethical and legal dilemmas. Correctional Mental Health Providers (CMHP) are presented with unique challenges and regular ethical dilemmas in balancing the ethical mental health care of inmates and their roles in the control and security of the paramilitary structures of jails and prisons (Bonner & VandeCreek, 2006). There are inherent conflicts related to managing the mental health care of inmates while upholding the safety and security of institutions (Simon et al., 2020). The second theme is the distinctive environment of correctional spaces with their primary foci on security, punishment and custodial control rather than on health and health care (Stoller, 2003). Clinicians may encounter and become part of the punitive cultures that become normalized and institutionalized in jails and prisons (Stoller, 2003). The third theme is the unique and extraordinary burnout experienced by clinicians in correctional settings (Simon et al., 2020). The intensity and complexity of practice in correctional environments has the potential to degrade the well-being of clinicians leading to burnout and retention issues (Simon et al., 2020). Correctional health care providers are reported to have higher levels of stress as compared to other

correctional staff due to the challenges of managing a caregiver role within the structured correctional environment and feelings of disempowerment within the paramilitary hierarchy along with physical limitations within these settings (Simon et al., 2020). Although there are no studies comparing the experiences of correctional and non-correctional mental health providers, correctional fatigue is a well documented phenomenon and is defined as a gradual deterioration of the spirit, mind and body (National Institute of Corrections, 2004). Clinicians experiencing unremitting stress are at greater risk of burnout which can lead to depersonalization and emotional exhaustion (De Bono, 2021). Again, studies of the subjective experiences of correctional health care providers along with how their experiences of burnout may different from non-correctional providers are needed to understand the factors leading to burnout and short tenure in these important clinical positions.

The proposed study was designed to address the established gap in the literature about the subjective perspectives of mental health providers in correctional settings. Specifically, we propose to examine the facilitators and barriers to providing high quality mental health care in California's rural and suburban jails. From 2007-2017 urban jail use declined significantly while rural jail populations increased rapidly (Kang-Brown & Subramanian, 2017). Correctional research has been mainly focused on urban facilities (Deller & Deller, 2010 | Ruddell & Mays, 2011 | Weisheit, Well & Falcone, 1995) which has the potential to establish policies and programmatic content in response to urban needs rather than differentiating by county size (Bassett, D.L., 2003). Insights from this study will inform recommendations and strategies for future practice, education, and policy designed to train and support the rural and suburban correctional mental health workforce. This study's focus also includes the experiences that this work force has with clinical supervision, how these providers care for the vulnerable inmate-patient population and how organizations can create a healthier patient care environment for both mental health providers and the inmates in their care. The overarching long-term goal of this work is to enhance the capacity of mental health providers in rural and suburban jail settings

to meet the needs of inmates while also protecting the mental health of CMHPs. Considering the social position of inmates and the cultural factors contributing to mass incarceration, it is also important to consider the health and safety of inmates who are in the care of jail mental health care providers.

Chapter 2: Literature Review

Incarceration in the United States

From the 1970s through the 1990s it was believed that incarceration was the most effective method in reducing crime (Beckett, 1997 | Mackenzie, 2001 | National Research Council, 2014) resulting in harsh public policies including mandatory minimum sentencing in nearly every state (Karch & Cravens, 2014 | Mackenzie, 2001). By 1995 the "three strikes" laws were active in 26 states requiring inmates to serve long prison sentences for three felony convictions regardless of the type of felony (Karch & Cravens, 2014 | Mackenzie, 2001). Since 2000, jails and prisons have become less punitive as capital punishment and mandatory minimum sentences have declined and the focus on rehabilitation has increased (Siegel, 2016). As a result of criminal justice reform, the populations in all correctional settings (jail, state and federal prisons) have decreased by more than 16% (Bureau of Justice Statistics, August 2022). The swift population decline was in part due to COVID-19, but decarceration efforts since 2008 have resulted in an overall 21% decrease (from 2.3 million in 2008 to 1.8 million in late 2020) in American prisons and jails (Vera Institute, January 2021).

Incarcerated Americans are generally held in jails, state prisons or federal prisons with each site distinctly different from the other. As compared to state prisons, jails are locally governed and typically operate on low budgets, with significant infrastructure issues, limited health services and few staff (Cornelius, 2008). Jails usually incarcerate individuals 365 days or less before release or transfer to prison (Bureau of Justice Statistics, n.d.). The majority of inmates within American jails—approximately 500,000 daily-- are detained prior to their trial (Walmsley, 2013). Considered "incarceration's front door," (Vera Institute of Justice, 2015) American jails admit nearly 12 million inmates each year (Beck, 2001 | Minton & Golinelli, 2014) which is 20 times the number of American state prison admissions (Vera Institute of Justice, 2015). In contrast, prisons are usually managed by state or federal government, or private organizations (Bureau of Justice Statistics, n.d.) | unlike jails, prisons typically incarcerate individuals for longer than 356 days. Federal prisons are distinctly different from state

prisons due to a much smaller inmate population, jurisdictional scope and offense distribution (Bureau of Justice Statistics, n.d.). American jails generally incarcerate unhoused individuals with higher levels of vulnerability who have significant physical and mental health challenges—including substance use issues—that far exceed the general population (Griefinger, 2007).

There are more than 3,000 jails in the United States (American Jail Association, 2015). According to the Vera Institute, there was a 25% downward shift in the rate of Americans jailed from 2019 to 2020 (January 2021). In midyear 2019 there were 237 people in local jails per 100,000 Americans at midyear 2020 there were 179 per 100,000 (Kang-Brown et al., 2019). With adjustments due to COVID-19 resolutions, populations have begun to increase again within local jails from 575,500 in June 2020 to 633,200 in September 2020—a 10% (57,700) increase in three months (Vera Institute, January 2021). In 2019, Black Americans were jailed at a rate of 600 per 100,000 Black residents, White Americans were jailed at a rate of 184 per 100,000 and Hispanic Americans were jailed at a rate of 176 per 100,000 suggesting a significantly disproportionate jailing rate of Black Americans (Bureau of Justice Statistics, 2019). It should be noted that 2008 to 2019 there was a 20% decrease in jailed Black Americans, 17% decrease of jailed Hispanic Americans (Bureau of Justice Statistics, 2019) and even with these decreases the rates of jailed Black and Hispanic Americans is still higher than the rate for White Americans.

Jails are typically considered to have extremely high risk and vulnerable inmates and many jails have high levels of violence, over-crowding and limited treatment opportunities (Grosholz & Semenza, 2021). Inmates in jails are typically impoverished and disenfranchised with low rates of education, high rates of unemployment, homelessness, substance use issues and mental illness (Vera Institute of Justice, 2015). While the majority of American jail and prison inmates are men, the number of incarcerated women is increasing rapidly jail populations—female inmate populations rose by 18% and males fell by

3% between 2010 to 2014—and women have significant histories of victimization, drug addiction, SMI and trauma requiring additional treatment (Scott, Dennis, & Lurigio, 2013).

While this study focuses on the unique aspects of rural California jails, as correctional systems are enmeshed, it is important to have context for state prisons. Each state has a prison system and within these 50 systems there are 1,833 state prisons in the United States (Sawyer & Wagner, 2020). From 1985 to 1997, the proportion of Americans incarcerated in prisons rose from 202 to 652 per 100,000 (Mackenzie, 2001), but by 2016 dropped to 458 per 100,000 (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2016). In 2017 there were 1,489,363 inmates in American prisons (Bureau of Justice Statistics, 2019). These summary rates of incarceration, however, conceal significant disparities by race/ethnicity. Non-Caucasian inmates are overrepresented in state prisons (Department of Justice, Office of Justice Program, Bureau of Justice Statistics, 2016). While there are downward trends in the imprisonment rate of Black adults, Black males were sentenced at a rate of 2,336 per 100,000, nearly six times higher than among White American males who were incarcerated at a rate of 397 per 100,000 (Bureau of Justice Statistics, 2017). Further, Black American males ages 18 to 19 were nearly 12 times more likely to be incarcerated as compared to White American males of the same age. The highest Black-to-White racial disparity during the year of 2017 was in the 18 to 19-year-old group (Bureau of Justice Statistics, 2017). Women account for 7% of the American prison population (Bronson & Carson, 2019 | Zeng, 2019) and have gender-specific health care needs along with rates higher than incarcerated males in the following areas: substance use, history of trauma and abuse, mental health issues and sexually transmitted infections (Sufrin et al., 2015). Prisons, usually managed by state or federal governments, or private organizations incarcerate individuals for longer than 365 days (Bureau of Justice Statistics, n.d.).

Mental Illness in Community Settings

Mental illnesses are common in the United States and major national organizations like the National Institute of Mental Health delineate two categories of mental illness: any mental illness or SMI. The category of any mental illness encompasses all mental, behavioral or other emotional disorders including SMI and ranges from no functional impairment to serious impairment. The SMI category includes those who are diagnosed with a mental illness resulting in serious functional impairment interfering with major life activities (NIMH, 2021). Mental illness is associated with significant individual and societal impacts as well as morbidity and mortality (NIMH, 2021). In the community, one in five (or 51.5 million) American adults are diagnosed with any mental illness (NIMH, 2019) and one in 20 or 6.3% with SMI (or 13.1 million adults (Kessler et al., 2005). Multiple factors contribute to the development of mental illness, including adverse childhood experiences (ACEs), chronic medical conditions, biological or genetic factors, use of alcohol and drugs, limited social connections and feelings of isolation (CDC, 2018).

According to the report *2021: The State of Mental Health in America*, mental health issues are worsening in all age groups in the United States (Mental Health America, 2021). As of June 2020, 40% of American adults reported struggling with mental health and substance use disorders (Czeisler et al., 2020). Specifically, this statistically representative sample showed that 31% in the general population were struggling with anxiety/depressive symptoms and 26% were experiencing trauma/stressor-related disorder symptoms (Czeisler et al., 2020). There was a three-fold increase in reporting of mental illness impacts from 2019 (8.1%) to 2020 (25.5%) (Czeisler et al., 2020). Also, within this sample, 13% of Americans surveyed had started or increased substance use and 11% had seriously considered suicide (Czeisler et al., 2020). These elevated rates may be attributed to stressors related to COVID-19 (Czeisler et al., 2020) which inevitably created impacts on the mental health of Americans. From anxiety and depression screening in 2019 and 2020, Americans seeking treatment for anxiety and depression increased dramatically, with a 93% increase for anxiety and 62% for depression, respectively (Mental

Health America, 2021). Alarmingly, since the beginning of the COVID-19 pandemic over 178,000 Americans have reported regular suicidal ideation and, of these, 37% (approximately 65,860) reported that these thoughts of suicide happened half of the time or nearly every day in September 2020 (Mental Health America, 2021).

Mental illness is closely associated with physical health concerns. Individuals with depression are 40% more likely to develop cardiovascular and metabolic diseases as compared to the general population. Americans with SMI are at even greater risk of developing these conditions (National Alliance on Mental Illness, 2021). As of 2019, 18.4% (9.5 million individuals) of American adults with mental illness also experienced signs or symptoms of substance use disorders (National Alliance on Mental Illness, 2021). Those with mental illness are at greater risk of unemployment (5.8%) versus those without (3.6%) (SAMHSA NSDUH, 2019). At least 8.4 million Americans are caring for an adult with mental illness, spending an average of 32 hours per week providing unpaid care (National Alliance for Caregiving, 2016). Issues of mental illness and substance abuse are involved in one of every eight (12 million) emergency department visits (Agency for Healthcare Research and Quality, 2010) and the overall annual U.S. economic impact of lost earnings due SMI is $193.2 billion (Kessler et al., 2008). Further, 20.5% of Americans experiencing homelessness have been diagnosed with a SMI (Housing and Urban Development, 2019).

People with diagnosed mental illness, particularly within specific diagnostic categories including depression, post-traumatic stress disorder, psychosis and substance use disorders are higher risk of death by suicide (Latalova et al., 2014 | Stone et al., 2018). According to the Centers of Disease Control and Prevention, approximately 44,965 Americans died by suicide in 2016 making suicide the tenth leading cause of death in the United States. The American Foundation for Suicide Prevention estimates that the average annual age-adjusted suicide rate in the United States is 13.42 per 100,000 people (AFSP, 2016). Although suicide is the overall tenth leading cause of death in the United States, it is the

second leading cause of death for individuals ages 10 through 34 years of age (CDC, 2016). Suicide is a significant and growing public health issue in the general United States population with impact on the individual who dies as well as on the emotional and economic health of the decedent's family and on society as a whole (National Center for Injury Prevention and Control, 2018).

Mental Illness in Correctional Settings

Many of the factors that contribute to the development of mental illness are disproportionately experienced by impoverished communities and people of color who are, in turn, disproportionately represented in prison populations (Reavis et al., 2013). For example, individuals in prison report four times as many ACEs as compared to non-incarcerated adults (Reavis et al., 2013) and are more likely to have concomitant mental health diagnoses and substance use disorders (US Department of Justice, 2006). Research also supports that inmates are at a much greater risk of entering correctional settings with a history of mental health issues and trauma backgrounds (The Center for Prisoner Health and Human Rights).

Incarcerated Americans with serious mental illness are over-represented in both US prisons and jails (Abransky & Fellner, 2003) (Munetz, Grande & Chambers, 2001 | Teplin, 1984). In 2018 there were a total of 1,285,260 (BJS, 2020) state prison inmates | approximately 20.6% (n=265,455) were diagnosed with SMI (SAMHSA, 2018) and of those, about 75% had co-occurring substance use disorders (American Psychiatric Association, 2000). Those with SMI are 4-5 times more likely to remain incarcerated for longer periods of time as compared to inmates without (American Psychiatric Association, 2000), an important consideration given the complexity of their mental and physical health needs. Importantly, those with SMI are more likely than those without to experience homicidality, grave disability and suicidality (SAMHSA, 2018), with the latter being the leading cause of death in American prisons (Smith et al. 2016 | Daniel, 2007) and jails (Bureau of Justice Statistics, 2016).

Inmates with SMI are more likely to develop physical health issues (heart disease, diabetes and HIV) and on average die 25 years prematurely, generally due to unaddressed but treatable physical health conditions (CDC, 2018). Additionally, suicide rates, which are key indicators of SMI, continue to increase in state prison settings (U.S. Department of Justice, 2020), exceeding those in the community (14.2 per 100,000 in 2018 | AFSP, 2020 versus 17 per 100,000 in 2016 | USDJ, 2020, respectively) in part, due to the high underlying prevalence of mental health disorders in population (Abransky & Fellner, 2003). The increasing rates of individuals with mental illness in the criminal justice system and their early mortality are persistent concerns (Drake & Latimer, 2012) and taken together, with increasing rates of suicide in correctional settings underscore the importance of interventions to address these problems.

Nationally, suicide is two times more common among prison inmates than in the non-incarcerated population (Suto & Arnaut, 2010). American jail suicide rates in 2016 were 46 per 100,000 jail inmates (Bureau of Justice Statistics, February 2020). Jail data regarding suicide at individual facilities/counties is not accessible and therefore information about the lowest and highest rates of suicide within American jails is not provided. The average suicide rate among state prison inmates is 15.66 per 100,000 in state prisons, with a range of 9 per 100,000 in Kentucky to 45 per 100,000 in Rhode Island (Bureau of Justice Statistics, April 2021). Inmates who have died by suicide generally had a history of mental health care or were currently receiving mental health services at the time of their death by suicide (Stoliker, 2018). A review of completed suicides within California Department of Corrections and Rehabilitation (CDCR), the state prison system with the largest number of inmates with mental illness in the US, from 1999-2004 remains the only known descriptive study of suicides (Patterson and Hughes, 2004). There were 154 inmates who died by suicide within CDCR during this six-year period and, of these inmates, the majority had a history of SMI, a history of multiple suicide attempts, serious medical concerns, were more likely to have severe personality disorders and coexisting mental health issues.

Further, the decedents had recent significant legal status changes and expressed safety concerns contributing to anxiety and agitation. (Patterson and Hughes, 2008). Although the risk of suicide in correctional settings is higher than in the community, the risk of suicide within Administrative Segregation Units (ASUs)—which are single cell, high risk units-- is of particular concern (Frost & Monteiro, 2016). There is evidence that "confinement under such restrictive and isolating conditions is especially harmful for this already vulnerable population" (Frost & Monteiro, 2016). ASU placement varies by inmate and by setting although the primary purpose is to separate an inmate or group of inmates from the general population of a prison in efforts to protect the overall safety and security of the institution. Inmates may be placed in this type of housing for their own protection, the protection of others and/or the protection of the institution (Frost & Monteiro, 2016). These reasons may be closely related and aligned with mental health issues and thus account for the higher rates of suicidality | at the same time, isolation itself may contribute to the higher rates of suicide, especially in ASU settings (Chadick et al., 2018 | Haney, 2018 | Medrano et al., 2017 | Nolasco & Vaughn, 2018).

Although suicides accounted for 7% of all inmate deaths in state prisons in 2014 it should be noted that this information is based on voluntary reports by prisons to the Bureau of Justice Statistics (BJS, 2016), which may underestimate the true rates of suicide. As of 2016, the rate of suicide within jails was 46 per 100,000 and accounted for nearly 31% of all jail deaths (Bureau of Justice Statistics, 2016).

Jails are the gateway into American state and federal prisons (Subramanin et al., 2015) and there were approximately 11 million jail admissions in 2018, including multiple admissions for the same individual, (Zheng, 2020) and at any given point there are approximately 750,000 (229 per 100,000) Americans in jail (Kaeble & Cowhig, 2018). Jails have a constitutional obligation (Brad H. v. City of New York et al., 2011 | Ruiz v. Estelle, 1980) and state regulations to provide mental health care to inmates (Jacobs & Giordano, 2018). These rulings and precedents are important as American jails often serve as

the default for community behavioral health hubs and are often the first point of entry into the American criminal justice system (Kopak et al., 2019).

There are unique patient flows through jails as the majority of patients move through the jail process within three weeks, but a portion of the population remains for much longer periods of time (Solomon et al., 2008), suggesting that jail clinicians must consider both short- and long-term treatment options. Most jails are in semi-urban and rural areas and lack highly trained mental health clinical staff (Applegate & Sitren, 2008). It should be noted that while most jail literature focuses on urban jails, these results may not be representative of the challenges faced by semi-urban and rural jails (Kopak et al., 2019).

Nationally, most jails are located in rural areas where communities are experiencing additional health vulnerabilities, especially substance use disorders (SUDs) (Kang-Brown et al., 2019). Recent data suggests that nearly two thirds of inmates in rural jails meet the criteria for SUDs (Kopak et al., 2019 | Proctor et al., 2018 | Raggio, Kopak, et al., 2017a) which fits as substance use is often associated with criminal justice system involvement (Kushel et al., 2005 | Desai, Lam & Rosencheck, 2000 | Lindelius & Salum, 1976 | Fischer, 1988 | Fischer, 1992 | Benda, 1993). It is well-established that mental illness is associated with increased risk for involved in criminal justice systems (Snow, Baker & Anderson, 1989 | Gelberg, Linn & Leake, 1988 | Martell, 1991 | Martell, 1995). It is estimated that 40-55% of adult jail inmates have a mental health diagnosis, including antisocial personality disorder, posttraumatic stress disorder, depression and manic disorders (Proctor & Hoffman, 2012 | Raggio et al, 2017a, b). Further, it is estimated that half of rural jail inmates meet criteria for co-occurring disorders (Victor et al., 2021).

Americans with SUDs and mental health issues have a higher risk of reincarceration yet limited research has been done at the jail level to understand these issues as most related research focuses on prison inmates (Kopak et al., 2019). While it is important to have a clear understanding of SUDs and mental health issues amongst prison inmates, the recidivism of jails inmates with SMI is significant

(AbuDagga et al., 2016) and this revolving door offers unique challenges to jail mental health clinicians. Nationally, there is an overrepresentation of inmates with SMI in correctional systems (Treatment Advocacy Center, 2015) and there are more mentally ill Americans in U.S. jails and prisons than in psychiatric facilities (Aufderheide & Brown, 2005 | Treatment Advocacy Center, 2015). Further 29% of American jails are detaining inmates with SMI who have no criminal charges who are waiting for a psychiatric evaluation, hospital bed, and/or transportation to a psychiatric hospital (James & Glaze, 2006 | Minton & Zeng, 2015 | Treatment Advocacy Center, 2015).

In California, there have been significant increases of jail inmates with active mental health care needs. In 2009 on any given day there were approximately 80,000 California jail inmates and 15,500 (19.4%) had active mental health care needs and 10,500 (13.1%) were receiving psychotropic medications (California Health Policy Strategies, 2020). In a 2019 survey of the California jail inmate population, there was a decrease in overall population, 72,000, yet an increase in the inmates receiving mental health care, 22,000 (30.1%). Further, in 2019 there were 19,000 (26.4%) California jail inmates administered psychotropic medications (California Health Policy Strategies, 2020).

The literature is limited in the understanding of the provision of mental health care in correctional settings (Rekurt-Lapa & Lapa, 2014). Mental health care in correctional settings includes multi-faceted complexities that must be simultaneously managed including illness severity, jail treatment infrastructure challenges along with ethical, legal and treatment quality concerns (Rekrut-Lapa & Lapa, 2014). Qualitative studies are needed to explore the experiences of mental health clinicians working with these vulnerable patients in California jails.

Mental Health Services in the Community

Institutionalization of people with mental illnesses is a part of the origin story of the United States (Gonaver, 2018). Early American treatment of mental illness came in the form of incarceration and use of almshouses (National Archive) which were often dark, leaving patients without clothing,

bathrooms or heat (PBS, 2021). In the mid-1800s, mental institutions were often over-crowded and involved inhumane treatment including physical abuse and deprivation (PBS, 2021). Dating back to records from 1752, those who were experiencing mental illness were generally taken care of at home with their families (U.S. National Library of Medicine, 2015). Those with more severe mental health issues were sent to almshouses or jails, meaning that jails were one of the original mental health institutions in the United States (U.S. National Library of Medicine, 2015).

Beginning in the 1840s Dorthea Dix, an American health care activist, began a campaign to improve the living conditions for free and incarcerated Americans with mental illnesses (Parry, 2006). Dix advocated against the, "horrendous treatment of individuals with mental illness in prisons, almshouses for the poor, and asylums" (Michel, 1994). Over two years directly observing both incarcerated and free Americans with mental illness, Dix witnessed mentally ill inmates being treated inhumanely (Strickler & Farmer, 2019) and her work resulted in improvements in the standards of care for free and incarcerated Americans and Canadians with mental illness (Donahue, 1985). Dix lobbied state governments to establish and fund mental asylums (Malsin, 2015). While the history of asylums is controversial (Scull, 1977) they became a part of the American culture that continues in current American mental health treatment under a new name: psychiatric hospitals. Once inside a psychiatric hospital, most patients were held against their will—sometimes for the remainder of their lives (Foundations Recovery Network, n.d.). By indefinitely institutionalizing many Americans with mental illness, the issue "disappeared" from the public eye (Foundations Recovery Network, n.d.).

In 1887 Nelly Bly, an investigative journalist, feigned mental illness and was deemed insane and sentenced to the New York City Lunatic Asylum on Blackwell's Island (Markel, 2018). Bly's experience and investigative journalism illuminated the inhumane treatment of patients including abusive treatment, mandatory cold baths, confinement in small, dark, vermin-infested, locked rooms and limited

or even no clinician contact and resulted in increased funding and public awareness of the conditions of asylums (Markel, 2018).

In the early 1900s clinicians were using "radical cures" to end mental illness including insulin-induced comas, lobotomies, malaria and electroshock therapy (Foundations Recovery Network, n.d.). Chemical interventions became popular in the 1940s and 1950s including the use of powders and oral medications later referred to as chemical restraints (Foundations Recovery Network, n.d.). The 1950s brought a campaign for deinstitutionalization and the establishment of psychiatry departments in many community hospitals (Drake & Latimer, 2012). In 1963, President John Kennedy ushered in the community mental health movement by signing the Community Mental Health Act (Dixon & Goldman, 2003). This act facilitated the establishment of a variety of community mental health programs especially for Americans with chronic mental health issues who would have previously been institutionalized (Dixon & Goldman, 2003). In the 1970s there was a decline in the population of institutionalized mentally ill Americans from 500,000 to less than 150,000 (Dixon & Goldman, 2003). With this population shift, came a variety of challenges in caring for those who had been institutionalized and were historically impoverished with limited opportunities for housing subsidies. As such, there was a shift of those with mental illnesses moving into inner city areas that were inundated with unemployment, criminal activities and drugs (Drake & Latimer, 2012). The movement of deinstitutionalization of psychiatric hospitals in the United States starting in approximately 1960 resulted in a significant increase in the number of inmates with mental illness (Primeau et al., 2013).

In 2019, of the 51.5 million American adults with mental illness, only 23 million (44.8% of those with any mental illness) had received mental health services in the past year (NIMH, 2021). Females were more likely than males (50% versus 37%) to receive mental health services (NIMH, 2021). In a recent systematic literature review of 35 randomized control trials that compared the efficacy of psychotherapeutic techniques and neurobiological interventions, specific pharmacological approaches

were found to benefit those with mental illness (Hertenstein et al., 2021). Psychotherapy and psychotropic medications are the primary treatment for mental illness (Gelenberg, 2010) and approximately 50% of patients have reached a remission status with their mental illnesses, suggesting a need for continued improvement in treatment opportunities (Demytteraere et al., 2004). Effective psychotherapy improves brain functioning and changes brain structures, improving the quality of life of those with mental illness (Karpova et al., 2011). The introduction of synthetic psychotropic medications like lithium carbonate, introduced in Australia in 1949, and chlorpromazine, introduced in Paris in the 1950s, have positively impacted the lives of those with mental illness (Baldessarini, 2014). While there has been a group of effective psychotropic medications with limited side effects available since the 1960s, innovation in psychotropic medications has essentially stalled since this time (Baldessarinin, 2014). Access to effective psychotherapy and psychopharmacological interventions are of vital importance for individuals with mental illness and especially to those in correctional settings who may be uniquely vulnerable to SMI.

