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Engagement processes in model programs for community reentry from prison for people with serious mental illness

Beth Angell [a,*], Elizabeth Matthews [a], Stacey Barrenger [b], Amy C. Watson [c], Jeffrey Draine [d]

[a] School of Social Work, Rutgers, The State University of New Jersey, New Brunswick, NJ 08901, USA
[b] Silver School of Social Work, Ehrenkranz Center, 1 Washington Square North,New York, NY ,10003, USA
[c] Jane Addams College of Social Work, University of Illinois—Chicago, 1040 West Harrison Street, Chicago, IL 60607-7134, USA
[d] School of Social Work, Temple University, 1301 Cecil B. Moore Avenue, Philadelphia, PA 19122-6091, USA

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ABSTRACT

Linking prisoners with mental illness with treatment following release is critical to preventing recidivism, but little research exists to inform efforts to engage them effectively. This presentation compares the engagement process in two model programs, each representing an evidence-based practice for mental health which has been adapted to the context of prison reentry. One model, Forensic Assertive Community Treatment (FACT), emphasizes a long-term wrap-around approach that seeks to maximize continuity of care by concentrating all services within one interdisciplinary team; the other, Critical Time Intervention (CTI), is a time-limited intervention that promotes linkages to outside services and bolsters natural support systems. To compare engagement practices, we analyze data from two qualitative studies, each conducted in a newly developed treatment program serving prisoners with mental illness being discharged from prisons to urban communities. Findings show that the working relationship in reentry services exhibits unique features and is furthered in both programs by the use of practitioner strategies of engagement, including tangible assistance, methods of interacting with consumers, and encouragement of service use via third parties such as families and parole officers. Nevertheless, each program exhibited distinct cultures and rituals of reentry that were associated with fundamental differences in philosophy and differences in resources available to each program.

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1. Introduction

Studies show that as many as 16% of prison inmates meet criteria for a serious mental illness (Ditton, 1999). Recognition of the overrepresentation of people with serious mental illness in the criminal justice system has led to the development of specialty services for prisoners with mental illness, both within prisons and jails (Hills, Siegfried, & Ickowitz, 2004) and within community settings (Steadman, Morris, & Dennis, 1995; Wilson & Draine, 2006). Intervening at the point of transition from jail or prison to community, commonly referred to as community re-entry, is considered a prime opportunity for halting the cycle of reincarceration (Petersilia, 2003).

Reentry from prison is known to be an especially vulnerable transition for all offenders, not merely for those with mental illness. As Draine, Wolff, Jacoby, Hartwell, and Duclos (2005) detail, offenders typically exit prison with painfully few financial or social support resources to enable them to adjust successfully to community life. The situation is further compounded by the fact that former prisoners return disproportionately to destitute communities which possess inadequate resources to meet the needs of their own residents, much less the inflow of offenders (Clear, 2007).

As a result, the transition from prison to community poses great risk to offender health and safety. In a landmark study, Binswanger et al. (2007) demonstrated that, adjusting for sociodemographic factors, the risk of death (primarily from suicide, homicide, cardiovascular events, and drug overdose) rises thirteen fold in the two weeks following release from prison. Lacking homes to return to, many former prisoners often turn to shelters and other congregate environments with inadequate sanitation, compounding their health risk. Immediate tasks of securing a place to live, making contact with parole authorities, finding a job, and/or applying for financial benefits are all necessary to ensure survival, yet a felony record represents a serious disadvantage to accomplishing these tasks. As Binswanger et al. (2011) found in a qualitative study of newly released offenders, the formidable tasks of transition coupled with the disadvantage associated with a criminal record may lead to demoralization, fear, and anxiety. For offenders with mental illness, who lack connection to a mental health service provider

* Corresponding author at: School of Social Work, Rutgers, The State University of New Jersey, 536 George Street, New Brunswick, NJ, USA. Tel.: +1 848 932 5872.
E-mail address: angell@ssw.rutgers.edu (B. Angell).

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following the transition, the risk of suicide, reincarceration, and/or hospitalization may be even higher than that of their counterparts who do not have mental illness.

For all of the above reasons, connecting people with mental illness to mental health treatment and other support services during the transition out of prison is deemed critical to reducing the risk of negative outcomes. Engaging them in these services, however, is a major challenge. Prisoners treated for psychiatric disorders are often released with only a very limited supply of medication, which runs out before connection to mental health services is assured (Binswanger et al., 2011). Such connections, when they are made, must be negotiated by the former prisoner, who may lack the necessary information, access, and health insurance in the early period following release. Even when resources are available, they may be concerned about using them: studies of prisoners' attitudes toward mental health treatment suggest that fear of formal labeling, concerns about stigma, and distrust of authorities are major barriers to service engagement (Howerton et al., 2007; Kenemore & Roldan, 2006). Thus, programs which serve people with serious mental illness during the high risk reentry period must incorporate strategies of service engagement to remove barriers and build motivation to participate in treatment. Little research has been conducted, however, to guide programs in effective engagement practices. This qualitative study of two reentry programs serving adults with serious mental illness leaving prison examines engagement processes across two reentry models in an effort to build knowledge regarding effective engagement.