In the community, only 44.8% of individuals with mental illness reported receiving treatment within the past year (NIMH, 2021) and 24% of Americans reported at least one unmet need for treatment (Mental Health America, 2020). Even with increased funding streams such as California's Mental Health Services Act, in 2020 24% of adults with a mental illness reported an unmet need for treatment (Mental Health America, 2021). Thirty-eight percent of Americans living in states with higher levels of access to mental health services still did not receive mental health services. For example, 23.6% of adults with mental illness reported unmet treatment needs in 2017-2018. Further, since the passage of the Affordable Care Act (ACA) the number of uninsured adults with a mental illness increased for the first time (Mental Health America, 2021).

In the report, *The Comparative Efficiency of National Health Systems in Producing Health: An Analysis of 191 Countries,* Evans et al. ranked countries' mental health systems using three main goals:

1) Improvement in the health of the population, 2) Responsiveness of the health system, and 3) Fairness in financing and financial risk protection (2000). These goals were adjusted to fit population health needs for mental health related issues creating a framework for a country's overall health ranking. This framework not only considers the population's overall health (including mental health) technology and resources, but also how each country deploys services and resources (Evans et al., 2000). It also includes equity and responsiveness to the mental health consumer's expectations and needs (Evans, et al., 2000). While the United States far outspends for health care as compared to other industrialized countries, population health outcomes do not suggest that these investments have improved the health of Americans. In a study conducted by Tandom et al., using this framework, the United States ranked 37 out of 191 countries in overall health system performance. Tandom et al.'s study found a direct correlation between health expenditures and health outcomes and while the United States financially invests in health services (2000), Sood & Cohen assert that the United States does not actively include mental health in primary health care (2014) whereas other countries integrate these services.

Mental Health Services in Correctional Settings

In the early 1970s, California led the nation in deinstitutionalization with a marked decrease in state psychiatric hospital census and marked increase of inmates with mental illness in jails and prisons (Torrey et al., 2010). In the 1980s clinicians and policy makers recognized that deinstitutionalization forced Americans with mental illness out of psychiatric hospitals with many eventually ending up in the criminal justice systems (Torrey et al., 2010). As state funded psychiatric hospital beds were closed, jail and prison censuses increased dramatically (Torrey et al, 2010). Jails and prisons were not established to be structurally appropriate for inmates with mental illness, do not have coordinated health systems, and generally provide little to no psychiatric aftercare which contributes to recidivism (Torrey et al., 2010). For example, in Los Angeles County jail—one of the largest jails in the United States—90% of inmates with mental illness are repeat offenders and 31% have been incarcerated ten times or more

(Torrey et al., 2010). Approximately 63% of incarcerated Americans do not receive mental health treatment while detained in state and federal prisons and less than 45% of Americans with mental illness received mental health treatment while held in jails (US Department of Justice, June 2017).

In addition to the challenges that come with safely housing inmates with mental illness, the cost to house and care for these inmates far exceeds the cost of housing those without mental illness by perhaps more than tens of thousands of dollars per inmate per year (Torrey et al, 2010). In California, CDCR operates with five levels of mental health care progressing from outpatient through inpatient with higher staff to inmate ratios and, concomitantly, higher cost of care (California State Auditor, 2017). The average annual cost of custody for a CDCR inmate receiving the highest levels of mental health care ranges from $218,000-$345,000 in comparison to $75,000 for the average annual cost of custody for a CDCR inmate (Stanford Justice Advocacy Project 2019). At the state level of analysis, Torrey et al. found a strong inverse correlation (Spearman's rho = -0.4974 | $p < 0.001$) between the number of inmates in jails and prisons and spending on mental health services (2010). The cost of care is also greater for inmates with mental illness because they tend to have longer periods of incarceration due to the types of offenses, differences in sentencing and long wait times for psychiatric hospital beds (Torrey et al., 2010). Inmates with mental illness may also require specialized housing including padded cells, less destructible clothing and retrofitted cells for environmental suicide prevention (Torrey et al., 2010). Further, inmates with mental illness are sometimes abused by correctional staff who have limited training or understanding of how to work with mentally ill inmates (Torrey et al., 2010) thereby further increasing the likelihood of attempted suicide or death by suicide.

The decline in incarcerated populations has coincided with various court orders and changes in laws that have increased treatment opportunities for incarcerated Americans. For example, in a 2008 amendment of the Americans with Disabilities Act, expanded the criteria for mental health treatment in correctional settings and led to an influx of individuals qualifying for mental health treatment

(Americans with Disabilities Act, 1990 | Cohen, 2008). Further, Gibson v. County of Washoe, Nevada, 2002 required that inmates are screened for mental health disorders and Woodward v. Correctional Medical Services of Illinois, Inc., 2004, required that correctional systems provide suicide prevention services. These and other related court orders and changes in laws created intentional shifts in how inmates with mental health diagnoses are cared for in jails and prisons (Ricks et al., 2019). With more inmates qualifying for mental health services, correctional health care staffing levels became important concerns, especially in state prisons with litigation concerns. For example, one of the main tenets of Coleman v. Newsom seeks to improve inconsistent mental health staff vacancy rates (1995).

Correctional environments typically negatively influence the mental health of inmates due to overcrowding, violence, solitary confinement, privacy limitations, limited activity, social isolation, uncertainties about future vocation, relationships and support and inadequate health and mental health services (WHO, n.d.). Taken together, these stressors can result in higher rates of suicide (WHO, n.d.). When correctional systems respond to inmates' mental health issues with high-quality mental health services, a variety of benefits can be realized. First, promoting the use of correctional mental health services combats the stigma and discrimination associated with accessing mental health services while potentially increasing use of mental health services within the facility which may decrease inmate recidivism and impact subsequent use of services in the community upon release (WHO, n.d.). Second, treating inmates' mental health issues may increase the health and safety of workplaces for prison employees, including mental health clinicians. Addressing mental health issues in correctional settings may lead to decreased recidivism, reduction in prison populations and diversion of those with SMI to treatment programs rather than correctional settings—all while decreasing the societal cost of mass incarceration (WHO, n.d.).

To some extent, litigation can drive the funding and availability of mental health services as was seen in the Coleman litigation in California State Prisons. Since 2012, there was a 60% increase in the

number of CDCR inmates requiring care at higher level, reflecting the increasing prevalence, severity and complexity of mental illness in the population (Stanford Justice Advocacy Project, 2019). According to the Prison Law Office, there are a variety of class action lawsuits that are directly related to medical and mental health care of American inmates including, Budd v. Cambra, Farrell v. Cate, Gates v. Deukmejian, Madrid v. Gomez, Marin v. Rushen, Plata v. Newsom and Teneng v. Trump (2021). Taken together, these trends have important public health and societal implications. Litigation offers the opportunity for government agencies, private healthcare organizations and organizations to prioritize mental health care funding in correctional settings. While the cost can be astronomical, well managed mental health services in correctional settings offers inmates the ability to be treated for mental health conditions—sometimes for the first time in their lives—leading to the potential for improved patient outcomes. Correctional settings cannot exist without health services and health care professionals as access to constitutionally appropriate health care including mental health care services is a basic measure of legitimacy of jails and prisons (Allen & Aburabi, 2016).

Mental Health Workforce: Community and Corrections

CMHPs are a vital part of the correctional health workforce and there has been an increase in these positions within correctional settings since 2000 yet there has been limited research focused on this role and the experiences of clinicians (Ricks et al., 2019). Prisons are one of the largest employers of psychologists (Dvoskin & Morgan, 2010) and other mental health clinicians (Ricks, et al., 2019). The core role of correctional mental health is rehabilitation which is also a central mission of correctional systems (Ricks et al., 2019) although correctional systems are also tasked with providing punishment (Ricks et al., 2019). The balance between providing rehabilitation in a punitive environment adds a layer of complexity to the work of CMHPs (Ward, 2013). in a punitive environment adds a layer of complexity to the work of CMHPs (Ward, 2013). Given the public health importance of mental health services and the oversight by the Coleman class action litigants and federal receivership related to related Constitutional

violations (Coleman v. Newsom, 1995), research is needed to develop and establish best practices related to preparing and supporting CMHPs to address inmates' mental health needs.

Research of CMHPs became more available in the 1980s. In 1981 Otero, McNally and Powitzky estimated that there were approximately 600 master's and doctoral level psychologists working in correctional settings. Within four years, there were nearly 1,100 master's and doctorally prepared clinicians (Camp & Camp, 1992) and as of 2000 there were approximately 2,000 psychologists in correctional settings (Boothby & Clements, 2000). It is unclear how many master's prepared clinicians were present by the year 2000 as many studies were focused on the experiences of psychologists. Considering the rapid growth of CMHPs and their role in addressing the vulnerable inmate populations, it is of vital importance that the understanding of CMHPs is expanded. To date, two national surveys of CMHPs have been conducted to this end: one in 2000 by Boothby & Clements, and an expanded survey in 2015 by Ricks. The data from these surveys was analyzed and published in multiple articles from both author groups.

The survey by Boothby & Clements (2000) specifically investigated the work satisfaction of psychologists working in prison settings. Among 830 psychologists surveyed, 78% worked in state prisons and 22% worked in federal prisons. Although this survey provided an important initial understanding of the experiences of psychologists in correctional settings, none of the participants worked in jail settings and only one clinical classification (psychology) was represented. The survey by Ricks (2015) included 261 participants with multiple clinical classifications. The sample inclusion criteria differed from that of Boothby & Clements (2000) and included private correctional health care contract agencies (for example, Correct Care Solutions), six state prison departments and the Federal Bureau of Prisons.

Both surveys provide important information and an initial understanding of who practices correctional mental health care | however, comparison of the findings is complicated by their different

populations, settings and measures. Boothby & Clements (2000) included psychologists and master's trained psychology staff in state and federal prisons and excluded psychologists in jails and other mental health professionals in both prisons and jails (e.g. clinical social workers). Ricks (2015) included private correctional healthcare organizations and Boothby & Clements (2000) only included correctional psychologists while Ricks (2015) included multiple mental health classifications. Further, Boothby & Clements (2000) focused on the work satisfaction of correctional psychologists whereas Ricks (2015) considered the demographics of CMHPs and their duties.

To further prepare both master's and doctoral clinicians, Ricks et al. (2019) has recommended that graduate educators shift their curriculum to include correctional health care information. Increasing exposure to classroom material and experience in correctional environments through practicum and internships may attract developing clinicians to the field. Ricks et al. also recommends that graduate students and new mental health clinicians in correctional settings become familiar with the duties of CMHPs so as to understand the scope of clinical care required in this role in these settings (Ricks et al, 2019). Additionally, Ricks et al. recommends that professional associations, such as the American Psychological Association and National Association of Social Workers, create targeted recruitment and advocacy strategies to attract clinicians to these settings (Ricks et al., 2019). Boothby & Clements (2000) reported that accredited internship and postdoctoral residencies for psychologists were increasingly available at the time of the survey—especially within the Federal Bureau of Prisons. Since then, however, the Federal Bureau of Prisons has limited CMHP hiring to mainly psychologist while state prison systems, private organizations and jails hire master's level clinicians. Although the results from the Ricks survey in 2015 exhibit an increase in the percentage of master's level clinicians, they also consider multiple types of organizations that hire CMHPs (i.e. private organizations, jails).

Roles and Responsibilities

The role of the CMHP is complex and the scope of their duties is broad, as they are expected to engage in crisis management, provide therapeutic interventions, maintain positive relationships with custodial staff, advocate for appropriate medical care of inmates, perform cell-front welfare checks, and provide group therapy among other tasks (Galanek, 2013). The CMHPs are charged with preventing and responding to inmates' mental health crises, management of mental health symptoms and provision of therapeutic services (Ricks, et al., 2019). Additionally, CMHPs are also expected to offer inmates hope, support exploration of their world views and provide exemplars of prosocial relationship strategies (Wampold, 2001).

In these complex roles, CMHPs often face challenges in providing care in settings that are often restrictive, harsh environments (Karcher, 2003 | Ricks, 2015). Numerous job dimension categories are related to staff recruitment and retention of prison psychologists including autonomy, personally meaningful work and achievement within the job (Boothby & Clements, 2002). Boothby & Clements (2002) discuss the potential for role confusion amongst correctional psychologists. The dual-roles that CMHPs hold in correctional settings may include various ethical dilemmas between providing clinical care and maintaining security within settings (Pope & Vetter, 1992). The potential for duality in the CMHP role may lead to inmates having less trust in the impartiality of their mental health clinicians insofar as they perceive that their mental health clinicians are primarily focused on their custody (Althouse, 2000). This model may also lead to correctional administrators influencing clinical decisions and treatment as CMHPs may be pressured to conduct clandestine evaluations that could, for example, negatively impact the outcome of a parole board hearing (Weinberger & Screenivasan, 1994). Under this model, clinicians may feel pressured to label an inmate as being mentally ill if this allows for an expedited transfer of inmates who have caused problems in the past to another institution (Weinberg & Screenivasan, 1994). Weinbert & Screenivasan (1994) also propose that the potential for ethical

conflicts may be addressed through independently managed mental health services systems that are not also managed by the correctional system. In California, for example, mental health services for inmates in the CDCR are under the auspices of a separate state agency: the California Correctional Health Care Services. This a separation of both services and supervisory systems for clinical and custodial staff. This system also has the potential to create silos and chasms between professions and departmental missions. Another way for correctional systems to manage and address ethical dilemmas is to hire clinical staff through contract firms to assure independent provision of mental health services (Weinbert & Screenivasan, 1994). With this, there is the potential for more objective view of the mental health services delivery system and potential areas for improvement. In contrast, there may be areas that outside firms are unable to ascertain due to closed systems and ongoing litigation.

Considering the complexities of the role and various responsibilities of CMHPs, additional understanding as to the experiences of CMHPs, their job duties and job satisfaction is warranted. With this understanding, there is the potential for better informed recruitment and retention strategies – especially for underrepresented clinicians, more and better training in clinical and correctional settings, and more deliberate prioritization of the work responsibilities of CMHPs (Ricks, et al., 2019).

Distinctive Correctional Environments Contribute to Workforce Challenges

Correctional environments are distinctive settings that bring unique challenges for CMHPs (Stoller, 2003). The concept of preparedness to work in correctional settings is multi-faceted. The CMHPs are expected to have a broad understanding of the system, the clinical expertise to address complex cases (Magaletta et al., 2007), and thorough awareness of policies and procedures to collaborate within the custodial chain of command (Lamberti, 2007). CMHPs may enter the field with clinical expertise gained in other settings, but still have a steep learning curve to understand the custodial functions of jail and prison environments. Andrews & Bonta (2010) further assert the

importance of ongoing training and support of all correctional clinicians given their unique clinical practice circumstances and large, complex caseloads.

While it has become standard practice to offer mental health services in Amerifofcan carceral settings (Rhodes, 2000, 2004), the provision of these services in correctional environments is challenging—with significant impacts on clinician well-being and emotional health, including clinician burn-out and safety concerns (Simon et al., 2020). Along with the challenges of caring for individuals with complex physical, mental health and substance use problems (James & Glaze, 2006 | Lovell & Jemelka, 1998 |Manderscheid, Gravesande, & Goldstrom, 2004), generally, the correctional health care workforce experiences challenges related to staff recruitment and retention, restricted and stressful work environments, clinician physical and emotional harm from violent patients and vicarious trauma (Joseph Penn, Chair of the National Commission on Correctional Health Care, 2020) defined as the emotional reaction from exposure to traumatic incidents (Jenkins & Baird, 2002) that can lead to debilitating anxiety for years following an event (Lerias & Bryne, 2003). In correctional health settings, frontline health care staff are regularly exposed to, and receive reports of, traumatic incidents (Middleton et al., 2021). While vicarious trauma is a well-defined and studied topic amongst mental health care professionals in various settings, less is known about the specific impacts to correctional health care clinicians (Middleton et al., 2021) including CMHPs. Vicarious trauma decreases the quality of patient care (Conrad & Kellar-Guenther, 2006 | Tehrani, 2011) and impacts the health and retention of health care clinicians and the stability of the agency providing care (Arnold et al., 2005 | Horwath & Tidbury, 2009 | Regehr et al., 2004 | Schauben & Frazier, 1995 | VanDeusen & Way, 2006).

The frequency of traumatic incidents in correctional settings underscores the importance of understanding the forces driving correctional clinicians to work within these environments. In an ethnographic study of mental health clinicians at a Pacific Northwest Penitentiary, researchers considered the clinical complexities experience by correctional clinicians (Galanek, 2013). Considering

the distinctive environment in terms of the complexity of illness in the population, one clinician reported, "The nature of this environment is so drastically different from the community, and the complexity of the clients we work with. Part of what makes them so complicated is that there is no one dimensional clear cut kind of mental illness or problem, particularly with this population. There's layers of psychopathology. All that co-morbidity converges and comes together in a perfect storm." Within this ethnographic study, the clinical staff were full-time state employees who are expected to be front line responders for inmate mental health crises, while ensuring safety within the environment for all (Galanek, 2013). These clinicians are expected to have a broad understanding of the correctional systems in which they treat inmates with high levels of vulnerability (Magaletta et al., 2007), yet often have limited preparation for the role, a factor Simon et al. (2020) suggest may contribute to poor clinical outcomes.

CHMC Stress, Vicarious Trauma and Burnout

CMHPs have the potential to experience stress, vicarious trauma and burnout. Correctional health care providers have higher levels of stress as compared to other correctional employees (Simon et al., 2020). One of the main areas of concern noted for correctional health care providers was emotional exhaustion/distress as a result providing care to vulnerable and extremely challenging patients along with the tensions present in the distinctive correctional environments (Simon et al., 2020). Non-clinical correctional employees experience different stressors and their attitudes have the potential to impact the care that is provided to inmates with mental illness (Callahan, 2004) and can even lead to limited referrals for high-risk situations like suicidality (Garbutt & Casey, 2015).

The Corrections Fatigue Model (2016) was developed by The Desert Waters Correctional Institute to capture burnout to specific to correctional settings as distinct from that in other settings. Specifically, corrections fatigue is defined as a gradual deterioration of the spirit, mind and body (National Institute of Corrections, 2004) with impact on the mental health of correctional employees

including posttraumatic stress disorder (PTSD) (Denhof & Spinaris, 2012 | Denhof & Spinaris, 2013 | Denhof, Spinaris & Morton 2014). Correctional environments are considered high-stress occupational settings (Brough and Williams, 2007a | Dowden & Andrews, 2004) with high rates of stress/burnout and PTSD among staff including CMHPs. (Boudoukha et al., 2013). Boudoukha et al., 2013 measured stress/burnout with the Maslach Burnout Inventory (MBI) and PTSD level using the Impact of Event Scale Revised (IES-R), both commonly used scales in research and clinical settings (Wang et al., 2011). However, the current literature does not differentiate the rates of PTSD among CMHPs and this is an important consideration given their higher levels of burnout and vicarious trauma.

Burnout is defined as emotional exhaustion and depersonalization of patients –increasing the potential for negatively viewing patients, cynicism and limited ability to express empathy- limited feelings of personal accomplishment, loss of work fulfillment, and reduced clinician effectiveness in patient care (Dzau et al., 2018). In Simon et al.'s (2020) scoping review, no articles were found that considered the linkage between correctional health care provider well-being and the experiences of care by inmates (Blankenship et al., 2018 | Brinkley-Rubinstein, 2013). Further, this scoping review found that correctional provider burnout may be due primarily to feelings of disempowerment within the correctional facility hierarchy and physical plant limitations rather than from feeling threatened by patients with a history of violence (Simon et al, 2020).

Experts at Desert Water Correctional Outreach, Inc. suggest that CMHPs are prone to burnout given they frequently witness or experience violence, including physical assaults | are in the presence of deceased inmates and mutilated corpses | witness sexual assault | and are involved in riots and other life-threatening and traumatic experiences (Denhof & Spinaris, 2012). Taken together, these traumatic experiences have the potential to negatively impact the well-being of CMHPs and contribute to high rates of burnout (Skiles & Hinson, 1989). CMHP burn out, in turn, has the potential to increase the possibility of negative health outcomes for inmates. For example, in the general population of mental

health clinicians, burnout is associated with poor decision-making, limited ability to concentrate, and suboptimal patient care, including management of patient crises (Fagan et al., 2010 | Panagioti et al., 2018). Considering the complexities of correctional environments, burnout may have catastrophic outcomes for both patients and CMHPs.

Moral and Ethical Dilemmas

Every mental health profession has a code of ethics that guides specific practice areas (Bonner & Vandecreek, 2006). For example, social work practice is guided by the National Association of Social Workers has a published *Code of Ethics* (1999) along with the *Ethics Code of the American Board of Examiners in Social Work* (American Board of Examiners, 2004). The *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (American Medical Association, 2001) is utilized as a general ethics guide by psychiatrists and mental health counselors follow the *Code of Ethics* of American Mental Health Counselors (American Mental Health Counselors Association, 2000). The American Psychological Association maintains the Ethical Principles of Psychologists and Code of Conduct (2017). Common themes through these codes are: working for the welfare of the patient, maintaining confidentiality, exhibiting caution with dual relationships and avoidance of boundary violations, gaining informed consent, maintaining professional competence and maintaining social responsibility (Bonner & Vandecreek, 2006). These general ethical concepts are of vital importance in treatment, mental health care practice in correctional environments may challenge these basic ethical fundamentals.

Ethical theorists have considered the challenges of practicing in correctional environments. Clinicians in correctional settings are challenged with the need to balance ethical and constitutionally appropriate mental health care to inmate-patients while participating in the safety and security of correctional institutions (Bonner & Vandecreek, 2006). The fundamental mission of most correctional environments is security and punishment (Allen & Aburabi, 2016) not health promotion and rehabilitation. Bonner & Vandecreek provided a critique of the Anti-corrections Model and Pro-

corrections Model (2006). The Anti-corrections Model suggests that the health care of inmates is often undermined by the security and punishment agenda in correctional institutions and that mental health clinicians are particularly impacted by pressures from non-clinical staff that may negatively impact the mental health care of inmates (Weinberger & Screenivasan, 1994). This model considers mental health providers as being primarily correctional officers and then mental health clinicians (Weinberger & Screenivasan, 1994). The primary role as a custodial representative may create challenges for mental health clinicians in maintaining ethical practice principles such as patients' self-determination, autonomy and dignity. If clinicians first focus on safety and security of institutions and custodial processes, there is the potential that vital clinical assessments (i.e. suicide risk assessments) become secondary to custodial functions.

The Pro-corrections Model was established by Dignam (2003), a prison mental health administrator also employed by a correction system. Dignam understood the ethical dilemmas presented by Weinberger & Screenivasan (1994) to be exaggerated and that of a narrow view outside the reality of mental health care in correctional settings. This model purports that mental health care adds positive functions to the custody-related functions of institutions. Dignam (2003) argues that providing mental health care within the correctional setting promotes personal responsibility amongst inmates, increases their respect for authority and enhances prosocial behaviors of inmates. This argument suggests that the goals for inmates are equally shared and valued by clinical and custodial staff (Dignam, 2003). This perspective means that all staff members are a part of the mental health treatment team and that all inmates may need of mental health services at any given time thus lowering the need for confidentiality and patient records privacy (Dignam, 2003).

One critique of the Anti-corrections Model is that its proponents, Weinberger & Screenivasan are ethical theorists who have not worked in correctional mental health care and thus, may not have the insight necessary to understand the complexities of these distinct environments (Bonner & Vandecreek,

2006). The Pro-corrections Model (Dignam, 2003) assumes a correctional system where all staff are focused toward rehabilitation and ethical mental health care practice. Both models illustrate the inherent complexities of providing mental health services in correctional settings, but both models are extreme ends of the spectrum of the true ethical challenges faced by mental health clinicians in correctional settings. To address the ethical challenges of these distinct settings the International Association for Correctional and Forensic Psychology (IACFP) and National Commission for Correctional Health Care (NCCHC) established standards of practice for mental health correctional clinicians (IACFP, 2010 | Gibson & Phillips, 2016). While these standards provide vital information to the field, the NCCHC standards are available only by purchase and the publicly available IACFP standards are not widely distributed. The NCCHC surveyed clinical members and held workshops to develop a code of ethics that crosses clinical practice areas and addresses the distinct environmental needs in correctional systems (Bonner & Vandecreek, 2006).

As each correctional environment is unique in staffing, culture and patient population, it is likely that CMHPs may manage ethical dilemmas by operating within the gray area in the spectrum between the Anti-corrections and Pro-corrections models. Professional organizations have attempted to provide guides and professional standards to assist with these complexities. The IACFP and NCCHC standards allow for CMHP support specific to their areas of practice and allow for professional development and guidelines not often offered in jails and state prisons to CMHPs.

CMHP Recruitment and Retention

American correctional agencies experience many challenges with recruiting mental health clinicians (Morris & West, 2020). In a 2018 survey of 20 correctional representatives across six states, 85% had challenges recruiting CMHPs and 70% struggled with retaining competent CMHPs (Buche et al, 2018). Considering the complexities and health vulnerabilities that incarcerated Americans present within jails and state prisons, recruiting and retaining competent CMHPs is of vital importance if there is

hope for transforming the prison system from a punishment orientation to a health-promotion orientation.

Summary

In a scoping review of the experiences of correctional health care providers generally, Simon et al. (2020) synthesized 23 articles underscoring the unique needs of clinicians in correctional settings with particular focus on the tension clinicians experience in their efforts to provide clinical care and help to uphold security. Simon et al. (2020) suggest that there are three themes from this scoping review — all of which have been synthesized above — 1. Correctional environments as distinct practice settings, 2. Ethical dilemmas in correctional healthcare and 3. Clinical burnout and safety concerns. Taken together, the complexity of inmate mental health care needs and the challenges faced by CMHPs create unique vulnerabilities and opportunities to improve care in correctional care settings.

These three major themes from Simon et al. (2020) provide a general foundation to understand the needs of CMHPs. The Boothby & Clements survey of 2000 and the Ricks et al. survey of 2015 add additional detail to create a more specific understanding of the needs of CMHPs. Major recommendations from the 2000 survey were related to recruitment and retention of correctional psychologists including enhanced training in graduate education to prepare for these distinct environments, expectation-setting around the various roles of psychologists in correctional settings and the need to improve job satisfaction to retain trained correctional psychologists (Boothby & Clements, 2000). Ricks et al. recommended that correctional organizations recruit women and clinicians of color to correctional environments, increase the exposure to correctional environments for training and practicum/internship opportunities for graduate students, consider the cultural needs of patients in correctional environments and encourage professional organizations to assist in preparing CMHPs for these distinct practice settings (Ricks et al., 2019).

Further studies are warranted in state prisons and jail settings, particularly given their populations have higher rates of mental illness and serious mental illness. Both existing surveys of providers in these settings have limitations in understanding these distinct clinical settings including their reliance on quantitative methods that preclude "thick description" of CMHPs perceptions and experiences. In addition, qualitative inquiry is needed to better understand the complexities of the roles and responsibilities of CMHPs that cannot be discovered through quantitative formats. Further research is needed specific to the issues and challenges in the correctional mental health care work environment. In particular, qualitative research is needed to understand the subjective perspectives of CMHPs who provide mental health services—across disciplines and correctional settings. Understanding the qualitative perspectives of clinicians themselves is essential to expanding the understanding of the CMHP workforce especially as there is limited knowledge on this subject in the current literature. Descriptive qualitative inquiry, specifically, will provide an initial needed contribution to the state of the science and guide more complex qualitative study designs in the future.

The proposed study will provide insights into the views of CMHPs, specifically those working in jails in the 27 rural and 17 suburban counties of California, related to the facilitators and barriers experienced when providing care. As previously stated, non-urban jails have increasing populations, inmates with physical and mental vulnerabilities and limited infrastructure/resources. As most studies referenced in the literature review are quantitative, this study has the potential to establish a qualitative exploration of the experiences of CMHPs. The study will further seek the recommendations of strategies from CMHPs to better understand how this role may be better supported. Insights from this study will provide a foundation for future research to develop and establish best practices related to preparing and supporting rural jail mental health providers in addressing inmates' mental health needs, including initiatives related to job support, training and addendums to clinical supervision. Importantly, this study will explore these issues from the perspectives of individuals engaged in the work day-to-day,

to better understand the challenges they face and to identify solutions to address the challenges. Findings from the study are expected to reveal facilitators, barriers, recommendations and opportunities to support for those who serve the increasing population of inmates with mental illness, including SMI.

This study will provide insights into the view of mental health clinicians related to the facilitators and barriers experienced when providing care. The study will further seek their recommendations of strategies to optimize jail mental health services. Insights from this study will provide a foundation for future research to develop and establish best practices related to preparing and supporting CMHPs to address inmates' mental health needs. The findings from this study will enhance the body of literature and may assist with initiatives related to job support, training and addendums to clinical supervision, with possibly transferability of the findings to other similar settings

Theoretical Model: Social Ecological Model

The Socio Ecological Model provides a systems level perspective emphasizing intrapersonal/individual, interpersonal factors, institutional/organizational factors, community factors, public policy factors and their interactions (McLeroy et al., 1988) for a more inclusive focus on health issues. Using all levels of the Socio Ecological Model, researchers can consider interactions at different levels and suggest holistic interventions (Bunting et al., 2018). This framework can be applied to diverse settings including jails. This model allows a focus on, "equity, partnership, human rights, respect and decency" (Baybutt & Chemlal, 2016) and has been utilized in English correctional settings to impact the health of inmates as well as prison staff (Baybutt & Chemlal, 2016). The Socio Ecological Model considers health as a holistic concept defined by the complex interactions of the environment, organization and individual factors. Its application has the to guide our understanding of mental health services in correctional settings—supporting both clinicians and incarcerated populations. Use of the systems perspective acknowledges that the entire correctional system, not only the health care areas, must collaborate to consider and address individual health issues of inmates, in additions to the less

proximal social issues that contribute to incarceration (Baybutt & Chemlal, 2016). Bunting et al. suggest that the use of the Socio Ecological Model provides the opportunity to clearly assess outcomes at the various levels of the model allowing for interventions tailored to the needs at each level (2018).

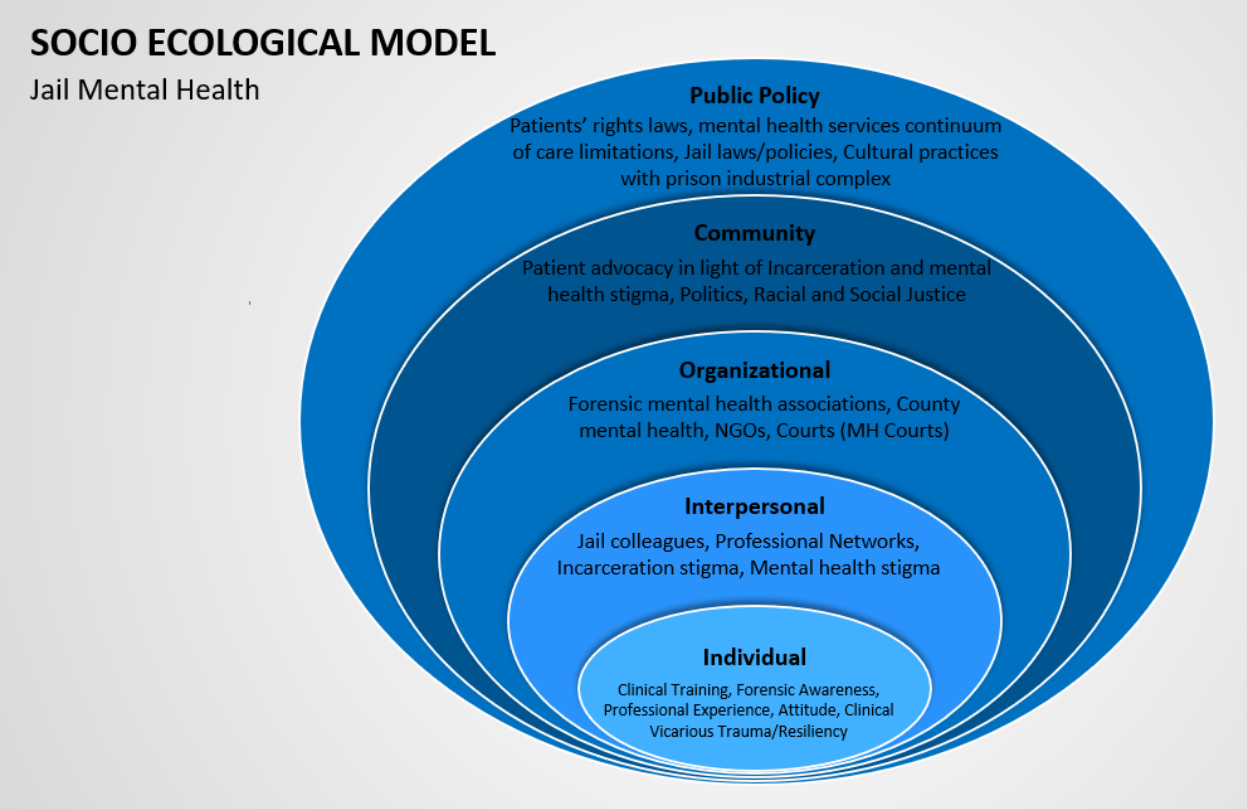

Figure 1: Socio Ecological Model: Jail Mental Health

Applied to this study, Figure 1 exhibits the Socio Ecological Model specific to jail mental health clinicians. Individual factors include clinical training, forensic awareness, professional experience, attitudes, clinical vicarious trauma and resiliency. Interpersonal factors include jail colleagues, professional networks, incarceration stigma, and mental health stigma. Organizational factors include forensic mental health associations, county mental health, non-governmental organizations and courts—specifically mental health courts. The Community level includes patient advocacy considering incarceration and mental health stigma, politics, racial justice and social justice. Finally, Public Policy includes laws pertaining to patients' rights, the limitations of the continuum of mental health services

available in jails and the community, jail laws/policies and cultural practices within the prison industrial complex. It should be noted that this model is applied to focus specifically jail mental health clinicians and not the experiences of jail inmates.

This qualitative investigation was guided by a socioecological framework to articulate themes in the specific social context of mental health provision in jails. A foundational understanding of the clinical care in these settings may improve our understanding of how jail mental health providers can be better supported to provide more optimal care to an extremely vulnerable population.

Chapter 3: Methods

Project Objective and Aims

The objective of this study was to examine the factors that support mental health clinicians in providing mental health care to inmates in non-urban California jails. The overarching objective of this study is to improve the mental health care services received by inmates in rural and suburban California jails. Jails provide a unique opportunity for providing mental health care especially as jails have a constitutional obligation (Brad H. v. City of New York et al., 2011 | Ruiz v. Estelle, 1980) and state regulations to provide mental health care to inmates (Jacobs & Giordano, 2018). This is important as American jails often serve as the default for community behavioral health hubs as they are often the first point of entry into the American criminal justice system (Kopak et al., 2019). The majority of jails are in semi-urban and rural areas and lack highly trained mental health clinical staff (Applegate & Sitren, 2008). It should be noted that while the majority of jail literature focuses on urban jails, these results may not be representative of the challenges faced by semi-urban and rural jails (Kopak et al., 2019). Considering the literature above, the Socio Ecological Model and fundamental principles of qualitative inquiry, the specific aims of this study were to:

- Explore the **individual** factors that support jail mental health clinicians in providing mental health care services to inmates in rural and suburban California jails |
- Explore the **interpersonal** factors that support jail mental health clinicians in providing mental health care to inmates in rural and suburban California jail | and
- Explore the **organizational** factors that support jail mental health clinicians in providing mental health care to inmates in rural and suburban California jail.

This study focused specifically on three levels of the five level Socio Ecological Model to better understand the experiences of CMHPs. The long-term goal of this research was to enhance the capacity of CMHPs to meet the complex mental health care needs of inmates. The findings from this study serve as a basis for clinical practice recommendations, policy adjustment opportunities and guidance for

further research aimed at establishing best practices in the support of correctional mental health clinician functioning related to ethical dilemmas, distinct practice settings and clinician burnout.

Study Design

A qualitative descriptive study design using thematic analysis was used to examine the factors within each of the first three levels of the Socio Ecological Model that may support mental health clinicians in providing clinical mental health care services to inmates in jail settings. This study design used analytical categories within a socioecological framework to articulate themes in the specific social context of mental health provision in jails.

This study was approved by the UC Davis Institutional Review Board (IRB) initially in February 2022 (for rural counties only) and a modification to include suburban California jails was approved in August 2022.

Project Setting

Jails are classified by county type: rural, small/midsize, suburban and urban for the purpose of collecting statistics. According to the California State Association of Counties (CSAC) California has 27 rural counties, 17 suburban counties, and 14 urban counties (CSAC, 2014). The Board of State and Community Corrections maintains the average daily population of California jail inmates, which is updated quarterly. From January-June 2022, the average daily population of both un-sentenced and sentenced rural jail inmates was 6,088, for suburban was 18,932 and for urban was 79,047 (BSCC, 2015). While the average daily jail populations listed above show that there are more inmates in California's urban counties, rural and suburban jails now have the highest jail incarceration rates and have significant infrastructure challenges (Henrickson & Fishman, 2016). Smaller counties now hold 44% of Americans incarcerated in jails-up from 28% in 1970 (Henrickson & Fishman, 2016).

As a result, clinicians working in rural and suburban jails may experience a revolving door of patients and have limitations in areas to provide mental health treatment. Non-urban counties also struggle with basic resources and capacity in providing mental health services to jail inmates and the

clinicians who provide their mental health care (Henrickson & Fishman, 2016). A recommendation of the Vera Institute, a leading organization in the transformation of criminal justice systems, is to increase research projects in non-urban counties to understand the phenomenon of increasing rates of jail incarceration in these counties along with understanding the factors leading to continued capacity and resource restraints.

It should be noted that some counties combine jail resources meaning that multiple rural counties will manage a single jail and some rural counties have multiple jails within their county. As such, it is important to cast a wide net for recruitment in all 44 rural and suburban counties. Further, recruiting from all 44 counties allows for de-identification of the data collected.

How Recruitment Occurred

Email scripts were utilized to advertise to county/jail leaders (Appendix A) and to communicate directly with potential study participants (Appendix A-Script 2). For both the county/jail leader and potential participant, if a response was not received to the first message, a second or reminder email was sent. If the county/jail leader provided member contact information for potential study participants, I contacted the potential study participants using the second script (Appendix A - Script 2). If no response was received to the initial recruitment email to members, I sent up to two follow up emails one to two weeks apart. If the potential study participant expressed no interest in participating, a correspondence thanking the potential participant was sent and no further communication occurred.

Once individual participants were identified, I scheduled phone calls to discuss specifics of the study for those who replied with interest in learning more about the study. This provided an opportunity to answer any questions that potential participants may have had about the study and opened the opportunity to use snowball sampling as needed.

I maintained a separate spreadsheet with the name, contact information and status of participation in this study for tracking purposes. This spreadsheet was utilized for organizational purposes only and was not connected to any other study documents.

If an individual agreed to participate in this study, I scheduled a one-to-one interview at a time based on the participant's preference. All one-to-one interviews occurred over the phone. Interviews generally lasted 60 minutes although many participants chose to speak for a great amount of time after the conclusion of the recording.

Inclusion and Exclusion Criteria

Inclusion Criteria:

The sample included mental health providers who have worked in the past five years or were currently working in rural or suburban California jail settings as a mental health provider. As each jail provided different services, any provider who conducted mental health services (direct therapy, psychiatry, case management, discharge planning, etc.) qualified as a mental health provider. California jails were selected in part as there are active changes occurring to the mental health systems of care within California Jails (consent decrees) making it important to focus on one state. Further, as there are regular changes in the services and patient distribution in jail settings, it was important for the study participants to be currently practicing in correctional settings or to have recent (past five years) experience for at least 12 months in these settings. Participants were additionally required to have access to a phone to be able to engage in the interview.

Exclusion Criteria:

As federal and state prisons are distinctly different from jail settings due to longer lengths of stay and more stable populations, jurisdictional scope and offense distribution (Bureau of Justice Statistics, n.d.), mental health clinicians who have worked solely in prison settings were excluded. Further, those who had not worked in rural or suburban California jails were excluded.

Instrument Development

The one-to-one Interview Guide was developed using the Social Ecological Model, which provided a systems level perspective emphasizing interactions amongst and between the intrapersonal/individual, interpersonal factors, institutional/organizational factors, community factors and public policy factors (McLeroy et al., 1988) for a more inclusive focus on health. With the use of all levels of the Socio Ecological Model, researchers have the opportunity to consider interactions at different levels and to suggest holistic interventions (Bunting et al., 2018). As seen in Figure, this framework can be applied to diverse settings including jail settings. This model allows for a focus on, "equity, partnership, human rights, respect and decency," (Baybutt & Chemlal, 2016) and it has been utilized in English correctional settings not only to impact the health of inmates but also prison staff (Baybutt & Chemlal, 2016). The Socio Ecological Model allows for health to be considered as a holistic concept that is defined by the complex interactions of the environment, organization and individual factors having the potential to guide correctional settings' understanding of mental health services — supporting both clinicians and those incarcerated. Use of the systems perspective acknowledges that the entire correctional system, not only the health care areas, must collaborate to consider and address not only the individual health issues of inmates, but also the social issues that contributed to incarceration (Baybutt & Chemlal, 2016). Bunting et al. suggest that the use of the Socio Ecological Model provides the opportunity to more clearly assess outcomes at the various levels of the model allowing for interventions to be conducted that are tailored to the needs of each level (2018).

The work of CMHPs is complex and the Socio Ecological Model offers a well-established approach to assessing the quality of health care in these complex settings. The one-to-one interview guide includes open ended questions with probing or follow up questions (Appendix X). In summary, the interview guide begins with demographics questions and then transitions into three major sections: individual, intrapersonal and organizational socioecological levels.

This semi-structured one-to-one interview allowed for further inquiry as needed including probes to clarify and summarize participant respondents. Prior to use of this interview guide, the questions were piloted with three jail mental health providers who did not qualify for this study. Piloting allowed for improving the clarity of questions, examining the flow of the entire guide and getting a firmer understanding of the approximate time of the interview with this guide. Piloting questions assisted in strengthening questions, identifying flaws/limitations in questions and making modifications prior to data collection (Kvale, 2007).

Risks to Project Participants

The study protocol was submitted to the UC, Davis Institutional Review Board (IRB) for review/approval of this research with human subjects. This study was deemed exempt on February 24, 2022 with only rural counties and modifications to the study (to include suburban counties) were approved on August 10, 2022.

As the one-to-one interviews focused on the experiences of CMHPs and the context in which they provide clinical care, the interviews and questions were not expected to cause potential risk or harm and special care was taken to avoid a breach of confidentiality. Potential for discomfort when answering questions was addressed by reiterating multiple times during the consent and interview process that participation was completely voluntary and could be revoked at any time in the process and participants could decide not to answer certain questions without any negative consequences. Three participants who chose not to answer some of the opening demographic questions, but all recorded questions were answered without verbalized concern.

To protect confidentiality, all study materials were de-identified | no links were made between participant names/identifiers and the data (recordings/transcripts). Further, I have not and will not share information with the recruitment organizations about who participated or decided not to participate in this study. Only I have access to the Otter.ai and Dedoose program log-in information.

Benefits to Project Participants

There are no direct benefits to participants. A $15 virtual gift card was provided to participants of this study as a token of appreciation for their time.

Data Collection

At the beginning of the interview, prior to starting the recording, the participant was asked if they had any questions. Also, before starting the audio recording of the one-to-one interview, participants were asked not to say their name, others' names, or their institution affiliation while the recording of the one-to-one interview was active. Participants were asked if they had a chance to review the emailed informed consent and I reviewed the informed consent with each participant. I made it explicitly clear that participants had the opportunity to stop the interview at any point and to decline answering any questions without penalty. At the beginning of the recorded interview I asked the participants if they had a chance to review the informed consent, if they had any questions and if they agreed to participate in this interview. All participants verbally reported on the recordings that they consented to participate in this study.

One-to-one interviews followed the Interview Guide (Appendix C) and recordings lasted for approximately 30 minutes in total. The entire process over the phone was generally around 60 minutes with some calls lasting two to three hours depending on the amount of conversation before and after the interview. Participant were notified of the beginning and end of the recording. At the conclusion of the recording, it was not uncommon for the participants to discuss or further explain off the record comments.

If the participant self-identified or mentioned their name or other's names or institutions during the recorded portion of the one-to-one interview, this information was redacted in the transcript.

Data Analyses

Recorded one-to-one interviews were transcribed with the use of Otter.ai (https://otter.ai/about) and I reviewed each transcript for verbatim accuracy. To collect memos, the audio of interviews were listened to multiple times. High level notes were kept for specific themes and weekly discussions occurred between myself and the research mentor. The verified transcripts were uploaded to Dedoose (https://www.dedoose.com/), a qualitative data management software system in preparation for data analysis. I used the thematic analysis approach to analyze data for patterns and themes. Thematic analysis is a foundational method for qualitative data analysis (Braun & Clarke, 2006). Before data collection and analysis I established an *a priori* coding schema that was adjusted as additional data was collected. The data gleaned from interviews was analyzed by themes.

With thematic analysis, large amounts of data can be organized to allow for clarity of results (King, 2004) and, "underlying systems of meaning," are established (Taylor & Ussher, 2001, pg. 297) allowing for expected and unexpected themes to emerge through the interviewing and coding process. The established codes allow for an understanding of the data and connection back to the research question (Clarke & Braun, 2014). Coding from thematic analysis is not for the purpose of reducing data, but rather for capturing the superficial (surface) meaning and concealed (underlying) meaning (Clarke & Braun, 2014). For example, the literature supports that participants of this study will likely discuss initial themes related to individual, interpersonal and organizational levels as the questions were structured in accordance with the Socio Ecological Model. Although the original aims of this study focused on the individual, interpersonal and organizational levels of the Socio Ecological Model, probing questions assisted in establishing richer data that included the community and public policy levels of this model.

A list of *a priori* codes was created based on the study's theoretical framework, the Socio Ecological Model. These codes supported initial organization of the data as a basis for further analysis as additional data was collected (Colorafi & Evans, 2016). New codes were added as new concepts and

concept categories emerged. The interviews were reviewed multiple times for multiple levels of coding and coding categories to identify emerging themes and patterns based on the phases proposed by Braun & Clarke's (2006): 1). The researcher familiarizing themselves with the data, 2). Generation of initial codes, 3). Search for themes, 4). Review of established themes, 5). Defining and naming of themes, and 6). Production of analysis/report of data. I met regularly with my primary research mentor to review data excerpts, coding practices, coding definitions and coding decisions.

Interviews occurred from early March 2022 through late October 2022. Analysis began with the first interview which provided insights that were considered in subsequent interviews and continued into November 2022.

Trustworthiness and Rigor

Lincoln & Guba assert that trustworthiness of a research study is vital in evaluating the study's worth (1985). The trustworthiness of a qualitative study involves credibility (confidence of truth in findings), transferability (applicability to other contexts), dependability (consistency and potential to repeat findings) and confirmability (researcher neutrality) (Lincoln & Guba, 1985). This study used various techniques to establish trustworthiness including, debriefing with my primary research mentor throughout the data collection and analysis processes and confirmation of coding practices (Lincoln & Guba, 1985).

I also had routine meetings with my primary research mentor to review interview approaches, discussed the process of interviews, engaged in debriefing, reviewed excerpts of the data and verified coding practices. Debriefing occurred with my primary research mentor for the purpose of assisting in exploring implicit perspectives that may have otherwise remained concealed (Lincoln & Guba, 1985). Another important consideration for this study was the transferability—level results can be generalized or transferred to other contexts-- of the data (Forero et al., 2018). Lincoln & Guba (1985) speak to the

thick description, detailed account of data collection, to be able to consider having a richer and fuller understanding of the experiences of participants in this study.

Reflexivity, a part of confirmability, considers the background and position of the researcher to understand and acknowledge the judgments and direction the study has used-often created by the researcher's background influences (Lincoln & Guba, 1985). To foster reflexivity, I engaged in routine debriefing with my primary research mentor as a way to identify and address any bias, related to my perspectives, beliefs and values throughout data collection and analysis processes. I took into consideration my positionality during this study. As a previous CMHP and administrator of the California Correctional Health Care Services (the health care organization for CDCR), I had some awareness of the processes and concerns that were discussed by research participants. This positionality sometimes helped me to initially build rapport and trust with participants. I was also able to understand the complexities of certain correctional issues (i.e. solitary confinement, chaos within the environment, coordination with custody staff) more quickly than a researcher without this experience. I also was able to understand participant hesitation and concern for confidentiality related to participation in this study.

At the same time, based on my previous experience I had to closely monitor for any assumptions, pre-conceived ideas and impacts to my analysis and interpretation of the data. It was important for me to notify participants of my previous experience within CDCR, and to explain that I no longer worked within CDCR and had never worked in a jail environment.

Study Challenges and Processes to Address Challenges

I initially assumed it would be difficult to establish rapport with participants and that data collection over the phone may create challenges to study recruitment. These assumptions were incorrect and I found that conversations over the phone were fruitful but that most individuals contacted were not interested or able to participate in the study. I expected those who would not agree to participate would be CMHPs experiencing severe burnout and vicarious trauma as they may not have

the ability and bandwidth to participate in this study. However, most of those who declined participation were concerned about being understaffed, concerned about participating while being part of on-going litigation (consent decrees) and were concerned about their employment status as mental health jobs were difficult to access in certain counties. I did not expect that one of the main limitations would be lack of follow through in communication. It was not uncommon for me send emails and make phone calls that were never returned—even with private organizations and groups unaffiliated with the counties and jails.

Chapter 4: Results

In this chapter, I present results of the interviews with 14 mental health providers who currently or previously worked in rural and suburban county jails.

Recruitment

Although qualitative inquiry would ideally include 20-30 interviews for study results to reach or hover near saturation, recruitment for this study proved to be extremely complex and fraught with challenges. We view the reasons for this reluctance of jail mental health providers to participate as part of the phenomena under study. From February 2022-late July 2022, 26 rural counties were contacted through multiple avenues. With an additional review of the literature over the summer of 2022, it became clear that there were similarities in the mental health programming, infrastructure and staffing in suburban jails and thus, I contacted the IRB to expand this study to include the 17 suburban California counties. This amendment to the original IRB application for this study was approved in late July 2022 and I began suburban recruitment immediately.

I began by contacting the behavioral health offices within each county and then the county jail mental health offices. I made contacts multiple times by phone and sent follow up emails. In addition, for both rural and suburban counties I contacted county-level National Alliance for Mental Health (NAMI) groups, the Forensic Mental Health Association of California (FMHAC), WellPath Care (both regional and corporate levels) and the California Jail Association Program. From these recruitment efforts, I made direct contact with over 150 individuals resulting in 14 participants for this study.

When contacting potential participants for this study there were regular concerns from county administrators regarding how short staffed their departments were and how overwhelmed the mental health staff of their county were due to COVID-19. Many administrators were unwilling to advertise the study for these reasons and many did not return voicemails and emails. It was also made clear that

there were concerns about staff being involved in any study or outside project due to the consent decrees that almost all county jails in California are currently under.

Multiple counties declined involvement in this study due to extremely short staffing, concerns with participation in a study during new litigation with county consent decrees, and concern that staff would feel overwhelmed with an additional request considering their efforts through the COVID-19 pandemic. Individual clinicians who declined participation discussed their concerns with confidentiality considering that they had limited employment options within their rural or suburban communities. These clinicians also discussed concerns about their involvement considering consent decrees in their counties. Some clinicians also discussed safety concerns with speaking openly about challenges with custody staff as they rely upon custody staff to keep them safe while they provide mental health services in these jails. I engaged in multiple hour-long conversations with potential participants about the measures taken maintain confidentiality in the study, validate concerns and leave space for questions. There were times that these conversations resulted in completed interviews and other times that participants declined further involvement in the study. I ensured that all conversations were open with free of coercion. As a previous correctional health professional, I worked within the constraints of a system involved in litigation and I understood high levels of suspicion when contacted by outsiders for information. This positionality allowed me to intimately understand and respect these concerns.