1.1. Concept of engagement

Engagement in mental health care is a phrase commonly invoked to refer to a variety of attitudinal and behavioral phenomena related to involvement in mental health services (Staudt, 2007; Littell, Alexander, & Reynolds, 2001). In the narrowest sense, researchers use the term "disengagement" to denote dropping out of, or demonstrating poor attendance to, treatment (Kreyenbuhl, Nossel, & Dixon, 2009). Dropping out of treatment is thought to be an especially negative outcome for people with mental illness because it not infrequently leads to medication discontinuation, and readmission to institutions such as hospitals, jails, and prisons (Kreyenbuhl et al., 2009). When engagement is equated with treatment attendance and continuance, the task of the engagement process is to motivate the client to continue to attend treatment and to resolve environmental barriers to participation.

In other studies and literatures, engagement carries a broader meaning encompassing not only behavioral participation, but also affective and cognitive elements (Gopalan et al., 2010). As Littell et al. (2001) discuss, participation in services may be viewed as a 2×2 typology in which both activity level and valence are considered. Those with higher activity (e.g., attendance, participation) and positive valence (cooperative attitude) are considered "engaged", whereas service providers tend to regard clients exhibiting a pattern of cooperative behavior but little investment in the work of treatment as "acquiescent" or passive participants. Clients with a less cooperative attitude are seen as either "disruptive" or "disengaged," depending upon how active they are in opposing treatment goals. Their conceptualization points to not only the importance of considering engagement as not simply attendance, but also the degree to which the client is invested in the work of treatment and the pursuit of treatment goals.

Broader conceptions of engagement also shift focus from the intrapersonal to the interpersonal realm, in that engagement is a reflection not only of the client's attitudes and efforts, but also of his or her interactions with service providers. Stanhope (2012), for example, describes that engagement is "a process made up of multiple events…[and] is shaped as much by the quality of interaction between providers and service users as it is by the specifics of the service provision." (p. 414). To be successful in engaging clients, programs must induce clients not only to attend or "show up," but also to get their "buy in" (Yatchmenoff, 2005) by inviting them to collaborate in the work of treatment and recovery. In the context of community reentry from prison, the key tasks of treatment are not limited narrowly to amelioration of mental health symptoms, but must also include engaging clients in the work of "making good": developing new identities, restoring or recreating connection to the social structure, and desisting from crime (Maruna, 2001).

Hence, while engagement is often measured by examining either the attitudes or behaviors of the client, practitioners play a pivotal yet underappreciated role in the engagement process (Staudt, 2007). Engagement strategies are those activities undertaken by programs and providers aimed at fostering client participation and investment in both treatment and the pursuit of life goals. Within the field of mental health services, engagement strategies may be divided into those activities aimed at maximizing the possibility of entering treatment and/or returning after the first visit (initial engagement); and those activities which aim to increase continued participation or compliance with treatment regimens or plans (ongoing engagement) (McKay, Stoewe, McCadam, & Gonzales, 1998). Roter et al. (1998) classify the various strategies of promoting compliance as being behavioral, educational, or relational (or a combination) in nature.

Behavioral strategies include reminder letters or phone calls to increase attendance at appointments, providing praise or tangible rewards when attendance or participation goals are met, and even providing financial incentives for attending treatment or taking medication (Priebe et al., 2010). Initiatives to remove access barriers by providing transportation, allowing scheduling flexibility, or arranging child care could likewise be seen as behavioral or task oriented in nature. Educational strategies are exemplified in psychoeducation programs which aim to teach consumers about the symptoms of mental illness, to help them to identify their personal warning signs of relapse, and to reinforce the connection between adherence and preventing relapse (Kelly, Scott, & Mamon, 1990).

Relational strategies seek to further participation by creating or reinforcing a bond between clients and service providers or programs, drawing upon literature suggesting that a strong therapeutic alliance is associated with more consistent treatment participation (Marsh, Angell, Andrews, & Curry, 2012). McKay, Nudelman, McCadam, and Gonzales (1996) and McKay et al. (1998) undertook a unique relational approach to initial engagement by telephoning clients prior to the first scheduled appointment to discuss and resolve barriers to participation and open lines of communication between providers and clients, reducing client hesitancy to ask questions and clarify information about the treatment process. The recent movement to incorporate shared decision making into mental health practice likewise reflects the importance of collaborative relationship building to foster engagement (Drake, Deegan, & Rapp, 2010).

Recent research suggests that relational strategies are uniquely important in the engagement of clients with serious mental illness who have multiple system involvement or are making a high risk transition. Stanhope (2012) used an ethnographic research design to study the engagement process in one particular model of service delivery for people with serious mental illness making the transition out of chronic homelessness. The model, Housing First, is unique in its provision of housing as a guaranteed resource at program entry. As Stanhope describes, the provision of the housing catalyzes engagement of clients because it signifies that the service provider has made good on his or her word, thereby creating a bond of trust. As service delivery proceeds, concrete, everyday acts of shopping, home visiting, and errand-running further cement the treatment bond because they provide a window into the clients' personalities, needs, and desires on the part of the service provider and create for the client a sense that they are seen and known — experiences that they have little access to in their former lives as homeless people living on the street. Case managers also promoted an egalitarian tone to the treatment relationship by meeting with people in everyday environments and eschewing typical prohibitions of familiarity and intimacy. For example, case managers hugged

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