These consent decrees follow the Coleman litigation in the state prison system (discussed in Chapter 1) which has provided oversight to CDCR for nearly three decades and are at various stages of establishment and are focused on concerns of violations of cruel and unusual punishment as it relates to mental health treatment within California Jails. It is understandable that during a litigation process that there would be less interest and higher levels of suspicion related to engagement in this research study of a sensitive topic.

In contrast, snowball sampling within this study was successful, possibly due to trust built with initial participants who spread information about the study. At the end of each interview I requested that participants consider sharing information about the study with their colleagues. Although snowball sampling is used in many different populations, it appeared that it was vital in rural and suburban county recruitment.

Due to these challenges, in nearly nine months of recruitment efforts with countless hours of engagement with mental health providers, county and jail administrators and outside organizations, fewer participants agreed to participate than initially anticipated. Some participants clearly felt relief in not having to describe the complexities of correctional healthcare, safety considerations and how the community views their work. It was also clear that even with my own lived experience in the state prison system that there was still concern for breaches in confidentiality, suspicion and mistrust.

Sample

This study included 14 total participants from rural and suburban counties. Ten participants currently or previously worked in rural counties, two participants currently or previously worked in suburban counties and two participants worked in both rural and suburban counties. Participants came from different areas of practice including Associate Professional Clinical Counselor, Unlicensed and Licensed Social Workers, Licensed Marriage and Family Therapists, and Certified Case Managers. Most participants were licensed and the average length of licensure amongst licensed participants was 10.3 years with a range of 4-32 years of licensure. Most were county employees (64%) followed by contracted employees from a National correctional staffing organization (29%). One participant was employed by both the county and a National correctional staffing organization. No members of this sample had specialized training prior to entering the jail setting and the most did not intentionally apply to work in the jail.

Table 1 Sample Characteristics (n=14)			
Participant Characteristics		Mean (range)	N (%)
Licensure Status	Licensed/Certified		10 (71%)
	Unlicensed		4 (29%)
Length of Licensure (in years)		10.3 (4-32)	
Employment Type	County Employee		9 (64%)
	Contracted Employee		4 (29%)
	Both		1 (7%)
Specialized Training Prior to Entering Jail Mental Health			0 (0%)
Length of Employment in Jail Setting (in years) (N=13)		4.3 (1-17)	
Held Multiple Roles	Yes		5 (36%)
	No		9 (64%)
Live in the Community Worked In (N=12)	Yes No		10 (71%) 2 (14%)
Live in a Rural or Suburban Community (N=12)	Yes No		11 (79%) 1 (7%)
Number of Jails Worked In (N=13)		1.8 (1-11)	

Worked in Other Correctional Settings (N=13)	Yes	0 (0%)
	No	13(93%)
Additional Qualifications (N=11)	Yes	8 (57%)
	No	3 (21%)
Involved in Loan Repayment Program(s) (N=11)	Yes	2 (14%)
	No	9 (64%)
Reason for Joining Jail Mental Health Workforce (N=11)	Salaries/Wages	0 (0%)
	Loan Repayment	0 (0%)
	Interest in Forensics	4 (29%)
	Other	6 (42%)
	No Data	1 (7%)

Table 1 Sample characteristics

The average length of employment within the jail was 4.3 years with a range of 1 to 17 years. Most study participants lived in the community where they worked (71%) and in rural/suburban counties (79%). On average, participants worked in one or two jails with one outlier having worked in multiple jails through a National organization that provides staffing to jails and prisons. The participants in this study had not worked in any other correctional/forensic settings outside of rural/suburban jails. Most participants were not involved in student loan repayment programs (64%). Their reasons for joining the jail mental health setting ranged widely from an interest in forensics (29%) to other reasons (42%) such as being "voluntold" into the role, having strengths in crisis related work, covering from staff while they were out ill and staff never returning, and "stumbling into the role." A few participants partially opted out of answering specific demographic questions. When there were less than 14 participants, the N indicated in the specific row of Table 1.

Data Collection

Data were collected via phone interviews from late March 14, 2022 through October 17, 2022. Prior to the phone interview, participants were sent the consent form (Appendix C) via email and at the beginning of the phone interview I reviewed the consent form with each participant. I provided time to answer any questions and confirmed that the participant was comfortable participating in the study. As this study was deemed exempt from full review by the IRB, participants were not required to sign a physical consent, but to confirm record of the review of the consent form at the beginning of each recording and assent to the interview.

Before beginning the recording, general information was collected verbally (Table 1). While the interview recordings ranged from approximately 15 minutes to nearly 60 minutes, the process of reviewing the consent form, rapport building conversations and collection of demographic data (Table 1) before the interview along with post-recording conversation resulted in some the entire phone interview process lasting anywhere from one to three hours. Most participants who were involved in more in-depth discussions after the formal recording had stopped were taking time to process their experiences of working in jail mental health services.

Data Analysis

Demographic data collected prior to the start of the recorded interview was analyzed in an Excel spreadsheet with simple calculations (Table 1). Recorded interview data was collected with the consent of participants with OterAI and I listened to each transcript multiple times to clean up any errors in transcript, improve formatting and establish initial themes. Once files were completed in OterAI, I imported these files into Dedoose for further thematic analysis. In Dedoose, I established a code book (Table 2) and coded the data from each interview.

Main Themes

Main themes and subthemes that emerged from the data are summarized in the table below, organized by socioecological level.

Table 2 Main Themes by Socio Ecological Model

Category of Model	Main Themes	Sub Themes
Individual	Entering the Field	Why I Entered What I Knew What I Thought It Would Be
	Typical Day in the Jail	
	Successes	
	Challenges	
	Main Priorities for Jail Mental Health Providers	
Interpersonal	Training	
	Key Components of Successful Jail Mental Health Provider	
	Connecting with Custody	
	General Support	
	Difficult Things	Support Collaboration
Organizational	Main Priorities:	
	Organization	
	COVID-19	Access to Care Changes Due to COVID-19 Facility Preparedness Impacts to Providers Impacts to Patients Outbreaks Sentencing Changes and Transfers COVID-19 Specific Impacts to Substance Use
Community	Rural/Suburban Patient Differences	
	Resource Needs and Access to Care	Resources for the Community Resources While in Custody Resources for Homelessness Resources for Registered Sex Offenders
	Structural Racism and Cultural Considerations	
Public Policy	Distinct Environment	For Patients For the Clinical Process

	Substance Use Jail Infrastructure Dreaming Big	Impacts to Confidentiality Empathy and Compassion Infrastructure Additional Clinicians Training Resources Substance Use

Individual Experiences of Jail Mental Health Providers

The main themes that emerged at the individual level include Entering the Field with Sub-Themes of *Why I Entered*, *What I Knew* and *What I Thought It Would Be*. Other main themes were *Typical Day in the Jail*, *Successes*, *Challenges* and *Main Priorities for Jail Mental Health Providers*.

Entering the Field

Entry into jail mental health in rural and suburban communities was categorized within three subthemes: *Why I Entered*, *What I Knew*, and *What I Thought it Would Be Like*. Participants described intentions of entry, previous knowledge before entering the distinct environment of jail mental health care, and preconceived notions of what this clinical environment would be like.

Why I Entered.

One clinician in this sample (n=14) expressed that they had a specific interest in and purposefully sought this employment. This participant stated:

> *Working in correctional mental health, due to growing up with family members being involved in criminal justice, having an interest in what makes those people do this behavior they are doing, barriers up to offenders and seeking treatment.*

Another participant who had an interest in criminal justice and psychology, but did not intend to enter employment in jail mental health shared a similar interest due to having family involved in correctional systems:

> *…since I knew that when I was going to school that that's the type of population I wanted to focus my career on. And also just family members I've seen in the correctional*

system not getting the support that they needed, when it was like the most vulnerable time in their lives.

Multiple clinicians discussed that their entry into the field was the result of being hired for a different role within the County and then ending up in the jail for coverage and/or on a "volun-told" basis—having limited choice in the decision to enter into jail mental health. The majority of providers did not intend to work in correctional mental health care:

It was honestly more dictated by the director and my supervisors at the time. That's how I started.

Similarly, another participant stated:

It was not a decision. I was directed by my program manager that I would be conducting jail assessments.

Some clinicians who were not intending to enter jail mental health found that the role was a good fit:

I hadn't actually applied for the job, but decided that it was something that was of interest to me and important to me.

Another participant explained that they felt fear initially when considering working in the jail, but after being hired developed an interest in working in jail mental health:

Well, I was pretty scared actually to work in in jail at first. I was offered that position as the entry into a county position. And I definitely wanted to get out of the nonprofit sector. So I accepted. I was looking forward to working, to continuing to work with law enforcement I felt pretty comfortable in that realm. So for me, that was a pretty easy decision. The other thing that made it a very positive experience for me right away was the team that I was introduced to in terms of working at the at the jail itself. The mental health team was obviously right away a very excellent group of people.

Similarly, one participant was initially drawn to their job out of financial necessity, but ended up developing an interest in the work and the setting:

I needed a job after grad school, to get my hours and so forth and to pay the bills. And I applied for a County position that I didn't realize was a forensic position at the time…And I ended up really enjoying it and I worked there for four years. Then I got licensed, and my position at the time was an unlicensed position. So I was able to promote to a licensed position that was a clinic clinician in the jail running drug and alcohol education program. And we also had a dual diagnosis group that we did, we did CBT, DBT…And so

that's probably when I really made the decision that I like working in the forensic world and I started a second job as mental health staff in the jail…not with the county with a different company that the sheriff's department contracts with and yeah so I've been doing both jobs for five years now.

Another participant stated that they were hired for another role and there was recognition by a supervisor that they had skills in crisis management and therefore suddenly the job became solely jail-focused. Although this participant was willing to engage in this work, they did not seek out this employment opportunity:

> I was solicited for the job based on my years as a clinician and my prior experience as a psychiatric emergency services clinician which had included going in and out of the jail frequently.

One participant discussed an interest in the work, but had been hired for another position within their county. This participant expressed an interest in systemic change and brought some level of background knowledge into the jail setting:

> *I took a class at the law school called mitigation matters. That was with law students as well as like social work students and… it was about Capital Punishment mitigation. And that piqued my interest even more in criminal justice reform and in in my policy class… I read Just Mercy and that was very inspiring. So I had kind of already on my radar. I would be interested to go into criminal justice reform, hopefully at a policy level eventually and so in the meantime right now in my kind of nascent stage in my social work career, I'm trying to gather direct experiences and get as not, I guess, a firsthand look at what within these systems.*

A few clinicians discussed that there were only a few mental health employment options within their communities, especially outside of non-profit organizations, and that in order to take care of their families a role in jail mental health became one of the few options for stable employment with benefits. One clinician stated:

> *It was probably just by accident, but the hospital I worked at the psych program that I was running, closed due to the funding, and I needed the job and I was wanting to county job because of retirement benefits. And that was open and I applied for it and I got it…I had no idea what was going to be… And it turned out to just be absolutely fascinating and exciting and very rewarding.*

What I Knew.

Most participants stated that they knew nothing or very little about the jail environment upon entry into a role in jail mental health. Many also stated that they had never had exposure to being within a jail or other correctional setting:

> *Nothing. I don't think, I mean, I had no experience at all in correctional facilities. I had some experience, doing ride alongs and working with deputies and you know, watching a small town kind of operate in terms of how it arrested people and how it would refer people to diversion counseling. But I had no actual experience inside of you know, a jail facility.*

Multiple participants indicated that having experience in other clinical settings was the only experience that they had when beginning the job. As one participant explained, she was learning the forensic aspects of the role on the job:

> *I didn't know much. To be honest. I just had the background and working in the psych hospital, and just doing that side of it. So part of like being, the forensic part also I didn't know much at all. So I've just been learning as I go as I work.*

Another participant explained that their initial knowledge came from the actual

interview

with the county along with their own independent internet research:

> *I only knew what was provided by the program, in the interview and then also the program manager-you know how you interview with the county and then you have a separate conversation usually with the program manager who wants to hire you. So I knew about that. I asked a lot of questions. And again about, the internet researching really provided that information.*

In contrast, another participant explained that they had no knowledge of jail mental health and they had limited support from both mental health administration and jail administration as they began their role in jail mental health:

> *Nothing, honestly. And I didn't have I kind of had to learn as I went, because the last supervisor left pretty suddenly so and the deputy that was in charge of the jail didn't really know much about what was happening in the jail. And so we kind of had to, I built my team from the ground up. And yeah, so that's kind of, yeah, I knew nothing.*

Some providers noted that they did not know the details and procedures of jail mental health, but that they understood that vulnerable patients would be in need. These clinicians found motivation in this:

> *I knew that there would be mental health clients, there would be substance abuse clients, that there would be scared clients, people that were guilty, people that were not and that everybody there had a was somebody's son, daughter, parent. And would potentially want to be able to have someone to hold the flashlight for them and walk them through.*

Knowledge regarding jail mental health for a few participants came in the form of college courses that they specifically sought and not a part of their mental health graduate program or certificate program. One participant with the most extensive pre-jail employment experience stated:

> *So after that class in grad school, I actually ended up taking an internship with the…nonprofit Defender's Office for folks facing the death penalty. So that was another step in my journey…But so I had that experience on the legal defense side of things, but not in the jail. And I was quite intimidated. I think a lot of the information is still quite siloed from me, but there's more of a sense of like, at least my function of like, my personal cog in the system. And so like, I can flow about my work pretty comfortably, but there's so it has its own culture, and all these processes that are still pretty not hidden but not very clear to me, I guess, if that makes sense.*

Participants reported that during their formal educational processes that there were limited or no opportunities for training and exposure to correctional/forensic mental health courses and internships.

What I Thought It Would Be.

Participants reported a range of expectations regarding what they thought jail mental health would be like. Multiple clinicians reported that they believed that jail mental health services would be similar to the work that they did in community mental health:

> *I didn't think it would be any different than working with any of my regular clients out in the community. I just see every individual as a human being that has challenges or has made certain decisions, certain choices in life that have resulted in them being in jail. So I*

approach every interview using that same lens that everybody is a human being and I just gather information as I go through my interviews.

One participant was not expecting the level of intensity that the work with inmates would present. This participant expressed his understanding of his role at the individual and community levels in the depth of services that their patients may benefit from:

I mean, I went in, not really knowing what to expect. And then I came out like where I'm at right now and you know. I guess I really felt the depth and the weight of generational, historical trauma, racism and all that I got, to see it from a different lens as a person that works for the system. Not a person that was in the system. And so it really, it just, I mean, it was very hard to have that eye opening experience, but also, now it's like, Hey, I'm going back to work with you in a wraparound setting, and I feel like that's the best way where I can really help impact my community and help youth to not go to prison. Not have to go to county jails. Give them the support they need but they're young to try to break that generation. Families that I'm serving, I mean, that cycle, these families that I'm serving because a lot of the families in our areas, rural counties, are you know, you get to work with multiple generations of one family. And so it's definitely different. There's a part of me that kind of wants to stay to try to impact change.

Another participant considered the systemic level change and advocacy that they may be able to provide:

I thought it might be it might be a great opportunity to impact change, and assist people with navigating the system that they're in to achieve success and break the cycle of incarceration. So I was very excited about it. I knew that it could be a little bit tense because you never know exactly who you're dealing with in a county jail setting, because everybody's still going through their court process and they maybe haven't, they've not been convicted and so you know, you have different variations of like risk levels for people I guess, according to their criminal acts. Yeah, I expected it to be a- I expected the experience of providing services to be more medical based and conducive to providing therapeutic mental health services.

One considered their own preconceptions as they entered this work and potential frustration toward the "system" stating:

I definitely had some preconceived, like liberal notions of like, you know, I've been pretty anti incarceration and I think I was expecting a lot more frustration towards the system from a lot of our clients

Another participant was surprised by becoming a jail mental health provider and

discussed appreciation for the work:

> *I actually never thought I would work in jails. I always thought that I would work with a Latino population. Just because of my language skills and because historically, I've kind of fallen into that role because of the culture because of the language. So I kind of, that's where I thought I would be doing most of my work. I never really planned to work with inmates but it's kind of evolved and turned out to be such.*

One participant explained the need to consider inmate criminality along with mental health concerns. This participant was surprised by the level of mental health acuity amongst the inmate population—especially considering that jail was the setting of their first clinical position outside of graduate school:

> *So I been you know, like, there's obviously a criminal element. There's folks that have mental health needs, there's an overlap of both. So I think that that was pretty much what I expected. What I probably didn't expect was the level of the acuity. Or let me say the acuity I expected I didn't expect so many acute folks. But also you have to remember that this was in the beginning of my-that was my first job as an intern. So I had not worked in any clinical setting before. So maybe I would have had the same experience if I had worked for an outpatient program because I didn't have a lot of experience with let's say folks who have schizoaffective disorder or schizophrenia. So that was definitely something that was-how many sick folks there were.*

There were multiple participants who explained that they initially had a great amount of fear regarding working in jails and were not expecting the level of safety and collaboration with custody staff:

> *It was very different than I thought it would be. I was very scared to work at the jail. I thought it was going to be complete mayhem. And I didn't know, the one thing that I didn't expect was that the mental health deputies and the mental health staff were so amazing and professional and that I could rely on them and they could rely on me. That was something that I didn't, I guess I didn't think about it until I got there and started experiencing it. The other thing I did not expect was how safe I felt in the jail. Always. I trusted, I trusted my own calls. I trusted the calls of the mental health workers that I worked with and I definitely trusted, not all of the deputies in the jail that I trust. But like 99.9% of them I trusted and I only had one situation where an inmate charged me from his cell and the deputy handled it and the other thing that I didn't expect was how gentle the deputies would be when they were handling situations where they had to go hands on.*

Entry into jail mental health care came with varied levels of fear, experience and understanding of what the role turned out to be. Multiple participants discussed having limited understanding

of what the role would be, yet developed passion for the work and the inmates that they serve(d).

Typical Work Day in the Jail

The participants of this study explained that there are variations in the "typical day" in their work, explaining that they generally engage in screenings, assessments, individual/group treatment, suicide prevention/intervention, crisis management and responding to inmate requests. Multiple participants discussed that they are not stationed within the jail for their entire shift and/or only on certain days.

In addition to specifics of the process of conducting clinical care in the jail setting, participants also discussed their workload and the fast-paced environment. This participant discussed seeing ten patients in a 7.5-hour day:

> *I will see them [inmates] in rapid succession. So they will be brought in to the visiting room, the professional visiting room at the jail, and officers will bring people in one by one and then leave the area. So there's confidentiality. I will provide an assessment for each individual inmate if it's the first time I've seen them or if I suspect that there're needs, safety concerns. If it's someone that I've already known and worked with, because often we have folks that show up repeatedly, then we will sort of continue whatever issue we were working on before. I will do a notes at the end of the day, I take process notes throughout each individual session and I compile those into a progress note for each person at the end of the day.*

One participant discussed the various tasks that they were required to complete within the portions of the days that they were present in the jail:

> *Well, we don't work the entire day [in the jail]. We have designated hours that we're there. During those designated hours, we're doing very specific things. On days where we have groups, we go in to do the group. We leave when the group is finished. On days that we have case management we go in from nine o'clock until 11 o'clock and we do case management. That can be connecting a person with the contractor that is our service provider for the jail system, that could be connecting them with a behavioral health or alcohol and drugs services, which they would do when they are exiting from jail. That could be to listen to them because they just are having a bad day. Sometimes they want to start medications so we would fill out the forms to get them started on medications. Once our time is up, then we're done in the jail for that day. And then we go.*

Considering previous results about entry into the jail setting and the learning curve required it is important to consider that there may be a variety of obligations through the course of a typical day. This participant explains high caseloads with multiple priorities along with the potential for unexpected patient care needs:

> *So in the suburban jail where I worked as a mental health discharge planner work, started at eight, I usually was there at 730 and I looked at the releases that were coming up and then assess people for safety in the jail and pretty much scheduled my day according to the releases, and then also I had a caseload of about 50 people that I tried to do case management for which was discharge planning. So it was really a 10-hour day probably at least, and very fast paced…So you had, you organized your day you needed to meet every spontaneous needs as well as the needs of your established caseload. So very, very fast paced.*

One participant discussed the process of conducting mental health care for inmates via Zoom and the transition back into the jail setting as COVID-19 restrictions were lifted:

> *Okay. So basically due to COVID-19, I initially started doing zoom telehealth care. So, when I was doing that, it would be basically I would have a list of consumers, our patients that I would see. And I would just stay on Zoom for, you know, multiple hours, spending time building engagement with people and identifying needs. And coming up with next steps. I would I would typically be using our strengths based model, like a strengths based assessment and then a personal recovery plan that would outline next steps that either the patient or together myself and the patient would be responsible for before the next session. Care coordination. You know, I would do care coordination calls, you know, interviews for treatment centers with inmates, when they wanted to go into inpatient once they were released or when it was going to be a part of their court proceedings, the deal that they were gonna get from the judge or whatever. So that's kind of like what a typical day would be on Zoom. And then very similar in person when I started going in person once some of the restrictions were lifted for people entering the jail to do services again in person, it was basically I'd go down there, I'd be processed in and then I would see clients for the duration of my stay. I started off with just the four hours that they increased the 8 hour shift not too long ago.*

Most participants reported similarities in the clinical work that they do in the jail setting and it is likely that these levels of understanding and expertise built with time—especially considering the participant reports of how they entered the jail system with limited understanding of the role.

Successes

Participants discussed successes not only at the patient level, but also collaborative successes with custody staff counterparts. Participants were able to talk about successes with ease and were able

to provide multiple examples. One participant discussed the process of building rapport with an inmate and being able to conduct a full interview:

> *So one of the successes is, I think, being able to build a little bit of trust with not only with county jail staff and being able to connect with inmates. I mean, usually what ends up happening is when I start an interview, you can see they're guarded, they're tense or anxious, and as the interview progresses, I can see them become a little bit more relaxed, less anxious. I usually do a check in how they're feeling. And they're able to compare you know, some are able to compare how they were feeling at the initiation of intake, and how they were feeling at the end. So I think being able to have that interview with them and not overwhelming them more in their situation. I think that's a success.*

Another participant discussed the process of rapport building as well as stigma reduction with an inmate and also with custody staff:

> *Some of my successes, I would say just to have a different perspective. On the clients that we are working with in jail, their viewpoint of mental health, that we are being able to be more of a positive outlook on it then more of a negative where they're like, now they're willing to talk with us and also having the officers having different viewpoint of what we can do to help them that we're not working against them or working for them.*

Although many participants discussed that their patients would move throughout the system quickly leaving little time for mental health engagement, this participant discussed being able to see a narrative shift within inmates as they took steps toward major life goals. Further, this participant noted that a success is seeing inmates consider that their long term mental health concerns could respond to treatment:

> *I would say my, my successes would be some of those people that came to a determination that, for whatever period of time that perhaps they weren't as bad as they thought they were. And that they could in fact make different choices. That they could acknowledge they might have choices. Those people that decided to finish high school, that engaged with mental health and started making plans for what they would do next. People that sometimes would talk to, be willing to talk to family. Look for resolution. Maybe acknowledge an illness that they've been unwilling to treat.*

One participant discussed the transformation of inmates from their time in Booking (entry into the jail system) and moving toward stability and meeting basic needs. This participant discussed that

periods of sobriety, starting/restarting psychiatric medications, having access to sleep, food and water allowed inmates to transition toward stability:

> *I think that the successes every time - the thing that I loved a lot about the jail was in booking when somebody would come in and they were floridly psychotic we would all work together really well to get them to a safe place. And then a couple of days later, I would go up onto the module to check in with them and see how they were doing and because they would come in in such a different state I wanted to see if anything had changed. Lots of things would change. You know, maybe they could tell me what medications they had been on for example when they couldn't before. So I would go and talk with them and I always loved seeing how stable they could get really quickly. Coming into our system and just getting you know, not having any access to drugs for a while and being able to get some good sleep and some food and hydration in their systems. And then they would just like perk up and be ready to go.*

Another participant discussed the success of rebuilding a drug and alcohol education program within the jail.

> *Successes I guess when I was the program person for the drug and alcohol classes, I think I was really proud of the program that I developed. When I first got there it was kind of a mess and you know, inmates could just kind of do whatever they wanted, and it wasn't really like meaty, like coping skills, kind of a thing. And so I really developed classes that were like CBT, DBT. These are concrete life skills, coping skills, symptom management, you know, all these kinds of things that I think we're really helpful and I got feedback from the inmates that they were helpful, and sometimes you'd run into someone on the street and they're like, "I'm still using those techniques". And so that I think, was a huge success…I think when you get a super challenging inmate, and you're able to build a rapport with them, where, you know, they're kind of acting out and you can go over them and be like, "Hey, can you please just knock it off?" Like, "Let's do some different coping skills." And they're like, "Okay, that's like a huge success."*

Participants of this study were able to consider the individual patient level successes, interpersonal successes with custody staff, and organizational/community level successes with programming. These successes were sometimes discussed as reasons for staying within the jail system and their ability to continue their work in what was perceived at times as a harsh environment.

Challenges

Along with successes, participants discussed the various challenges of working within jail mental health. One clinician discussed the challenges related to caseload:

> *A challenge in that program was the enormous caseload. Like I said, I had a 50 people caseload where I was trying to do discharge planning work and then also you know, you have spontaneous releases where you just go in and you try to gather some history…So that was a*

little bit, a little bit hard to do that. So you had to work your buns off. But I'm sure it's even worse right now with Covid…

Another clinician considered the complexities of the legal system and having inmates ask them questions about the legal process:

And I would say some of the challenging parts of it is not fully having the understanding of like the legal process of it all to help them along with that part. Just because we don't usually deal with that, but they always have lots of questions around that.

One participant discussed the challenges that the removal of the involuntary medication process within the jail setting had caused clinicians, custody officers and patients. Further, this participant considered the litigation related to involuntary medications and how they believed this had increased the suffering of patients within their jail:

The biggest challenge is when they took away our ability to see-for years when they closed the psych hospital we would release people and then we would send them off to the hospital which was just a- it wasn't long term. It was just a 72 hour hold up there. 48 hours for first shot there. You know psych medicine and come back. We did this for years. The judge would come in we you know we presented, we get a Shell hearing that was approved. Recertify, the judge approved that and then we would get the person at the hospital to come back and they would get better. And but then the Prison Law Office came in and did a you know an assessment and halted that procedure all together. So when they took away the ability to medicate inmates, and you saw them suffering so much more. That was this really painful, because it was totally unnecessary. And I don't like seeing people suffer that much. It just increased the suffering.

Most participants in this study were extremely dedicated to providing the highest quality mental health services for the inmates that they serve. When there were challenges with providing the care that they believed to be necessary, feelings of limitations in clinical connection to inmates brought great concern:

Sometimes there were inmates that I felt like we just couldn't connect right. I couldn't figure out how to help them right. I'm not, you know exactly sure why that was like personality or just like diagnoses. Or I'm not, you know, we just didn't make a good connection. And I actually had a guy who got so mad at me once that he charged me. But then of course the deputy was right there so he's kind of got him back in the cell and it was fine. Nobody got hurt, but those kinds of instances. I think because sometimes they, the inmates would come in and get released so often and so irregularly that at times I didn't have the ability to be on staff enough to make connect, like ongoing, consistent, contained regular and structured connections with them was more irregular and so we didn't get I didn't get to know them as well because I worked on a module that was like sub-acute mostly like this one module where they would get moved up to when

they were doing a little bit better. I worked there more and I knew that was inmates more, but the really acute inmates that came in some of them would stay down in this one module for a long time either because they were in a psychotic state or in a state of high need or highly dangerous and so those inmates I didn't get to connect with more regularly and I wish that I would have had the time to at least just go by and introduce myself, make my face known see them like have them see me like let us be more regularly in each other's presence. Because I think that would have helped when there was like an emergency call where I had to, you know, go down and handle them on a night when it was just me

In addition to challenges with connection, multiple participants discussed the concerns of having limited resources within their communities.

I think most of the challenges I think, for lack of resources in our own community, you know, everything has to be referred to four or five hours out of our area. We're finally gonna get a sober living program in the community. We don't have any transitional housing programs in their area. We don't have any inpatient psychiatric units in our county. There's a huge lack of resource. So that's one barrier and that's whether it's in the jail or anywhere else.

Also related to resource limitations, another participant stated:

I think the challenges are there's not a resources in the community. So you work hard to kind of stabilize someone in a setting, and then they just go back out to homelessness, they go back out to us, they go back out to whatever abusive relationship they were in or whatever, got them in jail in the first place, usually drugs. So I think that's the hugest challenge is like, you patch people back together and then they go back out into whatever environment that brought them there in the first place.

Culturally, within the jail setting, one participant noted that they have seen significant issues related to patient respect, confidentiality and violation of rights:

Then I think the other areas were really not knowing how to navigate management system. The lack of respect for people treatment and dignity. See I use it for patient rights. And people got uneasy with people who say patient rights, but a patient's rights that I read to people on a daily when I do intakes and stuff like that, an outpatient setting, people like you have to be treated with dignity and respect at all times. And what that means to me is that you should be entitled to a confidential setting when you're going to talk about your trauma you know, whether it's to a Case Manager, a Nurse, to anybody you know, so I that's one area where I really struggle with the justice system that I'm working in right now, because it's not-I don't feel like it's respectful of people's dignity and respect when they can't have a safe place to talk about what they need to talk about the heal.

Similarly, another participant discussed how challenging it is for them to be viewed differently and generally negatively by various systems interacting with the inmates that they treat. They

considered how exhausting it was to need to engage in advocacy all the time and to have to defend their clinical opinions:

> *I think the challenges is like, being a clinician in the jails nobody's ever happy with you, outside of your organization, so the DA and the public defenders are always thinking that we need to do more, and that we're not doing enough and are always upset with us that we're not writing more people on holds or, you know, forcing meds on this person or that person or conserving these people. And then our own mental health system like our psychiatric hospital and our crisis unit are thinking we're, you know, sending them these criminals and you know, these people are dangerous, they belong in jail, they don't belong in mental health. And so you're always having that, to advocate for these clients who nobody wants--not to be like insulting to them but it's just, you know, everybody views them as criminals, they're drug users, they're just meth, antisocial personality, you know. And so that constant advocating can be kind of exhausting. And just having to defend your clinical opinion all the time is kind of exhausting.*

As with other areas of inquiry, participants considered their individual challenges in the role of jail mental health provider and how various systems interact to contribute additional strain to an already stressful clinical environment.

Main Priorities for Jail Mental Health Providers

Participants were asked about their main priorities in providing clinical care. Many presented similar areas of prioritization including empathy, compassion and ethical mental health care. Clinicians also discussed safety, especially related to suicide and psychological/emotional safety. One participant specifically referenced the need for compassion and connection:

> *As a clinician it's treating all- it's just I'm a very compassionate clinician. And it's just connecting. Connecting with my clients or inmates and normalizing mental health.*

Another participant discussed the importance of creating a safe space for clinical discussions to occur:

> *My main priorities is just to let the inmates there know that we are there to help them and what they need to be done. And that they have a safe space to talk to us. Even if the-in the jail, they still have the opportunity to show that that someone else cares about them.*

A focus on ethical treatment was also discussed, as it pertained to addressing and reducing barriers to patients' success:

I want to provide the most ethical treatment I can to individuals regardless of their location in life or current custody status. I want to foster hope and engagement with people. I want to maybe provide them restorative experience with therapy because oftentimes they have in the past been forced into some type of treatment and that doesn't always end well for them. And I really want to address whatever the barriers are to them getting adequate mental health treatment and once they're engaged in mental health treatment, providing support and tools to reduce impairments from whatever disorder or symptoms they're having.

Similarly, another participant discussed that connection, promotion of inmates' goals and building connections with inmates may decrease recidivism:

> My priorities for providing mental health services at the jail, provide support and services to people who are incarcerated, to allow them to meet their own personal goals. And increase their quality of life. You know to decrease barriers for people to access those services and supports and do whatever they need to be successful. You know, I think that that would be my priority. I would love to say to decrease recidivism, over representation, more individual services. I would also love to build relationships so they feel like they have someone to go to.

Safety related to suicide prevention/intervention was commonly shared in interviews with participants. Considering the level of screening and assessments that occurs as patients enter the jail setting, this participant also expressed their dedication to making sure that the booking process was run well:

> *Safety, I don't want anyone to kill themselves not my watch. That's always pretty rough. I like to make sure that things are like I work in Booking a lot and that things are moving smoothly. You know, that nothing's getting jammed up to take care of the serious problems. I keep my eye on absolutely everything. And that things are moving smoothly, well, good communication.*

The individual level themes provided a rich view of how the participants entered the field, priorities, successes, and challenges of jail mental health providers. In the process of each interview, these questions also allowed for a transition into more in-depth considerations of interpersonal, organizational, community level and public policy related issues.

Interpersonal Level Themes

The main themes emerging at the interpersonal level were Training, Key Components to Being a Successful Mental Health Provider, Connecting with Custody Staff, Difficult Things: Support and Collaboration and Accessing Support.

Training

Limitations in the training process of new jail mental health providers were central in discussions with multiple participants. There was concern about inconsistencies in training, limited forensic level training and minimal supervisory support related to training:

> *So we just have on the job training, there's nothing that you go to beforehand. And when I first got trained, it was like, here's these forms. Here's what you do. Okay, let me know if you need anything. So we've come a long way since then. So you basically shadow a staff for a couple of weeks and then you're kind of sent off to do certain tasks by yourself. And then you go back and you talk to the person, "Okay, how'd that go for you tell me what happened," you know, kind of thing and let's, "let's review the paperwork part of it." So, now it's much better you know, you're attached to a seasoned staff or I think they try to do at least a month, like either you're watching, they're watching what I'm doing as a seasoned staff and then we switch and I'm watching what you're doing to be there to kind of, you know, continue to train and pinpoint if you're, "not that form this form, okay, don't forget to ask this question." So we do that, but there's not like classes or anything that you go to.*

Connection to an established staff member and shadowing was reported by a few participants as the main training method. Other counties provided general county training and participants found themselves seeking training on jail specific issues in their free time:

> *Once we are on working, they usually send us different trainings online and just like the county wide trainings that we do on like NeoGov or whatnot, but majority of the time if we want any type of training specifically to our job, we have to do it on our own. So it's like reading different literature or trying to find different trainings online that will be significant to our work. But a lot of the time the trainings up here is very little or not specific to our job title.*

In addition to internet self-study, one participant discussed taking forensic-specific continuing education units (CEUs) and being a member of the Forensic Mental Health Association of California:

> *Well, I mean, I think a lot of us elected to take CEUs in forensics for example. You know, you have your 36 every two years. So a bunch of us would go to like the FMHAC conference or there was tons of books, talking to each other, but there really wasn't a lot of training in the institution itself. We did actually give mental health presentations to the deputies. But in terms of like specific forensic training, I don't think there was any it was more like experiential like on the job learning.*

One participant who is also a working clinical supervisor was unclear about the training process that was provided within their jail. In this jail there was a supportive and helpful team and mentoring and support was provided to new staff. It should be noted that some participants were the sole mental health providers in their jail setting and therefore, this pattern was specific to the participant's county/jail:

> *I mean, I don't know if I have a good answer for that honestly, I should as a supervisor. I don't know if I have a good answer for that. I think a lot of it is on the job training and having a supportive team to case different people with and different systems with but there is so much to learn about the forensic field and even just like all the laws and all the timelines, and you know, all the things with the state hospitals and the misdemeanor incompetent and the felony incompetent and learning all that is just in of itself as a whole different thing that most people never even have to think about if they're not working in the forensic population. So I don't know if there's a good answer for like, what the training would be like for social workers or clinicians working in the jail.*

Training is a vital component to the success of mental health providers and the patients whom they serve. With the distinct jail environment, it was reported by multiple participants that there were significant limitations to the training needed to be successful in their roles.

Key Components to Being a Successful Jail Mental Health Provider

Many of the key components to being a successful jail mental health provider were interpersonal in nature. For example, one typical participant also discussed the need for ongoing mentoring:

> And the other thing you need ongoing mentoring. You need to have a go to person, you need to be updated with forensics. I think ongoing forensic training also helps. And just having that that mentor who you can go to and ask questions when you get stuck or when a situation arises.

Boundaries were discussed by multiple participants along with the need for ethical decision making:

> My beliefs are that you need good boundaries. Good Self Awareness. Good insight. To be-not naive, but a human being and not the least, well, not the least not the most important aspect I believe, to be a good clinician. I think being a good human in that setting is more important than being a good clinician.

Another participant also considered the need for boundaries as a means of protecting themselves from vicarious trauma as inmates regularly share traumatic experiences in clinical interactions:

> *Good boundaries. I think my belief is that you have to be very cognizant of what your views are and your ethics. And, you know, and also know that there's going to be times where you may have to breach an ethical boundary to ensure safety of yourself and others. That was something that I had to really look at because you never know what's gonna happen. Really, if you're working with people that have, you know, if you're working with violent offenders, and sometimes it was like, even like typically, if you do an assessment and I breach confidentiality, right. If it's something you're telling me that you guys are gonna hit me, like that's something that I would more likely go tell the sheriff's department right. But I mean, at least ethics, but I believe but things like that I had to really look at be able to listen to I think you have to have the heart and the gut for the work because you're gonna have a lot of trauma, whether you're a therapist, a psychiatric or a little case manager. You're gonna hear a lot of traumatic stories. And so that's kind of my beliefs about it.*

Further, boundaries were discussed as a means of self-protection. One participant stated:

> *Protect yourself. You have to you have to protect yourself, you have to be cautious about what you say you have to be cautious about who you say it to. Always tell them the truth. Always. If you can't do something for them, you need to tell them you can't do that for them. You need to very carefully outlined specifically what you're there for. And if they are going on and on and on and on and on and on and on…You're not their friend. You're not gonna let them know that, you're not their friend. You're not there to get to know them. You're not here to be their Savior. You're there to provide a service. Being at the jail I don't get to show the same compassion to someone at the jail that I would show if we're standing in line at a food box because it's very cut and dry what I can do, what I can't do.*

Along with self-protection, other participants discussed the importance of humor, self-care and empathy for inmates' experiences:

> *The key component to successful jail mental health clinicians, I would say, lots of empathy. But also like a sense of humor as well. Having to kind of be really good with crisis and triaging. Learning how to triage is something that's mandatory because you constantly have people wanting your time and your energy and there's only so much you can give without burning yourself out so I think those would be like the key components.*

Another participant expressed the importance of showing inmates respect and being aware of the challenges that inmates are facing by being a part of the jail system:

> *I think the biggest thing for me is you have to know how to have respect and empathy for these people because it's easy to see them as being in a different position of life than you are and I*

don't personally agree with that. I think any one of us could be in any situation at any time. And so I meet every person I see in there with the amount of respect that I would want if I were in that position. So I think that opens the door. I also don't present myself necessarily as being super professional when I'm with them because that's not approachable to them. They don't like the system, typically. So I will be a bit rougher around the edges, I guess. And use their language sometimes to meet them where they're at.

Key components to successful jail mental health providers focused on specific mental health knowledge, the need for ongoing mentorship, importance of boundaries, empathy and respect for inmates along with self-care and provider coping.

Connecting with Custody Staff

The challenges of interacting with custody officers were discussed by participants. One participant discussed the importance of connecting with the custody staff:

I knew that collaborating with law enforcement was one of the biggest factors in providing treatment and I knew that finding ways to operating enforcement, factors and I knew that finding ways to connect with distrust of county workers.

Another participant expressed their positive experience interacting with custody staff:

I also was expecting a lot more hostility from the correctional officers towards me or towards the clients and I that's been another pleasant surprise at least as far as I witnessed is just like the humanity

Other participants discussed distinct challenges in providing care within the custodial setting:

It just makes the sense of hopelessness that people have while being in custody seem more real. I mean, they always tell you that the officers don't care. But when you actually see some of the officers that don't actually care, it makes me have a different sense of the hopelessness they feel.

Another participant discussed the differences that were present with officers had specialty mental health training:

A lot of the deputies working in Booking had specialty mental health training. Because we I mean, at least on swing shift, we had a lot-of a lot of the deputies that worked with the mental health mod that had the highest acuity would, they would, what do you call it, they would also work in booking so back and forth kind of third swing their shifts

would rotate that way. So and I think that the system did that on purpose. I don't think I ever really asked about why that was but we had a we people that worked in general population were kind of always working in general population. Occasionally those guys would come down and work booking but most of the time the men and women that worked in mental health, there was a lot of them on staff and booking on a regular basis, at least in my shifts. Which I think was I think the swing shift was when we got the most people in the booking and the night shift yeah. Because all the hospitals, the state hospital brought them back, you know, sent the competency, they would send them back in the afternoons.

An interaction with a paranoid inmate and untrained officer was also discussed:

I think so like if someone like we had a guy that was super paranoid, he thought he was being poisoned. And he only felt comfortable in this one unit, and they kept saying, "Oh, he's manipulating his housing." and I'm like, "no, he's terrified for his life." Like, you don't understand like, this paranoia is real for him. He really thinks he's being poisoned in this other housing unit. So it's those kinds of things where, you know, they see it through their correctional lens, which I totally understand. But I feel like my job is to help them see it a little bit differently. You know, that this person is acting out for these reasons, and I know that the acting out is a pain, but, you know, here's maybe some other interventions that we can do. And I feel like because there's such turnover in the jail with the jail deputies, because it's not a pleasant place to work and most of them want to use it as a way to get to patrol that it's a constant conversation with new people coming in. You know, like no, that person is really paranoid or that person really does think that you're going to try to kill them. So like try to have some patience, you know, that sort of thing.

Difficult Things

Participants were asked about what type of support is available when difficult things happen in the jail setting. Answers to this question were generally related to how participants received support and collaboration with other staff when navigating difficult experiences. Participants overwhelmingly reported feeling significant support and collaboration during difficult experiences:

Support.

There's definitely a lot of support we work as a team there and we have the doctors, nurses, a case manager and three social workers. And we are very close and so whenever there is something that arises that don't sit with us well we always have that comfort and that safe space to talk with one another to work out the kinks or whatever that's bothering us and get that support that we need to move forward and feel good about what happened.

Even with limited direct supervisory support, this participant reported feeling that there were others in the jail who could provide support. There was also awareness and understanding that many individuals working in this system were overworked and had limited capacity to provide support:

> *I had no mental health supervisor in the jail. There was someone I never met that I didn't have any contact with. In fact, she was hired I think after I'd been there a year. There was an HSA [Health Services Administrator] you know, who was a nurse and might be supportive, wanted to be supportive, but was stretched pretty thin, and actually looked to me the words were that for me to set up mental health. But I was mental health. I was the only full time person*

Another participant had a much different experience of direct support from others within the mental health team allowing for more real-time assistance:

> *Yeah, for sure, like pretty much any of the senior mental health staff that were there and had been there for a long time I could go to any of them and say, "Hey, I need to talk about this case." In fact, I think one of the times where there was like an emergency medication situation, I wanted to process that afterwards because I had a lot of ethical like, I'm not sure that that's the right thing to do. And or you know, sometimes, a lot of times I wanted to process about unhoused individuals being arrested for trespassing, like that kind of stuff. And what the deputies out on the street did with their things I'd always want to process about kind of the philosophical issues there and could always process that with senior staff.*

One participant was very clear that they did not receive support on the job and that this issue had been brought to the attention of leadership with limited success. This participant discussed how they created support outside the jail:

> *No, and I voice that to the sheriff's department and upper management, like all the time, like, you know, if there's a critical incident that happens, you know, you really need sometimes you need support, you know, so I know that our boss is like you can always call me you can always text me, I don't really do that. I do talk to my coworkers. I have some friends that I work with. I might text them or you know, reach out to them but it's really more about my own self-care. And so if I've had a particularly rough shift or I've experienced something, like the first time I ever saw someone hanging was like, "Oh my gosh," like I've never seen that in real life. You know, so that was kind of like oh my gosh, so I remember just kind of going home and like thinking okay, I need to I need to do something to take care of myself. You know, and I kind of just talked with a friend who*

was also a clinician at the jail. You know, put on a movie that was kind of like a fun movie to kind of like just okay, I can't have anything serious right now. You know, they mean so I think that there should be more support. But I think we're all just like busy and down staff and it's just not like on the forefront of people's minds to like, have more support around that.

Another participant discussed the importance of receiving support after a challenging clinical interaction:

I worked with a client she was very sweet. You know, we laughed a lot like we connected, you know, kind of same age and then I learned that she had and this is to her and to substance use treatment I like that she had. She was facing charges of involuntary manslaughter for accidentally killing her kid while she was while she was high on meth and she had accidentally smothered her infant and that really messed with me in a way that was like kind of surprised like I hadn't really encountered before and so I ended up talking about in supervision. I've talked about it more informally with [a colleague]…so just being able to kind of get that support from like, colleagues in my like, supervision meetings. (Yeah.) And then I guess practically also supervision and through like, same deal…I think like, I've gotten some great support from like now my supervisor also runs Diversion Court program programming and so she really knows the system and she's been working in forensic clinical social work for a long time and so yeah, just having strong mentorship and being able to communicate and then like also collaborate with jail staff and be able to, I feel safe like vocalizing if I if I run into an issue. I feel supported by the jail staff there and like the officers.

Collaboration.

In addition to support, collaboration during difficult situations was discussed by multiple participants. Collaboration with custody officers during difficult experiences came to the forefront of these discussions:

I typically will collaborate with my program manager. She knows the system really well and she knows the intricate dealings that can happen when working with law enforcement agencies because we do approach situations very differently most times. I will collaborate with the rehab specialists and other staff that are part of our forensic program now because they often know more about community resources that I might because they do reside in the community. And then, if needed, I can collaborate with law enforcement if it's something that's actually happening in the jail. Like example, if someone has disclosed that there's drugs in the jail, and that's obviously a safety concern. So that's the thing that I can, you know, work with law enforcement to address if needed if we have a release in place, which we usually do.

Another participant expanded upon collaboration with custody officers:

I always find custody to be really supportive. And they want good decisions made they want safety and safety, safety, safety, safety, then almost overly safe…I had the most phenomenal Lieutenant that I've ever worked with and we were able to we worked together for at least 10 years. And he was phenomenal…And, had my back all the time. And he knew about mental health. He had special needs kids. He understood the system very well. If we had an autistic kid come into custody, he'd get them out of here within two hours because he knew the system so well to move the system to get people into a better situation. So if you have a really good administrator working with you, it just works well. You're on the same team. You have each other's back, you get the job done. So it's good to have a good team, a good administrative team to work with.

Another participant expressed that they had worked not only collaboratively, but also with creativity to create solutions with custody officers:

But there were a couple nights where the deputies myself and the inmate had to come up with some creative solutions for what they were going through. And we were able to do that. And that always felt really good to like, like things that stretched beyond the boundaries of the system.

Accessing Support

Different from accessing support during difficult situations, the process of participants accessing general support was discussed. One participant noted:

So I think it's the same but better because I feel like there's more support for myself and if I have more support, I can provide more support to the inmates.

And when asked if this participant was receiving the support that they needed they responded, "No, absolutely not."

Another participant explained that support came from their clinical supervisor although noted that their interactions together were limited. This participant also holds a specialized role for their county and others cannot provide direct support to this role along with limitations to supervision:

I do have my clinical supervisor. I only meet with her one hour a week. I mean, I can always put out an email to individuals, but because I'm the one that has primarily worked, because of the position that I've been in triage, a lot of other clinicians don't have the experience of working in triage or doing jail assessments…So the interesting thing about where I work is, there are supervisors in a clinical setting that don't have the education. They maybe have a bachelor's in

something other than social work. So it's not always easy to go to them because my education is greater than what the education they have. And I am there's certain guidelines and certain limitations. There's just a code of ethics for social workers that they don't necessarily have to follow because they don't have the same education as I do.

Another participant discussed the potential for burnout in the jail setting without appropriate supervision:

And I also believe that you're gonna get burned down if you don't have appropriate supervision. when you say supervision. Yeah, I think that part of frontline health care has to have an impact and the justice system, has to put a transference and countertransference component to promote wellness of the staff member at the jail, working with people that have a high needs and a lot of barriers to be successful. I just think it comes with the territory.

Alternatively, one participant expressed a supervision support structure that is functioning well. This participant also discussed the benefits of having access to psychiatric providers and multiple supportive colleagues:

Our program manager or boss was always available to call me on my cell phone, day, night. Like whatever time it was. I think I did I think I called her at two in the morning once and she picked up, she picked up the phone right away and helped me figure it out. We also had on Saturdays or in the evenings we had emergency psychiatrists on call that we could call if we ever had to do like an emergency med. That kind of thing and often talking the situation through with that person was really helpful as well because we can kind of assess like, do we actually need emergency meds here? And we would of course, look through all of the you know, make sure that what we're doing is ethical, all of that kind of stuff like run it through several layers of thinking and processing with different professionals. And if a situation happened that was difficult that I handled, but like affected me personally, I could always process it with the next shift person coming in because the two-night shift workers I knew pretty well. And we would do Shift exchange and we would process anything at that time if something came up like I said that was hard to handle or something difficult that I saw or, you know, was hard to process.

Participants discussed support with multiple layers and presented examples of helpful and less helpful support structures.

Organizational Level Themes

Organizational level experiences of mental health providers in rural and suburban jails emerged within the following main themes: Main Priorities for the Organization, Changes Due to COVID-19 including Facility Preparedness, Impacts to Providers, Impacts to Patients, Outbreaks, Changes in Sentencing and Transfers and Substance Use specific issues related to COVID-19.

Main Priorities for the Organization

Participants overwhelmingly discussed that the main priorities for the organization (jail/facility) were related to safety and suicide prevention. One participant interpreted the organizational priorities in this way:

> *I think what they expect of us is to keep the inmates safe and not in the way where they are in a crisis and try to commit suicide or anything like that like to and to be open with what we can with the confidentiality between the inmate and us and to give them an idea of like what that inmate is going through so they don't see it as a behavior problem, more than that they're suffering or what it may be.*

Another participant explained:
The first concern is always going to be safety. If there's anyone that is suicidal or homicidal. That's something that we know addresses immediately as well as substance.

Relatedly, another participant expanded to state:

> *Custody's priority is safety. Right. So that's the main priority and also that the by law that has the obligation to return the inmate to, in the same or better condition than they have received that person into the community at the same what better condition received them. So I think these are the two priorities for custody.*

Expanding the need for safety, one participant discussed that their organization is also concerned about the safety of staff along with liability. This concern for liability may be related to the county's consent decree:

> *Where I work, it was pretty clear that they saw safety as the main issue, safety for the inmates, they do for the staff safety for the deputy- like safety for everyone, like making sure that the person got housed at the right level of care. And that was one of our, that was one of the main things that we were assessing people for in Booking anyway. And also on the modules like when you get called up, and there's an issue going on a module, if somebody is suicidal or needs further support, they're going to- they're not going to leave them there. They're gonna want to move them to a place that has different levels of support. So pretty clear to me right away that the jail wants to make sure that everyone was housed correctly for safety. And, you know, I mean, I'm, this isn't my first rodeo. I knew that they also wanted to make sure that cover their own liability. So I do think that, you know, I've worked with you know, when I worked in diversion, and when I worked in the jail, I know that they don't well, actually, I don't know about this in California, but if they didn't need to have us there for client rights, maybe they wouldn't want us there. I didn't get that sense from the county jail that I worked at. I felt like I've always felt like county that I've worked in, supports mental health rights and mental wellness really well. And I liked that about like, otherwise, I wouldn't have continued to work there. But I think that what I noticed and what I was told right away was that, you know, for everyone's safety, we have to make sure that people are assessed appropriately and housed in the right place. And*

then, of course, you know, by looking around and working but you're also protecting your liability.

Related to safety, one participant discussed the importance of inmate engagement in treatment along with linkages to services:

For the facility at large it's engagement and getting their clients or getting our inmates to want the services. So that's the main focus is to get them to understand that they do need help and these are the services that we can offer and to keep them engaged. That's the overall agency--I think that's what we really push for. And that's our ultimate goal is to keep them engaged and once they are linked into services.

COVID-19

Participants were asked multiple questions about the impacts of COVID-19 on their roles and correctional settings. From these questions, the following sub-themes arose: Access Issues, Changes Due to COVID-19, Facility Preparedness, Impacts to Clinicians and Patients and Outbreaks.

Access Issues.

Multiple participants discussed changes in overall care including the use of telehealth for screenings, assessments and regular individual therapy. One participant discussed the challenges with access to care for inmates they were working with while on probation, challenges that often arise as inmates move in and out of the jail setting regularly:

[It] was really difficult with my clientele because they often live in rural areas or are homeless or they don't really have somewhere safe to talk or they don't have a cell phone that has enough minutes on it or a number or enough reception to have a whole session. And so there were a lot of missed sessions. There were a lot of partial sessions where a phone died or went out of service.

Another participant discussed the challenges for patients not having access to programming such as AA, NA, religious groups and educational courses:

So also, I think it's been hard because our jail didn't have, they just started having outside providers come back. So we, our jail was actually was really good at having like AA and NA and the religious groups and we have our JC in there, our junior college. And there was a program that does like high school diplomas and so forth. And so we had parenting classes, I mean, all these different classes, the drug and alcohol education classes, all of those went away when COVID hit because we couldn't have outside

providers in and so we help people struggling, that normally would have utilized those groups or that support. So that was really challenging.

Further, treatment opportunities that were considered by inmates to be motivating and rewarding were not readily accessible as they had been prior to the pandemic:

Prior to COVID doing art therapy was big in terms of resources. If they had good behavior, they would be eligible for art therapy and so it's kind of a reward for not getting into trouble throughout the week.

The full scope of access to care issues was also unclear to some participants as many were not allowed within the jail for the majority of the pandemic.

Changes Due to COVID-19.

Changes in the admission process and how mental health treatment was provided during the COVID-19 pandemic created specific challenges for both inmates and clinicians. As will be discussed multiple times through this section, a top concern with clinicians was the impact to confidentiality in sessions. One participant explained not only the regular changes due to the pandemic, but also what occurred during an outbreak:

So, I think as far as the work at the jail has been concerned and you know, it's caused cancellations if you get exposed, they can shut down services, you know, or if there is an outbreak in the jail. And then it also made it to where like, if individuals were-so access, I guess has been impacted. You know, people have to get from quarantined when they first go into the jail and you know, you might be hard to get the fact to face interview to get the full benefit of like and then all of the confidentiality piece was a little more compromised when people were on a zoom or electronically with people within earshot speaking about, you know, their trauma and interacting with a provider.

Another participant discussed the differences in the population entering the system and changes to sentencing:

So right now, we're back to status quo as far as inmates coming in and out. There was a substantial length of time during the height of COVID, if you will, that individuals who had misdemeanors or substance charges or DUIs, they were given a ticket so they would be brought to the jail, fingerprinted and then never booked into the actual facility but released with a notice to appear to court. That was done to keep the custody count

down so there was less people in each cell. They were only keeping individuals for severe violent crimes or probation or parole violations. I feel like that went on for at least a year probably closer to a year and a half. But they have transitioned back to where they are keeping people we've also cycled through with a lot of the folks that were needing to serve some time and knew they needed a serve some time but had been told to come back when COVID isn't as bad. So we have had some of those individuals serve their time and be released. Something I also noticed is individuals that were sentenced to prison during COVID. A lot of them even if they were sentenced to eight or nine years or even released from prison and returned to the community. So kind of the idea and concept of inmates going to prison has changed.

Facility Preparedness.

Overall, participants conveyed positive feelings toward how facilities prepared for COVID-19 and the measures that have been taken since the start of the pandemic:

You know, I think they've done a really good job. I think once they know that there's an exposure they make sure that that person is moved away from the general population and they're- whatever the CDC guidelines are at the time they are pretty good about complying. They also have to wear masks.

Another participant expressed:

They definitely did it very well. It was stressful at first until we got it down but the system that we did was very helpful.

This participant expressed the specific steps taken within the facility to manage outbreaks:

Very well, actually. So the quarantined the entire pod. No one went in no one went out, everything brought into them. So the nursing staff would be like, in their I call them biohazard suits, because they're the paper suits that cover them all. They went in, they tested people they came out and they stripped down. They got out, there was the Biohazard containers right next to the door. So that once they came out, they took that paper suit off before they went anywhere else.

As not all participants involved in this study only worked in the jail setting, one reflected on the entire county's response stating:

I mean I think the County has done a fabulous job in trying to manage it you know as well as they can and you know you know personal protective things for masks and

everything. Everything is so well organized and I think they've done the best job as any anybody could

Impacts to Providers.

Participants of this study experienced a variety of impacts including their dissatisfaction with telework, their levels of physical and emotional exhaustion and the challenges with providing clinical care within COVID-19 protocols:

Well, it's I think that we've lost that face to face contact and that personable interaction, because we're, we've been divided by a monitor or by a telephone because we also did telephone assessments. And so I feel that we're not able to always get the full picture when we have, when we do telehealth and phone appointments versus if you actually have somebody in person.

Another participant explained the direct impacts of conducting telehealth in light of rising patient needs:

On my work personally COVID has exhausted me. We, you know we work from home for some time and I was still coming into the jail for my job clients. But my hours while working from home seemed to get longer and longer every week to the point where some days I was working 12, 14 hours, not because anyone was telling me to but because I simply had that much to do. Our referral rate went up after that initial wave of COVID. The first wave we were pretty steady. But after that when people realized that this wasn't going away, it definitely had an impact on the number of cases that I carry on my caseload and the severity of what they're dealing with.

Another participant discussed the prolonged stress of providing care during COVID-19:

So it's really for me, it's been kind of exhausting. I feel like just now this last month we're starting to kind of come out with that mindset here. And that's been nice for me. I struggled myself with dealing with COVID stress, just because it was a prolonged I don't deal well with prolonged stress. typically. I felt like providing clinical interventions over the phone during the time that we were having to work from home.

Telehealth created strain for participants. One felt the impact of distance from their patients:

It just for me, I felt very disconnected from my clients during those months.

All participants involved in this study are now able to return to care within the jail setting and at the time of interviews, no participants were working from home. Not all participants in county positions have returned to providing care in the jails and a few were providing telehealth assessments from county offices.

Impacts to Patients.

The impacts to patients were significant. Participants often sounded worried about how the pandemic shifted care for patients and were actively working on rebuilding rapport and milieu on units, especially considering continued infrastructure changes:

> *But I think the only thing that's really frustrating that I find that frustrating is like we can't, when people first come into custody like we can't take them to a private room to meet because they're in quarantine. So we have to wait until they do their quarantine, we can meet with them cell side but we can't take them to an attorney room or something to meet with them. If we want to because of the quarantine.*

Another participant expressed concerns with jail programming changes:

> *I just worry more about their extra level of vulnerability and then it has also prevented any programming from coming into the jail. So the clients are, I think it further exacerbates mental health issues that they don't they're not they're not getting the programming that they might have gotten before. Like they're they don't get any religious program or like church coming in any art programs or education I think they used to be able to complete like college courses and now it's they're just so limited in like, interactions with other people and filling their time. That I think it's taking a toll on my clients' mental health.*

Continued telehealth was reported by participants to create challenges with communication and also with confidentiality:

> *Or for inmates depending on where they are stationed on the day of the interview. Sometimes there's a lot of background noise. I think it also limits them from opening up to you and sharing information because there might be a COs in the room or people walking behind them or around them where they don't want to share information. And so I think it's there's definitely been a lot of limitations there.*

Another participant explained the difficulty of reading facial expressions of the inmates over Zoom with masks on:

Inmates also have to wear masks. So when I do my Zoom appointments, they have to have their face mask on. Sometimes it's difficult to kind of read their affect because their face is covered. So you kind of have to do the best that you can by looking at their eye expression. But the affect is definitely challenging to complete.

In person, inmates on quarantine were processed differently which created issues with confidentiality. One inmate refused to see a participant for a mental health assessment in Booking for his own safety:

Yes. I had one client who like he wanted to meet with mental health and he was in the quarantine but he was, I think he was accused of child sex crimes and he didn't want to talk with me, because he didn't want to be identified because of his charges, obviously because he would get attacked by his cell mates. He said, "No, no, no, I don't want to talk with you right now." So he had to wait until he was back into the PC dorm.

When inmates tested positive for COVID-19 there were changes in the level of treatment that they could receive:

And obviously also people were, when inmate patients got COVID we had to change you know, like admissions or we had to change how we, we couldn't do groups, we couldn't do treatment.

Finally, the return of participants to the jail setting was a relief to inmates:

And then once we returned to the office, all of my clients essentially came to me saying, "thank god you guys are back because that was awful. We never want to do that again." So, you know I have been providing face to face interventions for a year now.

Outbreaks.

Outbreaks of COVID-19 in correctional settings created unique challenges. One participant explained the impact of an outbreak within their jail:

Yeah, one whole dorm was positive. So in the first- when they were keeping you for longer because they did a whole vaccination clinic inside the jail to where the public nursing staff went into the jail and did vaccinations for all the inmates, all of the guards. I actually got my COVID-19 vaccination in the jail because it was running rampant through the jail. And so one of the ways that they stopped it was by vaccinating people. And I mean, you can say yes, I want a vaccine and even if you are an inmate they gave it to you.

Aside from the patient outbreak impacts, with a small mental health workforce, when mental health staff contracted COVID-19 there were significant impacts to the remaining staff (if any). One participant explained:

We only had one clinician here, that poor clinician, he was, yeah, I think he almost had a nervous breakdown, no, and he held it down. He was so yeah. COVID I mean, every time there's a covid outbreak, it always affects everything.

Sentencing Changes and Transfers.

Participants discussed changes in sentencing along with delays in transfers from county jails to state prison and state hospitals. One participant simply stated:

> *And, and there's less, less folks are kept in the jail because of COVID, right, there was an enormous reduction of folks in in the correctional system because of COVID.*

Another participant explained that their county released nearly all inmates directly after booking, suggesting a change in the population of inmates who were booked and remained in the jail setting:

> *And if, I mean, most everybody in our county, are book and releases. They don't hold people at the jail since COVID, like they were. It's like, I don't know how to explain it. Unless you show up with a severed head and an axe in your hand. They won't keep you. I mean most of the charges that people are getting arrested for right now-they're booked into the jail and booked out of the jail on the same day. So it makes so the population different.*

Sentencing and transfer changes were also reported to create chaos within the jail system:

> *There were people discharged early based on their level of you know, whatever their offense was and how much time they had left on their sentence. There were people that were held over that were on their way to prison and could not be transferred because the prisons had too many people. So they were held in jail longer. There was a lot of disruption and chaos, increased mental health challenges. Anxiety was very high because inmates were scared. They all were watching the news, they have TV and they were scared to death, particularly if they were going to prison hearing about the number of cases and people dying. And so they didn't want to get transferred. They didn't want to go and then they felt they were worried because they heard that, it was before there was any conversation about re-computing their sentences to start well they were in jail. So they thought they were going to be serving longer than they were sentenced for. There was a lot of fear with a lot of just trying to keep people informed, deescalated and*

particularly when there were some inmates of course, and others who seemed to have a secondary gain from inciting, getting people worked up and incited.

In cases where competency restoration was in process, there were significant delays in transfers-if transfers were possible-between the jails and the Department of State Hospitals:

It had-we also folks that we could not restore to competency in custody, we had to send them to the Department of State Hospital or to the state hospitals. If we were not able to restore them within 90 days. And I'll say that because of COVID. And they had troubles there with COVID. So it impacted it in the sense that I couldn't move people on but because the state hospitals are so hopelessly full and so I struggled to move people on and they kind of lingered so it slowed down my process.

COVID-19 Specific Impacts to Substance Use.

With overall changes to the jail system and impacts to services, COVID-19 specific substance use issues were discussed by participants:

But also substance use, has gotten significantly worse in my experience with my clientele people that were using recreationally are now pretty heavily addicted.

Another participant explained the impacts of an increase in fentanyl during the COVID-19 pandemic:

However, very quickly after that time period, the substance use picked up significantly in this county so then as soon as we had a bit of a lapse we had a huge uptick in withdrawal and overdose. We unfortunately had fentanyl overdoses thankfully, individuals did survive but some were in comas for a while. We just had kind of a run with the fentanyl situation. So that was a very new drug for our county. So a lot of folks didn't really know the warning signs or symptoms of someone under the influence of that drug. A lot of the inmates didn't realize that the drug that they had taken because it was laced into some other drugs that they thought they were taking. So it did change. I feel like I would still provide the same level of care but there were definitely weeks where I was stretched pretty thin and only had the other staff members for about the last three to four months. So prior to that it was just really only myself working with and so there were times I wasn't able to get to someone a second time and I wanted to or someone that I wanted to see weekly or bi weekly and I could only see once a month and things like that.

As discussed in other sections, participants of this study have significant concerns about the access to substance use treatment and other resources within rural and suburban areas. Participants provide an initial look into the impacts that COVID-19 made on substance use in these communities.

While the interview guide focused on individual, interpersonal and organizational levels of the Socio Ecological Model, community and public policy level themes also emerged from the data. The following are the main themes gleaned about these two levels:

Community Level Themes

Rural/Suburban Patient Differences

Participants discussed the differences between incarceration and accessing mental health services while in rural and suburban communities:

> *Because some people have, so let's say that somebody is incarcerated for you know, I mean, a rural county, small community, everybody's like in a fishbowl here and somebody had like a violent offense that was like on social media. And it was publicized and, you know, and they may need to be in a secured setting that doesn't allow for confidentiality, you know, so that those are instances where it's like, yeah, that has to be addressed and sometimes it is what it is*.

One participant discussed a specific example where an inmate/community member who experienced serious mental illness and potentially continued challenges with accessing mental health resources/a conservatorship which led to continual re-offending. With limited resources in rural and suburban counties it is possible that the jail system has become the place for treatment for many with serious mental illnesses:

> *Jails are, like acquiring this, like, failing this client that contributes to a lot of difficulty like you don't know exactly who but this woman keeps reoffending like most recently she and she has three mental illness. And I use her as like an example because you know, a few people in this position has to do illustrative anecdote in she like stole a burrito from someone's door dash or something and like, that's why she's back in jail. And she is so ill, that she just keeps getting she has so much sexual trauma, and she's vulnerable. And it's so and she can't she doesn't want to engage. She she's just so delusional and disorganized. She doesn't want to engage with behavioral health…but just like how can we support someone who's that gravely disabled, you know, without like being to the level that she could be hospitalized, but that she keeps putting*

herself in like extremely harmful situations because she's so childlike and vulnerable with her mental illness. And so…I don't know where that would necessarily fit in for your research, but that and these kinds of characters come up quite a bit where you're just like, in within all of our systems were just like, what do we do with you? Like, how, how do we help you?

Resource Needs and Access to Care

Resources for the Community.

Resources were regularly discussed as significant challenges in rural and suburban counties, especially as patients were set to be released. Some participants also saw these resource challenges as reasons for recidivism:

> *We do live in a small county where resources are limited. And I know that this is a thing across the state. So it's a state issue here in this county, limited resources and then language is a barrier as well. For some of these, the few resources that are available. So being in the rural community, we have very limited funds that we are able to access different resources in our community. And then when we do have it, it's very limited of who we can help and how many people we can help. And we usually have to put them on a waitlist and that waitlist can be so long where they don't even have the ability to want to do it anymore, or we have to refer them out of county and a lot of the time they don't because their support system is here in this county.*

One participant discussed the need for psychiatric-focused housing units within the county for patients who are in the competency restoration process:

> *Yeah, I think another thing that was I don't know, a million different things but I would really like to see a psychiatric housing unit for people in our county that you know at the Center that I was talking about. We don't have the means to restore competency because of lack of resource. So we got to get hospitals to take these guys, like Atascadero, Patton I think. So if we send them all the way to the coast to get treatment and get stabilized they come back and they have their mental health disorders when they get back, you know, some kind of like, you know, there's we also need for people that need to be conserved.*
>
> *Because, you know, in my opinion I'm not a psychiatrist or like a therapist but, from working in the field and working with justice involved patients that are actually incarcerated, you know, as a direct result of the symptoms of their mental illness, the behaviors that surrounded and I can't think of one person right now that was asking me for an inpatient hospital on this diagnosis, like I know, the voices are telling me things, we talked about conservatorship, you know, and so, the first thing is released within 30 days. And I believe auditory hallucinations. You know, and that's you not ok, it's sad*

because now that person is looking at prison again and it's like, there's got to be something differently for people like that.

Another participant discussed the frustration of stabilizing inmates within the jail setting and with limited resources, knowing that these inmates will struggle to maintain safety and health in the community:

I think the challenges are there's not a resources in the community. So you work hard to kind of stabilize someone in a setting, and then they just go back out to homelessness, they go back out to us, they go back out to whatever abusive relationship they were in or whatever, got them in jail in the first place, usually drugs. So I think that's the hugest challenge is like, you patch people back together and then they go back out into whatever environment that brought them there in the first place

Resources While in Custody.

Participants were generally relieved with the return of outside services to the jail setting as pandemic restrictions loosened. Internal resources while patients are in custody were discussed. One participant expressed appreciation for the jail library:

The jail does wonderfully for what they have but it is a very small jail. And I think everyone just sort of accepts that as being what it is. We don't have, you know, a lot of things for them to do in there. We have a really great library and folks that read or you know, enjoy looking at books, or things like that they tend to do very well in there because our library is incredibly stocked for the size of it.

Another participant discussed the important of the Moral Reconation Therapy groups that were able to be restarted:

It's Moral Reconation Therapy. It's a group that identify it's a program that identifies what caused you to start participating in criminal behaviors. You look at those reasons. You find different ways to reverse that process. And then you work towards correcting it. So like you don't you're not looked at like a criminal. You're looked at like being a criminal is a behavior that you learned. And the MRT program takes you through all of these different steps that help you learn how to not be a criminal anymore. But it's called Moral reconation therapy.

Resources for Homelessness.

Nearly every participant shared that their county did not have a homeless shelter. Various challenges related to homelessness were discussed:

We don't have any homeless shelters or really any sources of housing for individuals involved in criminal justice.

Another participant explained the challenges with unhoused inmates upon release and the challenges with coordinating placement:

Our biggest lack of resources is housing and homeless shelters. We don't have a homeless shelter, the local homeless shelters in other counties next to us typically won't take, anyone coming from our county if we if they think they're coming from our county, so it's up to individuals being released to sort of find somewhere that will take them if that's their desire. And we of course will facilitate transportation over there but we can't get them placement in there.

One participant noted that housing for inmates with mental illness was even more challenging to access and the potential for reoffending was significant in this population:

Of course, there's no housing for people so they go out there to the streets and have no housing back to drugs. And, you know, it's just a, you know, we've all been told, just keeps coming back. There's no housing for the mentally ill. That's a real problem.

Resources for Registered Sex Offenders.

As resources in rural and suburban counties were reported to be challenged by participants, the resources for registered sex offenders was even more concerning. One participant extensively explained these challenges:

There's a very, like, practical challenge that I brought up the other day at one of our forensic task force meetings, and it just kind of met with like silence because I don't think anyone really knows how to approach it, but I'm trying to connect a client who has a 290 on their record, sexual offense, like trying to get them housing or let alone like substance use treatment is near impossible and a lot of folks with a 290 suffer from some other type of SMI and you know, it's such a, it's such a loaded record to have and it can, it really runs the gamut of like, like how someone acquired it and like I had a client not in this position, another one who we had such a such a hard time getting housing for, because he was having a psychotic episode and broke into a house and took a shower in someone else's house in the woman came home and he now has a sex offense on his record, and like, he's you know, I think everyone is, should be have access to treatment, regardless of whether or not they're, you know, a pleasant person to interact with, but like, I think in this case, it was just like really glaring because he was just like, the sweetest guy. So just as an anecdote, but that if I would have any, like, say over some policy, that would be you know, to at least create some more nuance with it of like, I understand the intention behind like creating barriers for folks with sex offenses on the record. But like, if your goal is safety, that it can be kind of, I think, broken up and more,

you can become more descriptive with it or some, I don't know, I think there's a way to not just create more barriers to people getting housing and help for substance use or any other like mental health support.

Structural Racism and Cultural Considerations

A few in-depth conversations occurred regarding structural racism and cultural considerations.

In discussing Latino cultural practices and mental health stigma, one participant stated:

You know, there's a lot of stigma in the community and in our culture, and I know it's not just like an American culture thing, but even in in the Latino culture, the stigma is even tenfold so trying to normalize mental health is something that I often have conversations with, my clients and with the inmates. And at the end of the day, just providing education and talking about the benefits of getting mental health services.

Another participant discussed the concerns of racism and intergenerational trauma:

And then, you know, there's, there's racism that you can see in the justice system. You know, I mean, I'm not I'm not trying to play that card, but it's a reality that we face, you know, and like the population where I'm working. There's a huge over representation of Native Americans in the jail. And, you know, and I just think that, you know, that was something that was a little bit difficult to navigate through because there's a lot of bad blood before between the sheriff's department and the incarcerated population. Generational you know, so it was it was a dynamic that really came into play when I was working in the jail. As far as the way that I see, you know, confidentiality and fairness and stuff like that when it came to treatment, access and service provision.

One participant also expressed his own experience with being treated differently from other staff due to their race and having been previously incarcerated:

… a couple times, I was searched on a couple of occasions, which I expected that when you go in but you know, the taking my phones away from me and telling me I can't do coordination calls or linkage. You know, because when I when I'm trying to get somebody into treatment, you know, the treatment center they talk to me so much, but they want to have interviews with the patients and see if they're serious about coming to their program and stuff like that, do an assessment, and I can't really do that type of care coordination if I don't have phones or computer and, you know, and I felt like when they took my phones away from me fully, like, I then became incarcerated, you know, myself, I was like, Oh, this was really an aspect of the process that I didn't expect, I was like, because I'm a county employee you know, I work under the same organization that the sheriff's department are employed by and I just, I felt like that was whether it was due to somebody knowing my background as a previously incarcerated person, or, you know, as a being a Latino. I don't know where that would fall in there. But it did feel discriminatory. Definitely. Because other staff were not reporting the same experiences that I was having.

This participant also discussed their view of the reasons for continued recidivism from certain cultural communities within their county:

> Yeah, so when I heard about numbers in the jail, I mean, we did that the last time county I worked for I was working with juvenile justice in a neighboring county, and we did what it's about racial and ethnic disparities like process. And we looked at like, the stats on like, you know, inequities and discrepancies in incarceration rates amongst youth. And basically, you know, there was over representation of youth of color, you know, and the justice system, you know, they were more likely to be incarcerated than sent home on some other type of community based intervention and you know, so that was something that first opened my eyes to like, hey, this stuff is when you can look at the numbers. I still haven't seen the numbers for the county where I'm working right now, but basically going into the jail. I mean, I'll just share this one instance, I have sat down and met with multiple people from one cultural population that's over represented in this county, in the justice system in the jail, and I got them meetings at different times. Four different adults that all grew up in the juvenile justice system, who were all raised in the same household, that we're all at the jail at the same time. And when I heard a person telling me that I come back to jail because I get lonely at home. This is the only place I could really see my family. That person was a part of that household. And it finally made sense to me because I didn't- I struggle with that answer that this person gave me. And I was like, "Oh, my God," it saddened me deeply. But it really helped me to see like this stuff is real, but it's not like, you know, the people that say that racism doesn't exist and stuff like that. I'm like, you know, how is this possible? You know, and we're saying that they're bad people, like I'm not saying that, but the idea is that these are just people that are mess, and there just bad people, they make bad choices. And I'm like, Well, you've been incarcerated since you were a youth, you know, they had generational trauma and substance use, handed down to them from their parents and their parents had it. And everybody's been to prison. And we're saying that we don't need to make change in our community. That these peoples responsible for change. We need to ask them, "What are they going to do differently this time?" And I want to ask everybody, like, "what are you going to do differently? What are we going to do differently?" Because, you know, we're telling these people they need to fix it, but we're the ones who need to fix things, you know, stop depending on people who have created this broken system to this new perspective. And I don't know, I guess that's a tangent there. That's kind of like, you know, for clarification, that kind of where I'm coming from.

Structural racism and cultural considerations were identified by participants as contributing to long term community and public policy level related issues over the course of multiple generations.

Public Policy Level Themes

Themes at the public policy level allow for the highest view of the Socio Ecological Model.

Distinct Environment

For Patients.

The distinct environment for patients is an important consideration given the unique circumstances of jail mental health in rural and suburban communities:

> *It's far more acute. And, and there's less, less folks are kept in the jail because of COVID, right, there was an enormous reduction of folks in in the correctional system because of COVID. And then also because of diversion laws. We have a move towards decriminalizing substance use and mental illness which is absolutely legitimate. But there is there are less folks, now that I- let's say have low acuity mental illness and more even more acute people and the services that seem to be provided because of the lack of staffing and emergency medication are reduced. So I think that we unfortunately we don't do folks a favor anymore with regards to medication, so there's really an enormous acute level that people are struggling to handle.*

In addition, one participant explained that patients coming into the jail setting may present with higher levels of vulnerability:

> *Typically, it runs a little bit different than a traditional mental health assessment just in the fact that they're pretty raw from their jail experience. And they often are homeless or something floating.*

For the Clinical Process.

The clinical process within the jail setting has additional complexities. One participant explained:

> *Well, what I found out is that the work at the jail clinically is so much more interesting than I've ever experienced, certainly in private practice or outpatient or at different agencies. It's clinically much more interesting, more challenging, but far more interesting. And you have no clear-- no idea what's going to walk in the door. I have no idea and so that makes it sort of interesting, and somewhat of a puzzle to figure out what's going on and what's the diagnosis and you know, what's really happening here and how we can best take care of this person and, you know, best situations, so I find it more, I mean I've worked at [other setting] and psych hospitals I find it much more fascinating to be in forensics much more interesting. And you have the person for a long time and have some of for very long time. Whereas some hospitals, you may only have somebody for 10 days. In custody, you have somebody for a long time. And eventually they get sober so you can get them stable and you can actually see some improvement. Of course, there's no housing for people so they go out there to the streets and have no housing back to drugs. And, you know, it's just a, you know, we've all been told, just keeps coming back. There's no housing for the mentally ill. That's a real problem.*

Another participant explained the challenges that are created as inmates move quickly

through the system with limited mental health interventions possible before a "quick release" which can mean very little no discharge planning and establishment of resources:

> *Let's say somebody has a quick date and that was for whether it was arraignment or somebody posts bail or somebody gets released spontaneously by the court because they get referred to an outpatient program, which is a release that is not anticipated. Usually you can have an anticipated release when you have a release date. Let's say you serve your time, a couple of weeks or a couple of months, then you have that date already, but spontaneous releases are where somebody goes to court and maybe everything was dropped, or the judge said releases the parents and so the person comes back from court, you wait for the court minutes and then that moment the jail has a responsibility to release the person because they can't legally keep them anymore and then I went in if that person was flagged by mental health, and assessed them for safety prior to their release.*

Multiple participants explained that they believed that clinical practice outside correctional settings would be similar to practice within the jail environment—finding instead major differences. One stated:

> *You know, it was just kind of, I guess advertised to me that you know, "hey, people are people everybody's, you know, similar," which I totally agree with. So, basically, what you do on the outside should work on the inside, theoretically, so I wasn't expecting any "major differences" between the two populations and but you know, indeed, I believe that there is differences as I've learned since then, but yeah, when I first got started, yeah, I did not have any such knowledge.*

Substance Use

As discussed throughout this chapter, substance use is a major theme that fell into multiple areas of discussions with participants. Generally, participants felt that there were major limitations in substance use services. On participant discussed an out-of-county placement that was necessary to provide treatment:

> *You know, for sure substance use treatment programs. We are missing inpatient, like rehabilitation programs for dual diagnoses. Most of our clients that are able to, that need these types of services end up going to San Diego or out of county. We have outpatient services, but we don't have inpatient rehabilitation centers and if somebody is detoxing they go to the ER*

One participant discussed an informal resource for inmates upon release:

> *So that's like, that's important to me because if you get out of jail, and the only place that's open is your drug dealers house. That's where you're gonna go*

Another discussed the concerns related to the opioid epidemic in their county:

We have an epidemic of opiates in this county currently and so a lot of folks will enter the jail withdrawing from opiates and they often will not want to disclose that to jail staff because they falsely believe that they'll get in more trouble. And so oftentimes I'm brought in to figure out what exactly they are coming down from so we can provide the appropriate intervention and withdrawal protocols

One participant discussed the influence of methamphetamine and how this drug impacted the mental health of inmates:

I think I never imagined, I could not imagine the influence that like methamphetamine has on mental health. We get a lot of people who are in meth induced psychosis. I didn't realize all I didn't know all that. And so you do a lot of managing mental health symptoms that are actually brought on or exacerbated by drug use. And so I didn't realize the layering that mental health and drug use has together. So a lot of times you see someone one way after they're sober in the jail, and then you see them come back in when they're under the influence and they're two different people and I didn't really I didn't really know that that was gonna be so significant. We do a lot of talking to people about, hey, when you get out of here, you think about rehab? I didn't know that (substance use) was going to be such a predominant part of mental health.

Another participant was surprised by the gratitude expressed by some inmates for the periods of forced sobriety while incarcerated:

I was surprised by the expression of gratitude for having like, especially since a lot of what I do is connecting folks to substance use treatment and trying to get them door to door services to a residential SUD treatment providers in the county and they, I just encountered way more clients than expected who were grateful for the time sober and the forced period of sobriety in jail and then being able to go door to door from jail to residential. They say just like really increased their chances of sobriety and it could, you know, save their lives like there's so much fentanyl use up here and poly substance use and so that that was surprising to me.

Jail Infrastructure

Participants discussed a variety of challenges with jail infrastructure including availability of confidential space, midnight releases and the health impacts of the overall environment:

As far difficulties having to share the space with other professionals such as attorneys is quite difficult, that just kind of goes along with not having a large facility. So there have been times where I was unable to complete my list of individuals to see for a day because an attorney needed the room and they do have priority in this county.

Multiple participants discussed the concerns with midnight releases as there are limited resources available at this hour in any county, especially rural and suburban counties. One participant discussed a collaborative approach to assisting patients who had resources set up for the morning:

> *They get out of they get out of custody at midnight because they're due to be released this day. It's quieter at midnight, so the midnight shift will be in charge of releasing them unless you specifically specify, "I want this person released at this time because they're working with one of our programs." They used to get out of jail at midnight. There's not even anything open here at that time.*

Another participant shared a lengthy discussion regarding their concerns with infrastructure not only for staff, but also inmates:

> *So when I first the first two weeks that I was working there were the hardest for me in terms of I got sick right away. I was very, very, very sick and I think there's like a lot of you know, it's, I don't know, it's just kind of a gross environment. Like everybody knows that works in jail, but there's like a lot of feces around, there's blood borne pathogens kind of in the air and you really have to manage that and you have to have a decent immune system so I got sick right away to the point where they had to do something special to allow me to have like a week off cause I was down for all week. And that was not something that I expected. And then the noise level of the jail I noticed that after working there for a solid week, I was able to tune it out. But I know from experience now that that tuning out is something that you are kind of actively doing in the background, so it does take up bandwidth and energy. I did not like the environment for the inmates at all in that there's nothing pretty around. There's no beauty in the jail, unless you consider, unless you're like kind of into concrete and that kind of stuff like some people are into that aesthetic and they like it but not very-that doesn't happen very often. There's no place to go with your mind to rest like for example, if you're having like a psychotic episode, being locked in a very small box that's concrete with no visuals, it's really a sort of torture. I think. I didn't love that. I didn't love that there weren't enough windows or outside time, or pretty outside time. Like there's just not a lot of beauty there. Everything is made up of different concrete textures. It's also really noisy. I think it's also noisy at night. You know Sallyport doors, make a lot of noise when you come into a unit or leave a unit at your opening like our doors were all steel so they make a lot of noise when they open and close. They just find that it was it's not a soft place. You're not going to get any hugs. It's not going to feel like a hug ever. It's just going to feel very hard and not welcoming. As a worker there. I was constantly busy so that was the distraction from the harsh environment. But if you are an inmate there and you're just waiting out time, I think the harsh environment would have, I think it would be really difficult for somebody at like a body, mind and soul level to be there. That was hard for me to see that for them.*

The various impacts of infrastructure were reported by participants to have impacts on the care that they could provide along with their ability to work within the environment.

Impacts to Confidentiality.

Confidentiality was presented as a concern in two major ways: COVID-19 related treatment adjustments and the difficulty finding physical space for confidential clinical interactions. COVID-19 related confidentiality concerns were discussed:

> *So, I think as far as the work at the jail has been concerned and you know, it's caused cancellations if you get exposed, they can shut down services, you know, or if there is an outbreak in the jail. And then it also made it to where like, if individuals were-so access, I guess has been impacted. You know, people have to get from quarantined when they first go into the jail and you know, you might be hard to get the fact to face interview to get the full benefit of like and then all of the confidentiality piece was a little more compromised when people were on a zoom or electronically with people within earshot speaking about, you know, their trauma and interacting with a provider.*

Another participant explained:

> *Well, when we were doing zoom, it was because they had to set the computer up and they only had one place to put people and it was like it was in a secured, locked, like a cage. I don't like using that word when talking about people but you know, they'll put them in a security cage and with the computer up to the little slot where they're at and they would talk to me through like a interview cage on the computer. And that was located in a control center, where, you know, you had a deputy standing there doing their work or whatever the case may be. So it was never really, you know, confidential in my opinion, you know, I mean, that's just my opinion, though.*

General concerns for confidentiality unrelated to COVID-19 were also discussed:

> *So like privacy, you know, not having deputies or people being able to enter a session and stuff like and I kind of had the expectation that it was going to be more like you know, just providing services that I typically provide, but in a secured area, you know, I guess that I had a little bit of a misunderstanding of that.*

Another participant explained that even with access to a confidential space, custody officers were often coming into the interview space unannounced:

> *So you have, sometimes I'll have a room where I can sit with people confidentially, but you know, sheriff's that are working there depending on who was there and who you know, they may just come open the door or just barge in and, you know, interrupt the session and sometimes potentially, you know, keep the door open or and then other times you're asked to do services in areas where other inmates are frequently that are like workers or I had a couple of issues come up around this aspect of it. And you know, I just it's very difficult to do treatment that way.*

Impacts to confidentiality arising for multiple reasons were concerns for many participants.

Dreaming Big

At the conclusion of the interview, participants were asked to dream big and share their opinions of the perfect mental health system for inmates in their rural or suburban jail. Subthemes came for this question including Empathy and Compassion, Infrastructure, Additional Clinicians, Training, Resources and Substance Use. Although some of these topics had been presented throughout the interview, this question focused specifically on the design of a perfect system.

Empathy and Compassion.

Considering the impacts of incarceration for jail inmates was important to participants.

One participant stated:

> *I think there would just be a lot more awareness of how hard it is for some folks to be in jail. You know, we have our sort of frequent fliers who don't really care so much about being in jail but then we have people that even if they've been in jail before, maybe this times different for some reason, it's really difficult for them.*

Another participant considered the challenges with having PTSD and being incarcerated:

> *When people are in jail for serious charges have significant PTSD are being you know held in a cell where everyone's screaming in a particular pod where that is the norm or there can be more opportunity for day room release and interaction for you know inmates that can handle that with adequate staffing to manage that. To not make the mental health issues worse. Not to have somebody stay in the safety cell for 13 days.*

Basic needs issues were discussed by a participant:

> *I mean, that's like a really big multi layered program with a lot of moving parts. I mean, I think for one, you need to let mental health inmates out of their cells for longer time periods. You know, they need diet, exercise, sunshine. Basics that I don't think they were getting. Group programs, individual counseling more often. I mean, I don't know that I would be really able to suss that out in a minute, but because, you know, thinking from the very top to the very bottom like including bedding and what they eat, and you know, one of the things that I did like about the jail that I worked at was that the deputies are really close with the inmates in terms of talking with them a lot, checking in with them a lot. And you know, treating them like humans.*

Infrastructure.

Changes to the jail infrastructure was important to multiple participants.

Mental health treatment space was discussed as being difficult to access within jail for multiple participants:

> *If I could go to the jail, if I had my own intake office or a screening space. That would be ideal if I could go to the county jail and actually do the intakes in person. But because- so that would be the start having access to all the records and documents that I need ahead of time. Having the tools completed by the time I do my interview.*

Outside of treatment space, one participant explained the need for designated housing areas for mentally ill inmates:

> *I think if perfectly were going to happen I would like our county mental health and other medical system within jail to work us together and actually be able to be cordial with each other and to help the inmate in the best practice and also with our folks within mental illness in the jail to like have them in separate, if possible dorms so we can get more therapy or other guidance that to help them since they all would be in one area with groups and stuff like that.*

Similarly, another participant explained:

> *I really think that we need to have more specialized or let me say classified modules, because and where people maybe can roam according to their IBC code or innate behavior code or classification. Because the big modules sometimes where you stick everybody in that is less is more criminal than mentally ill. That really doesn't do anybody a favor. So we want to create specialized mods.*

With less specificity, one participant explained:

> *I would want to change what jail looked like completely in make it more of a genuinely rehabilitative environment, not furthering people's not further damage damaging folks' mental Health.*

Additional Clinicians.

Multiple participants explained the need for additional staffing:

> *That a mental health provider was there at least eight hours of every day. Cause we're not. We're there on Tuesday, for two hours and on Thursday for two hours and then group is an hour and a half. And on Wednesday crisis services happen. They call for a crisis that's going on and we come immediately but to actually have a mental health provider in jail for like, half a day. Each day is a week, whole day, one day a week so that you can know that you have someone to go and talk to. I think that would be a perfect system. There's not someone actually stationed inside the jail that has an office that you could go and talk to them.*

Another participant explained an ideal system for their jail:

For clinicians, there would be adequate staffing. There wouldn't just be one person who was 40 hour and on call with two on call people who live out of the area and work very limited, you know, on call hours. There would be whatever reasonable staffing would look like which would be probably at least two full time people and part time people and an on call or two so that there could be less dependence on those inmates that want to see a clinician to not only have one to choose from to be able to have more than one psychiatric sick call a week to have adequate time not feel pressured to see folks for and call it good for 10 or 15 minutes and move on to the next.

Other participants explained the need for psychiatrists and discharge planners:

I probably would have psychiatrists on, we don't have nearly enough for the population that we have.

I definitely would probably have more discharge planners, too, because we only have one for like 400 inmates. I'd have more discharge planners to help people when they get out. What are they going to do? And it definitely would have some substance more than one substance use counselor. So I guess I would turn out a little bit more therapeutic and counseling versus crisis management. That's what I would do.

To recruit and retain clinicians, one participant discussed the need for additional pay incentives to keep clinicians in these challenging settings:

I think I mean, I know that partially it's like, recruiting, and like staffing in jails. And I know I think one of the big things I know at our county level is there is no pay differential. The only- like there's a hazard pay it's like 0.9 or 9 cents more per hour, I don't know. It's just something very small. So there's no like incentive to work in the jail as opposed to working at the outpatient clinic or, you know, so we get paid the same amount. And it's like, I think from- I've worked in numerous fields in mental health. I worked in outpatient like an Access team. I worked in another county doing like out of county placements and traveling to all the different placements in California. I worked in this crisis clinic walk in, I worked in the Mobile Response Team, and I think the jail is probably the most intense hard job I've ever had with acuity, and so I think, I wish in our county there was increased pay and I could offer that to clinicians because there's not a lot of, there's nothing really sexy about working in jail.

Training.

Improvements in training, mentoring and training of custody staff were discussed. One participant proposed having a mentor as part of training:

Having a mentor and ongoing training I think would be very, very helpful, very beneficial. Maybe even education on the latest trends in this county- what's working, what's not working and just having like a solid clinical team for the county jails, and having them as the mentors that support. Often times I feel like I don't have that. Like I said the diversion program, I was the only task clinician and so you know who do you have to fall back on

what do you have, who do you have to go to if you're the only clinician that's kind of rolling it out in the county, right?

Custody-related concerns for training were presented as well. Two participants discussed the need for jail custody staff to receive specific mental health training:

The jail staff that directly work with mentally ill people also have training on what it means to be schizophrenic or what it means to be bipolar. They do have some training, but I think if they had more specialized training of what the DSM was, what people actually were that, no, this isn't intoxication. This could be un-medicated bipolar disorder. It might look like intoxication, but it's really not. I think that would be beneficial to the inmates.

We want to train our deputies well, we want to train as well as we train our deputies also deputy needs or custody need to train mental health professionals.

Resources.

Resource needs were discussed by multiple participants, especially resources upon release from the jail:

We would have greater access to resources upon release such as homeless shelters, transitional housing, hygiene items, very simple things. Excuse me. We would have a greater collaboration with other agencies. It can be difficult in this county to get other agency partners to go into the jail because of scheduling or lack of access or lack of staff to provide that service. Which is why we ended up providing Medi-Cal applications even though that sort of falls under a different department here. We started doing that because that was such a barrier to individuals getting treatment. We just saw fit to remove the barrier by doing it ourselves.

In-custody resources were also discussed. One participant discussed an interest in having inmates engage in the planning of their in-custody resources:

I think that it would be great for inmates in the jail to be offered a lot of different programs and let them select like, do you want to go to groups? How many times a week do you want to individual counseling? you know, Are you meds working?, like all these kinds of things that you would do like case management in a jail. And maybe that was happening, but I didn't get to see a lot of it because I was kind of taking care of the things on the periphery in terms of Booking and all that stuff.

One participant discussed at length resources needed to assist inmates to successfully transitioning back to the community:

I would create [a newly available county building] into an intensive outpatient program for people that are incarcerated. I would have on site psychiatry, case management, SUD and other community based providers that people can interact with before they go home, that it increases their chances you know, having service provision or access, once they're in the community I think that I would, you know, at least at the minimal have safe, you know, treatment, just safe treatment that people could get services in. And we're working on issues like security that the jail has with individuals, have more culturally appropriate services available to people and based on like, the stuff that I would do, I would have more informal wellness activities for people that are incarcerated that aren't, you know, like I've thought about having wellness activities for people where like they can do karaoke, all kinds of art classes and opportunities for people to participate in social activities with their peers and providers that promote a healthy outlet that but it's the label that I would work the jail and the courts to implement treatment programs that took with a certificate that come with a sentence incentive to get a little bit more. If they're gonna complete a six week course in substance use for incentive to get a little more time off their sentence, what is that going to hurt? Like let's get them into this. To me, don't forget to get seeds planted and you might get in with the right people. You know that feel safe enough for you to start participating in your recovery. I would have better psychiatry services available. I've seen people get started on meds before they even see a doctor and I think that in certain situations by stabilizing it can do good things, give somebody access to an anti-psychotic, they're still like dangerous. When they come into the jail I would have more support for people that are coming in with anti-psychotics and a lot more education. From my perspective, it doesn't sound like we're like all working together we should all be on the same page. I think we got to keep moving. Getting integrated care. We're all responsible for helping these people to get healthy because they're our community members, they're coming back to us, I think that's that's really not the best opportunities for people to heal. Their kids going to school with our kids. We're gonna we're gonna see them at the grocery store. We're gonna see them at church. We're gonna see them at all these different places. And that's because they're a part of the community instead of criminals.

Substance Use.

The need for additional substance use treatment services was discussed in the context of "dream big" planning. One participant expressed a need for dual diagnosis programs:

You know, I mean, here's the thing with mental health here, in this community, there's a lot of substances. I mean, dual treatment, I think is ideal in the jails, dual treatment. I don't know that that's happening because they primarily get their mental health.

Another participant explained the need for substance use counselors in the jail setting:

And it definitely would have some substance more than one substance use counselor. So I guess I would turn out a little bit more therapeutic and counseling versus crisis management. That's what I would do.

Conclusion

As depicted in Figure 2 below, themes emerged across all levels of the Socio Ecological Model. Rich data emerged relevant to community and public policy as well as the individual, interpersonal, and organizational level domains that were the initial foci of this study. This speaks to the broad utility of the framework as applied to mental health provision in rural and suburban jails, as discussed more fully in Chapter 5. In summary, although there were multiple themes found at all levels of the Socio Ecological Model, the main findings were related to CMHP training, mentorship and supervision and how CMHPs navigate difficult experiences. These main findings cross multiple levels of the Socio Ecological Model and have allowed for analysis across the entire model.

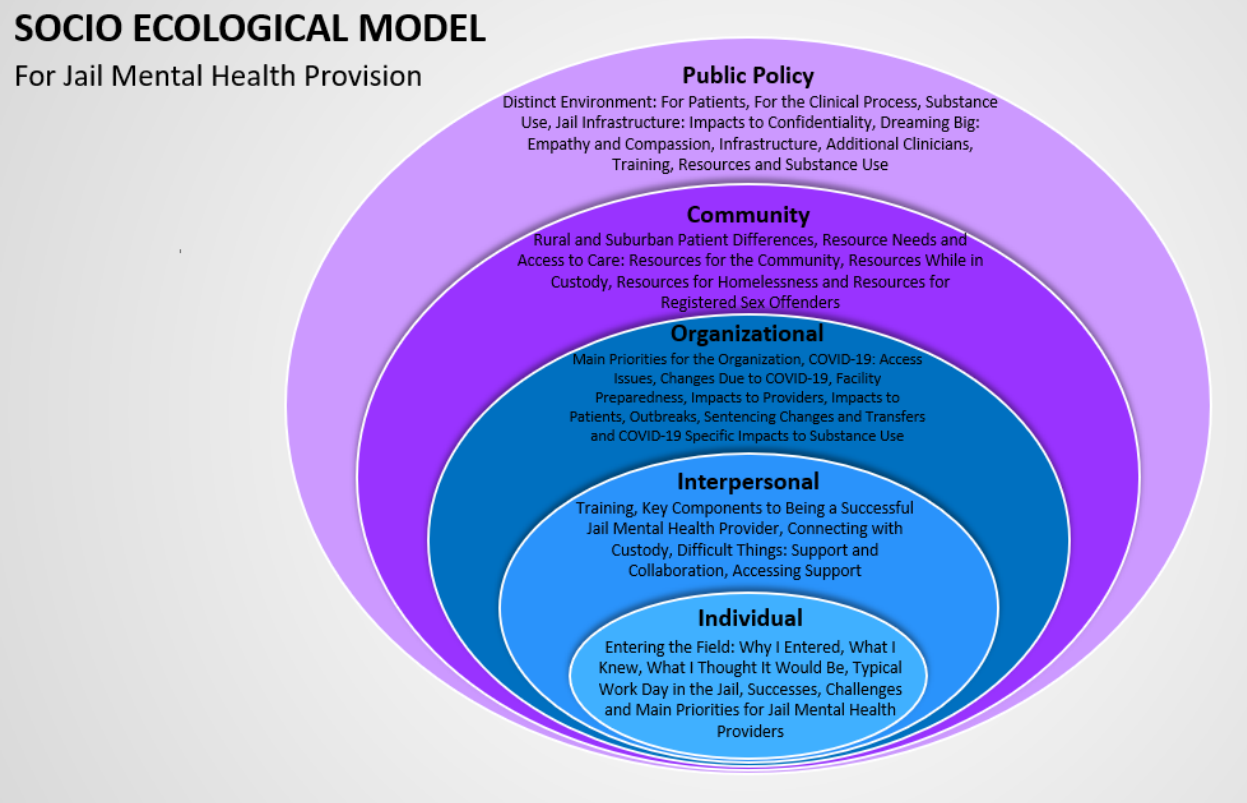

Figure 2: Socio-Ecological Model of Jail Mental Health Provision

Chapter 5: Summary of Findings

At the completion of 14 interviews with mental health providers in rural and suburban California county jails, multiple themes emerged at all levels of the Socio Ecological Model providing rich data and context to the experiences of CMHP in these settings. The key study findings connect to the individual, interpersonal and organizational levels of the Socio Ecological Model and allow for cross-level discussion. Guided by the piloted interview guide developed for the study, participants reported on all levels of the Socio Ecological Model: individual, interpersonal, organizational, community and public policy. The interview guide focused on the first three levels of the model, individual, interpersonal and organizational, yet the participants' answers expanded to include community and public policy themes.

At the community and public policy levels, both rural and suburban counties consistently struggled with resources including homeless shelters, substance use services and basic psychiatric care within the county. It is understood that smaller counties may struggle with access to some resources, but it was surprising to consistently hear that these resources were generally unavailable regardless of county.

Two key findings emerged from the interviews. First, participants discussed the need for improvements to exposure to the jail environment, training, mentoring and supervision. Second, participants discussed resiliency, collaboration and the support needed to navigate difficult experiences within the jail setting. These key findings provide opportunities for educational institutions, county behavioral health and jail administrators, contracting agencies and correctional health care organizations to further understand how to recruit and retain CMHPs—especially for California's rural and suburban counties. Each key finding is discussed below.

Planting Seeds and Nurturing the Growth of Jail Mental Health Providers: Exposure, Training and Support

This study found that there are opportunities for improvement in the preparation and on-the-job training and support for CMHP. Participants discussed the need for forensic courses in certificate/master's level training programs, exposure to correctional environments through volunteering/internships, forensic-related training on the job along with mentorship and enhanced supervision for CMHPs. The literature suggests that psychology training programs should include experiences relevant to clinical work in federal and state prisons (Magaletta, Patry & Norcross, 2012), but very little work has focused on jails. Although this study opened recruitment to all mental health providers within rural and suburban jails, I was never made aware of psychologists being employed within these jails. Considering that the vast majority of the 44 counties contacted only mentioned employing Social Workers, Marriage and Family Therapists, Case Managers, Drug and Alcohol Counselors and Psychiatrists, it is important to gain a better understanding of the experiences of these CMHP as well. Further, given that this study also found that the majority of CMHPs in this study came to the work opportunistically and without a clear understanding of the needs of inmates in jail settings, it would be helpful to establish support methods for potential CMHPs across the career trajectory—before, at and after entry to the field.

Some clinical graduate programs may provide exposure to correctional and forensic mental health, but the unique factors required to be successful in correctional environments are typically learned by clinicians while on the job (Magaletta et al., 2007). Importantly, recent graduates will experience an even steeper learning curve in understanding the clinical needs of these vulnerable populations along with learning the complexities of these distinctive environments. Numerous correctional mental health care experts have called for early clinician exposure to correctional mental health content in academic settings and through continuing education/training (Carter, 1991 |

Magaletta & Verdeyen, 2005). Given reports from participants of significant staffing challenges and limited knowledge about this area of clinical practice, it may be important for graduate mental health training programs to consider additional correctional/forensic learning opportunities and to cover the distinguishing features between jail and prison correctional environments.

Most study participants indicated they did not intend to work in jails and had extremely limited exposure to forensics/correctional environments. Most participants involved in this study did not choose to work within the jail environment, but found that they did enjoy the work in jail mental health. None of the participants had formal education in their graduate/certificate programs about practicing within forensic/correctional settings. Considering the high levels of vulnerabilities of patients within correctional settings, it is concerning that the workforce is not generally prepared to work in these settings. Further, participants discussed limited supervision structures and limited training related to forensic mental health once on the job.

In addition to formal education and exposure to these settings, it may be helpful to include professional organizations for training, peer support and networking. One of the main organizations for peer networking and continuing education is the Forensic Mental Health Association of California. This organization's mission statement is, "FMHAC is committed to the goal of first-rate evaluation and treatment of mentally ill offenders through quality education and training to forensic mental health professionals in a variety of disciplines (https://www.fmhac.org/). Considering that rural and suburban counties may have limited staff, supervisory bandwidth and forensic expertise, it may be helpful for CMHPs to establish relationships statewide with other correctional professionals.

Other organizations such as the American Jail Association, National Commission for Correctional Health Care and professional organizations supporting specific mental health providers (e.g. National

Association of Social Workers) may also provide support as CMHPs become accustomed to work in correctional environments. Further, participants in this study discussed the need for on-going mentoring and support from someone within their organization. Most discussed not having access to this type of support raising questions about organizational capacity to provide it. The available literature does not discuss resources for mentoring and on-going support of CMHP. This gap may negatively impact the recruitment, experiences and retention of CMHP raising concern about future staffing. Given the complexity of clinical work within these settings, it is recommended that each county/region has a more robust supervision and mentoring network and stronger, more formal ties to state or national organizations to provide this support. Particular challenges were noted in serving patients between agencies and care systems, and between the correctional environment and the community. These challenges cross levels of the Socio Ecological Model and underscore the need to strong supervision and mentorship and peer network support for CMHPs. Some rural and suburban counties involved in this study had only one clinician dedicated to this work (sometimes part time) | accordingly, it is unreasonable to expect support networks in these settings. Membership in professional organizations maybe be critical to providing this support, training and continuing education in such settings.

An area that came up in every interview was around staffing concerns. Some counties discussed having one or two mental health providers in the jail setting and some counties did not have a dedicated mental health provider available more than part time. Many counties rely on private contractors for mental health services yet may still struggle with filling positions. Some contractors advertise large sign-on bonuses for mental health providers in a suburban jails. Many participants in this study reported having chosen not to work for contractors due to their desire for county-level retirement benefits.

When Difficult Things Happen: Collaboration, Support and Fostering Resiliency

The second key findings related to participant experiences of navigating difficult experiences and situations in the jail environment. As one participant reflected, "…whether it is supervision, whether it is a community, whether it is conference or whatever, you definitely need to have a community that can understand and support you." This support may be critical after difficult experiences occur especially when considering secondary trauma and vicarious resiliency (Malkina-Pykh, 2017). Context to correctional environments is important to gain a better understanding of how and why difficult things may occur and impact CMHP. The current body of literature suggests three main themes that set correctional settings apart from other areas of mental health practice. The first theme is the frequency of ethical and legal dilemmas. Those who work in correctional settings are presented with unique challenges and regular ethical dilemmas in balancing the ethical mental health care of inmates and their roles in the control and security of the paramilitary structures of jails and prisons (Bonner & VandeCreek, 2006). There are inherent conflicts related to managing the mental health care of inmates while upholding the safety and security of institutions (Simon et al., 2020). The second theme is the distinctive environment of correctional spaces with their primary foci on security, punishment and custodial control rather than on health and health care (Stoller, 2003). Clinicians may encounter and become part of the punitive cultures that become normalized and institutionalized in jails and prisons (Stoller, 2003). The third theme is the unique and extraordinary burnout experienced by clinicians (Simon et al., 2020). The intensity and complexity of practice in correctional environments has the potential to degrade the well-being of clinicians leading to burnout and retention issues (Simon et al., 2020). Clinicians experiencing unremitting stress are at higher risk of burnout which can lead to depersonalization and emotional exhaustion (De Bono, 2021). While participants in this study did not discuss their own burnout experiences, they did discuss the potential for burnout and secondary trauma.

Experiences of secondary trauma have generally been studied in those who work with trauma survivors. Recent literature suggests that staff working with correctional populations do experience similar levels of secondary trauma and could benefit from support (Frost & Scott, 2022). More specifically, there is an emerging literature related to correctional fatigue. As correctional environments are distinct, secondary trauma may be different in correctional settings than in other settings.

The Desert Waters Correctional Institute developed a Corrections Fatigue Model (2016). Corrections fatigue is defined as a gradual deterioration of the spirit, mind and body (National Institute of Corrections, 2004.) and researchers at the Desert Waters Correctional Institute have published multiple studies examining the impacts of corrections fatigue including the development of posttraumatic stress disorder (PTSD) in correctional employees (Denhof & Spinaris, 2012 | Denhof & Spinaris, 2013 | Denhof, Spinaris & Morton 2014). Correctional environments are considered high stress occupational settings (Brough and Williams, 2007a | Dowden & Andrews, 2004) and are associated with high rates of staff mental health injuries (Carleton et al. 2017, 2019, 2018a, 2018). Rates of PTSD in correctional staff, including clinicians, are high and there is a strong relationship between PTSD and burnout (Boudoukha et al., 2013). Desert Waters Correctional Outreach also offers training, research and support networks. This organization may benefit CMHP and it is recommended that county and jail administrators along with certificate/graduate programs collaborate with this organization or other similar organizations to improve opportunities for the correctional workforce.

This study did not include those who no longer work in rural and suburban jails. As such, results did not include reasons for leaving, but participants did discuss the importance of support and collaboration when difficult things occurred. It was expected that participants would discuss their experiences and mitigation of burnout along with consistent expressions of secondary trauma. The majority of participants though did not discuss these experiences in depth. Rather, participants

discussed ways that they had managed difficult situations through support and collaboration with others in the jail. Building upon the strengths that participants discussed when difficult things arise along with enhancing education, training, support and mentoring, it may be possible to improve the experience of CMHP and enhance the clinical experiences of inmates within these settings.

Context of Findings

This study placed a special focus on the rural and suburban county CMHP and key findings listed above suggest that there are multiple opportunities to support these providers. One area of context that is especially important is related to the health vulnerabilities of jail inmates. Nationally, most jails are located in rural areas where communities are experiencing additional health vulnerabilities, especially substance use disorders (SUDs) (Kang-Brown et al., 2019). Recent data suggests that nearly two thirds of inmates in rural jails meet the criteria for SUDs (Kopak et al., 2019 | Proctor et al., 2018 | Raggio, Kopak, et al., 2017a) which is unsurprising given substance use is often associated with criminal justice system involvement (Kushel et al., 2005 | Desai, Lam & Rosencheck, 2000, Lindelius & Salum, 1976, Fischer, 1988, Fischer, 1992 & Benda, 1993). Mental illness is associated with increased risk for involved in criminal justice systems (Snow, Baker & Anderson, 1989, Gelberg, Linn & Leake, 1988, Martell, 1991 & Martell, 1995) and it is estimated that 40-55% of adult jail inmates are experiencing a mental health diagnosis, including antisocial personality disorder, posttraumatic stress disorder, depression and manic disorders (Proctor & Hoffman, 2012 | Raggio et al, 2017a, b). These serious conditions require specialized treatment and without the support of CMHP it may be difficult for jail inmates to receive constitutionally appropriate care.

Americans with SUDs and mental health issues have a higher risk of re-incarceration yet limited research has been done at the jail level to understand these issues as most research about these issues focuses on prison inmates (Kopak et al., 2019). Participants in this study discussed seeing inmates multiple times due to re-offending and discussed the impact that substance use had not only on their

mental health, but also the limited community resources for substance use services. While it is important to have a clear understanding of SUDs and mental health issues amongst prison inmates, the recidivism of jails inmates with SMI is significant (AbuDagga et al., 2016) and this revolving door offers unique challenges to CMHP. Nationally, there is an overrepresentation of inmates with SMI in correctional systems (Treatment Advocacy Center, 2015) and there are more mentally ill Americans in U.S. jails and prisons than in psychiatric facilities (Aufderheide & Brown, 2005 | Treatment Advocacy Center, 2015). Further 29% of American jails detain inmates with SMI who have no criminal charges while they are awaiting psychiatric evaluation, availability of a hospital bed, transportation to a psychiatric hospital or all of these reasons (James & Glaze, 2006 | Minton & Zeng, 2015 | Treatment Advocacy Center, 2015). This study shows that there are significant organizational, community and public policy implications to rural and suburban inmates' challenges with accessing services while in custody, but also upon release to the community.

The literature is limited in the understanding of the provision of mental health care in correctional settings (Rekurt-Lapa & Lapa, 2014). Mental health care in correctional settings includes multi-faceted complexities that must be simultaneously managed including illness severity, jail treatment infrastructure challenges along with ethical, legal and treatment quality concerns (Rekrut-Lapa & Lapa, 2014). The findings from this study provide foundational knowledge about the experiences and roles of rural and suburban mental health providers and can inform future studies in jail settings.

Implications of Findings

The findings of this study are consistent with the Socio Ecological Model and provide opportunities for change within the field. The Socio Ecological Model elicited data that was inclusive of all areas of the model rather than the original three levels of focus. Participants provided unique insights within the community and public policy domains of the Socio Ecological Model as well. Specifically, findings suggest that there are areas for improvement needed within certificate and clinical

education programs, increases to support networks and mentoring for those working in rural and suburban jails, overall improvements in on-the-job training, augmentations to staffing within these settings and improvements in community resource availability.

More specifically, participants discussed that certificate and clinical educational programs had not included courses about correctional/forensic mental health. It was also discussed that these programs did not allow for exposure to these settings. Many participants in this study discussed that they had no intention of entering into a career in jail mental health, but with exposure to the environment they found that the work was challenging and enjoyable. Clinicians who discussed that they were fearful or not interested in working in the jail found that this area of practice was fulfilling and enjoyable and learned adaptive safety strategies to feel more comfortable and confident in these settings. It may be possible that with exposure to correctional/forensic settings in certificate and clinical educational programs, additional clinicians may feel more comfortable with entering into careers in jail mental health. With exposure in certificate and clinical educational programs, misconceptions and fears may be addressed prior to clinicians formally entering the field. These adjustments may impact staffing and improve retention of staff.

Improvements in support networks and the overall training process for those entering the field may create opportunities for additional staff engagement and retention. Further, improvements in overall understanding of forensic mental health may improve the conditions of clinical care for inmates. Support networks may include internal support networks, but also membership to organizations such as the Forensic Mental Health Association of California (FMHAC). Outside organizations have the potential to improve overall connectedness to other correctional healthcare staff, but also may address gaps in knowledge that so many study participants discussed as a normal part of their entry into the field and their continued lack of training. Internal mentoring was a notable positive identified by some participants, and future training and support models may do well to build on this identified strength.

A much larger area for engagement at the public policy level is that each participants discussed significant concerns with their lack of community resource availability. Not only are a lack of resources problematic for the members of communities, but also create frustration for mental health providers and case managers who attempt to connect those exiting the jail with resources to address their basic needs. Some participants discussed the impacts to having limited resources available leading to inmates being released and going back into unhealthy environments, homelessness and with limited psychiatric services. Some participants discussed that recidivism was more likely with a lack of resources. The implication of this lack of community resources may include recidivism, lack of connection to community mental health resources, housing instability and impacts of poverty (i.e. challenges legally providing for oneself and/or family members, increased suffering, challenges advancing out of poverty). With the ability of CMHPs being able to connect transitioning inmates with community resources, there may be fewer inmates re-entering the jail system and overall improvements in the health of the community that inmates have returned to.

The results of this study have the potential to inform certificate/mental health training programs, county and jail administrators, mental health providers within these systems, groups such as the FMHAC, California Jail Association, local groups of the National Alliance for Mental Illness (NAMI), those engaged in litigation (consent decrees) and other researchers. The findings will hopefully create the opportunity for additional research in this area and illuminate current concerns, areas of success and bring voice to the mental health providers who are working in these settings. Policy implications include potential need for changes in the preparedness of the jail mental health workforce along with incentives for retaining staff in the field (i.e. hazard pay, increased support of continuing education and regular clinical support), an expansion of certification and mental health training programs to include forensic content, improvements in community resources especially related to substance use, homelessness and community mental health treatment.

Limitations

In the proposed study, I postulated that the potential limitations were that study participants may have limited comfort in sharing information over the phone than they may with an in person interview. I also discussed that there may be challenges with the sample size and that challenges with the sample size would limit the transferability of findings. I also considered that it would be possible that clinicians who are experiencing severe burnout and vicarious trauma may not have the ability and bandwidth to participate in this study. These proposed limitations were found to be mostly true except for potential discomfort with phone interviews.

No participants in this study had concerns about being interviewed over the phone. Considering continued concerns about COVID-19, phone interviews provided safety for myself and the participant. Even with interviews exclusively over the phone, accessing potential research participants proved to be extremely challenging. In terms of recruitment, the level of effort to establish participants was initially surprising yet as conversations and rapport was built with various counties, jails and agencies, I began to understand and empathize with potential participant's concerns. Many of the counties in California are in the process of a consent decree related to violations of cruel and unusual punishment related to mental health services. With this new litigation, county administrators and public information officers were hesitant to have any staff participate in this study. Administrators also mentioned concerns about asking staff to do "one more thing" considering their limited staffing, continued challenges with COVID-19 and inability to fill open positions. Some participants expressed that they were uncomfortable participating while at work and were concerned about their supervisor finding out that they were involved in a study. These observed barriers to jail staff recruitment have implications for how to conduct future research. Although it is understandable why accessing rural and suburban county CMHPs is difficult, the literature remains scant in this important area and thus, additional research is

needed to better understand the experiences of CMHPs. With a clearer understanding of how to support these providers, inmates with mental health issues may be better served.

As discussed in Chapter 4, the limited sample size of this study and challenges with recruitment did indeed pose limitations to this study. After nine months of recruitment efforts including an expansion of the study to suburban counties I was still only able to secure 14 participants in this study. As such, it is possible that alternative perspectives were not captured in the data and that limited saturation was achieved. Of the participants interviewed for this study, it was clear that many were accustomed to short staffing and had established self-care and support strategies for when difficult things occurred in their work. It appeared that many participants had experienced vicarious trauma and had the potential for reaching burn out, but no participants discussed burnout as a main concern. It is possible that recruitment challenges were related to burnout and vicarious trauma. When potential participants declined participation in the study they generally provided limited answers related to short staffing, concern for workload and hesitancy related to consent decrees. Often, at the county level, a county mental health administrator was the one to decline participation in the study and thus, it is possible that the advertisement of the study never reached potential participants.

One of the major limitations is that I assumed that many participants would be interested in participating to share their experiences. Regardless of the content of the study, most participants were concerned with being a part of any study-regardless of topic area. As an outsider to the rural and suburban counties, those who work within rural and suburban jail mental health may have been concerned about sharing these experiences about their role. Even with my correctional health care experience, participants may not have fully trusted me. Snowball sampling became the most successful way to engage participants. Naively, I expected that purposive sampling would result in 25-30 participants over the course of a few months. Sampling may have been improved by creating long-standing relationships with allies within the counties to vouch for this study but given the topic and

setting it may take years to build sufficient relationships and trust, and that was not feasible within a multi-county and time-limited project.

It would have been ideal to have more participants, and equal representation from rural and suburban counties. Unfortunately, this did not turn out to be the case. Despite the limited sample size, this study contributes initial understanding of the roles and experiences of jail mental health providers in rural and suburban counties and clarifies ideas for future research.

Future Directions

This study allowed for an initial view of the experiences and roles of jail mental health providers in rural and suburban communities. It is especially important to consider the experiences of these providers in light of rapid changes within jail settings during various consent decrees, changes and impacts related to COVID-19 and community movements for decarceration. Future research may focus on the differences between the rural and suburban counties along with a comparison of urban and non-urban (rural and suburban) counties. Another potential area of contribution to the field and the literature would be gaining a better understanding of what current certificate and mental health programs for Social Work, Marriage and Family Therapy and other areas of practice provide to prepare future mental health providers. With improved understandings, training and support of CMHPs in rural and suburban jail settings, it is possible that these providers may have improved retention and job satisfaction and that inmates within these settings may have improved health outcomes and decreased recidivism.

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Appendices

Appendix A: Initial and Follow Up Email Scripts

Part 1: Email Scripts for Rural and Suburban County Jails:

Initial Email:

Email Subject: Invitation: Participation in Rural and Suburban Jail Mental Health Clinician Research Project

Body of Email:

Hello,

I am writing to ask for your help recruiting members of your organization in a research study to increase our understanding of clinician's experiences of providing mental health care in California's rural and suburban jails. Considering the challenges of providing mental health services in jails, clinicians in your county are in an ideal position to provide valuable information from their unique perspectives.

Participant responses to this qualitative study will be kept confidential and interviews will be conducted over the phone. The interviews will take around 60 minutes and are completely voluntary. All study findings will be in aggregate summary format that includes all participants from this study so that your county and jail will not be identified. There will be compensation in the form of a $15 gift card for participating in this study.

To assist with this study, I am wondering if you may be willing to advertise and share this study information with your mental health clinical staff (i.e. forwarding this email, placing on the staff intranet, discussing in staff meetings) and/or providing mental health clinician contact information. I am available to discuss this study further via phone or email.

If you are not able to assist with the advertisement of this study, please reply to this email to opt-out of future emails about this study or call the phone number below, and I will not contact your organization further. If I do not hear from you, I will reach out up to 2 times over the next several weeks to remind your organization of this opportunity.

Thanks!

Amelia Lawless, Principal Investigator
UC, Davis PhD Student
Cell Phone: 916-708-0020
E-Mail Address: alawless@ucdavis.edu

Part 2: Email Scripts to Potential Participants:

Initial Email:

Email Subject: Invitation: Participation in Rural and Suburban Jail Mental Health Clinician Research Project

Body of Email:

Hello,

I am writing to ask for your help in participating in a research study to increase our understanding of mental health clinician's experiences of providing mental health care in rural and suburban California jails. As a jail mental health clinician, you are in an ideal position to provide valuable information from your perspective. The interview will take around 60 minutes and is completely voluntary.

Your responses to the questions will be kept confidential and interviews will be conducted via phone. I will not provide your employer with any information about whether or not you participated and any information that you provided. All study findings will be in aggregate summary format that includes all participants from this study. There will be compensation in the form of a $15 gift card for participating in this study. Your participation will be a valuable addition to this research and findings could lead to an enhanced understanding of your experience as a rural or suburban jail mental health clinician.

If you are interested in learning more about the study and participation, please respond to this email and I will follow up with detailed study information and information about scheduling an interview. Alternatively, you can call/text me at 916-708-0020.

If you do not want to participate, please reply to this email to opt-out or call the phone number above, and I will not contact you further. If I do not hear from you, I will reach out up to 2 times over the next several weeks to remind you of this opportunity.

Thanks!

Amelia Lawless, Principal Investigator
UC, Davis PhD Student
Cell Phone: 916-708-0020
E-Mail Address: alawless@ucdavis.edu

Follow-Up Emails:

Email Subject: Invitation: Participation in Rural and Suburban Jail Mental Health Clinician Research Project

Body of Email:

Hello,

I am following up regarding the invitation for mental health clinicians in your county to participate in a qualitative research study to increase an understanding of the experiences of providing care in rural and suburban California jails. Mental health clinicians in your county jail are in an ideal position to provide valuable information from their perspectives to create a better understanding of their work experiences. Please see the original message for additional details.

If you are interested in learning more about the study and ways to support this research, please respond to this email and I will follow up with detailed study information. Alternatively, you can text/call me at 916-708-0020.

If you do not to be a part of further correspondence about this study, please reply to this email to opt-out or call the phone number above, and I will not contact you further. If I do not hear from you, I will reach out up to 1 more time over the next several weeks to remind you of this opportunity.

Thanks!

Amelia Lawless, Principal Investigator
UC, Davis PhD Student
Cell Phone: 916-708-0020
E-Mail Address: alawless@ucdavis.edu

Email Subject: Invitation: Participation in Rural Jail Mental Health Clinician Research Project

Body of Email:

Hello,

I am following up regarding the invitation to participate in a qualitative research study to increase the understanding of providing mental health care in rural and suburban California jails. As a mental health clinician in a rural California jail you are in an ideal position to provide valuable information from your perspective. Please see the original message for additional details.

If you are interested in learning more about the study and participation, please respond to this email and I will follow up with detailed study information and information about scheduling an interview. Alternatively, you can text/call me at 916-708-0020.

If you do not want to participate, please reply to this email to opt-out or call the phone number above, and I will not contact you further. If I do not hear from you, I will reach out up to 1 more time over the next several weeks to remind you of this opportunity.

Amelia Lawless, Principal Investigator
UC, Davis PhD Student
Cell Phone: 916-708-0020
E-Mail Address: alawless@ucdavis.edu

Appendix B: Informational Flyer

UCDAVIS HEALTH | BETTY IRENE MOORE SCHOOL OF NURSING

Research Study:

Looking for mental health clinicians working in rural and suburban California jails.

This research study aims to learn about the experiences of providing mental health care in rural and suburban California jails.

You might qualify for participating in this study if you:

- Are currently working in a rural or suburban California Jail as a mental health clinician or
- Worked in a rural or suburban California jail as a mental health clinician in the last 5 years, and
- Can participate in an interview through a phone.

If you are interested in participating in this research study, please contact the researcher, Amelia Lawless, by phone **916-708-0020** or email alawless@ucdavis.edu.

Appendix C: Consent Form

UC Davis and UC Davis Health

Consent to Participate in Research

Title of study: Clinician Experiences of Providing Mental Health Services in Rural and Suburban California Jails

Investigator: Amelia Lawless

Introduction and Purpose

You are being invited to join a research study. The purpose of this study is to better understand the experiences of providing mental health care in rural and suburban California jails. Specifically, we want to know more about how social workers, psychologists, mental health technicians, psychiatrists and other mental health professionals provide clinical care to inmates in California rural jails. This study does not include inmates of jails and is specifically focused on mental health clinicians in rural and suburban California jails.

If you agree to be in this research, you will be asked to be a part of a one-on-one phone interview. You will be asked questions about what it is like to provide clinical care in jails, how you access training and support and how systems may impact the care you provide. It is expected that this phone interview will take approximately 60 minutes.

The interview will be audio recorded and transcribed, but your name will not be included in the transcription.

There is no direct benefit to you in taking part in this study. We hope that this research will help us to understand the experiences of mental health clinicians in rural and suburban California jails. This knowledge may help inform how clinical providers in these settings provide care, interface with colleagues and various systems and manage the complexities of jail mental health. Information from this study may inform policy and clinical programming in the future.

The risks of this research are minimal. Some of the questions may make you feel uncomfortable. You do not have to answer any of the questions that you do not want to answer.

Taking part in research is completely voluntary.

You are free to decline to take part in the project at any time. You can decline to answer any questions and you can stop taking part in the project at any time. Whether or not you choose to take part, or answer any question, or stop being in the project, there will be no penalty to you or loss of benefits to which you are otherwise entitled.

Confidentiality

As with all research, there is a chance that confidentiality could be compromised | however, we are taking precautions to minimize this risk. Your responses to the interview questions will not include information that identifies you. This identifiable information will be handled as confidentially as possible. However, individuals from UC Davis who oversee research may access your data during audits or other monitoring activities.

To minimize the risks of breach of confidentiality, we will password protect all data and identifiable information. Recordings will be deleted after transcriptions have been completed. Any identifiable data such as your name or contact information will be deleted once the research is completed. Participants will be given pseudonyms when transcripts are made and when writing up the research. Only the researcher and two UC Davis faculty will have access to password-protected recordings stored on a local computer.

Compensation

To thank you for your participation in this study, you will receive a $15 gift card to Starbucks or Target. This gift card can be mailed or emailed to you when you complete the interview.

Questions

If you have any questions about this research, please feel free to contact the investigator at 916-708-0020 or alawless@ucdavis.edu.

If you have any questions about your rights or treatment as a research participant in this study, please contact the University of California Davis, Institutional Review Board at 916-703-9158 or HS-IRBEducation@ucdavis.edu.

If you agree to take part in the research and allow the interview to be recorded, please give verbal consent.

You will be provided a copy of this page for future reference as well.

Appendix D: Interview Guide

Opening and Demographics (To be completed prior to interview)

- What is your area of practice (Social Work, Psychology, Psychiatry, other)?
    - Are you licensed?
    - If so, how long have you been licensed?
    - If you are unlicensed, at what point are you in the licensure process?
- How long have you worked in a jail setting?
    - Have you held different roles within correctional settings?
- Do you live in the community you are working in?
- How many institutions have you worked at as a mental health clinician?
- Prior to working in a jail setting, did you work in any other correctional settings (like a state prison, federal prison, probation, parole, etc)?
- What are the mental health services within your current institution?
- Which part of the jail mental health services have you spent the most time working in (inpatient, outpatient, NGRI, etc)?
- Outside of your degree and registration/license, do you have additional qualifications or special training that you would like me to know about?
- Do you live in the community that you serve?
- Do you live in a rural community?

Interview Questions to Elicit the Story: RECORDED

Individual

1. Tell me about how you decided to enter a career in jail mental health.
2. What did you know about being a mental health clinician when you entered the jail?
3. Tell me about what a typical work day from the time you show up to the time you leave.
4. When you went into jail mental health, what did you think it would be like?
5. Thinking about where you are now in your career, is it the same or different than you thought it would be?
6. Can you share with me some of your successes and some of your challenges?

Interpersonal

7. How do jail mental health clinicians become trained?
8. What are your beliefs about the key components to being a successful jail mental health clinician?
9. When difficult things happen at work, how do you manage it? Is there support available to you in managing difficult situations? Can you describe this?

Organizational

10. Can you describe what the main priorities are for providing mental health services for your institution? And can you describe your priorities for clinical practice?
    a. Potential follow up if main priorities are not mental health related…let's say they say the budget…or something non-clinical, then I would ask about how that impacts mental health care and their process as a clinician
11. Has COVID-19 had an impact on your work? If yes, can you tell me more about that?
    a. Have you had any cases of COVID-19 in your jail?
    b. How has the institution managed that?
    c. Have admissions and discharges changed during COVID-19?

12. Dream big: If you were in charge of jail mental health, what would the perfect system look like for mentally ill patients in a rural jail?
13. Is there anything that you might not have thought about before that came up during this interview?