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Interprofessional Relationships in Rural Offender Re-Entry and Management:

Mental Health Treatment Providers and Community Supervision Professionals

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A dissertation

presented to

the faculty of the Department of Psychology

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy in Psychology with a Concentration in Clinical Psychology

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by

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August 2018

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Keywords: Interprofessional Relationships; Mental Health Treatment; Community Supervision;

Rural Community Needs

ABSTRACT

Interprofessional Relationships in Rural Offender Re-Entry and Management:

Mental Health Treatment Providers and Community Supervision Professionals

by

Michael Patrick Lasher

The current prevailing approach to managing offenders in the community involves community

supervision professionals such as probation and parole officers partnering with other community

professionals, such as psychologists, social workers, and other mental health providers to address

offenders' needs. Each type of professional draws from a unique field with goals, values, and

theoretical orientations, which do not necessarily overlap. These relationships are rarely studied,

and previous examinations are limited. The current study aims to address this deficit in the

empirical literature. Drawing on data obtained from qualitative interviews, four aims were

examined. First, using thematic analysis, interview data are analyzed open-endedly to identify

major themes. Second, these partnerships are examined against the interprofessional

competencies in the healthcare system. Third, the perceived impact of partnerships on offenders'

success in the community is discussed. Finally, differences in themes within community

supervision professionals and mental health providers were quantitatively examined by

comparing groups using a variety of demographic variables. Major themes identified by mental

health providers include the appreciation for and challenges to collaboration, individual

characteristics and roles, characteristics of collaboration, elements of interprofessional

relationship, and the involvement of the courts. Community supervision professionals discussed

issues pertaining to collaboration and services coordination, professional roles, when conflict

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occurs, and their lack of basic knowledge about other professionals. Themes identified in the initial thematic analysis resembled healthcare values and ethics competencies and roles and responsibilities competences; healthcare competencies regarding interprofessional communication and teamwork showed partial congruence with the current data's themes. Perceived impact on offender outcomes was most evident in how collaboration helps each professional complement the others' work. Few significant quantitative patterns within groups were evident. Overall, treatment providers and supervision professionals value interprofessional collaboration. Their priorities differ, which provides better opportunities to address clients' needs but also creates the potential for conflict. Benefits to re-entry outcomes are the result of treatment providers addressing the needs of clients and supervision professionals addressing the motivation of clients. This research highlights the strengths of this type of interprofessional collaboration, and offers suggestions for improving the efficacy of collaborations.

ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION

Contemporary approaches to community supervision of offenders (e.g., probation and parole) suggest that mental health treatment improves offender outcomes. While over two decades of research support the benefits of treatment for offenders (Andrews & Bonta, 2007; Andrews, Zinger, et al., 1990; Lipsey, Landenberger, & Wilson, 2007; Lipsey & Wilson, 1993), few studies focus on the relationships between those providing treatment and the agents supervising offenders. Relationships between probation and parole agencies and mental health treatment providers merit further exploration.

These few studies of relationships between mental health and community supervision professionals are often driven by single-issue questions, such as referral processes (Holloway, Brown, Suman, & Aalsma, 2013), specific interprofessional roles (Thom, Herring, Bayley, Waller, & Berridge, 2013), or the degree of collaboration within treatment (McGrath, Cumming, & Holt, 2002; Turnbell & Beese, 2000; Watts, 2008). In contrast, other interprofessional systems devote notable research to this topic. Most notably, healthcare research pays significant attention to how mental health providers function alongside physical health providers and what qualities nurture effective partnerships (Interprofessional Education Collaborative Expert Panel, 2011).

The goal of this project is to explore the functionality and potential deficits within interprofessional relationships among mental health and community supervision providers. An improved understanding of these interprofessional relationships benefits both the criminal justice and mental health fields by providing a richer understanding of interprofessional functioning than past single-issue interprofessional research studies (e.g. Holloway et al., 2013, Thom et al.,

2013; Turnbell & Beese, 2000). Drawing from healthcare research provides a framework to conceptualize the potential best practice values for this type of interprofessional work.

This dissertation first presents an overview of the community supervision arm of the criminal justice system and the perspectives of mental health treatment providers in a criminal justice context. Second, the current state of community supervision and mental health treatment partnerships is reviewed, with emphasis on the prevailing theory guiding treatment and supervision allocation, the established benefits of treatment, and current interprofessional modalities. Finally, the core values for effective interprofessional relationships in healthcare, which may suggest values for effective community supervision/mental health partnerships, are reviewed. Following this discussion, I present a series of qualitative and mixed-methods analyses that provide a more robust understanding of community supervision and mental health providers' relationships and communication with one other.

Community Supervision: Theory, Values, and Roles

The primary goals of criminal sentencing are to protect society, punish offenders, and deter future criminal behavior. Incarcerating offenders in jails and prisons serves many of these goals by punishing, incapacitating, and making examples of known offenders (Greenberg & Ruback, 1982; Wrightsman, Greene, Nietzel, & Fortune, 2002). However, incarceration places a significant financial burden on community resources, which continues to increase over time (McVay, Schiraldi, & Ziedenber, 2004; Schmidt, Warner, & Gupta, 2010; Vera Institute for Justice, 2013). At the same time, incarceration limits access to community resources needed to facilitate offenders' behavior change (James, 2015; Vera Institute of Justice, 2013) and may not be the best means to meet the goals of rehabilitation for offenders at lower risk of recidivism (Andrews & Bonta, 2010b).

Community supervision provides an alternative to incarceration and costs about 80% less than jail or prison (McVay et al., 2004). The most recent census of adults in the criminal justice system shows that over 4,750,000 individuals are on community supervision, representing one in 51 American adults (Glaze & Kaeble, 2014), and approximately two-thirds of adults in the American criminal justice system (McVay et al., 2004). While the term "community supervision" is used generically in the current discussion, it actually describes a number of practices, including probation, parole, and community-based diversion (Center for Health and Justice at TASC, 2013; Petersilia, 1998; U.S. Department of Justice, 2011; Wrightsman et al., 2002). A hallmark of community supervision is supervision conditions, which typically include punitive efforts (e.g., fines, community service, house arrest), risk management strategies (e.g., mandatory follow-ups with a supervision officer), and interventions to prevent future crime, such as treatment to address underlying conditions (Petersilia, 1998).

A sentence of probation is a direct alternative to incarceration (Petersilia, 1998), with the goals of rehabilitation, deterrence, and restitution (Wrightsman et al., 2002). Offenders who violate probation conditions may receive a longer period of probation, additional or enhanced conditions of supervision, or resentencing to incarceration (Petersilia, 1998). Parole, on the other hand, is the discretionary release from jail or prison for individuals who have completed a designated portion of their incarceration. A specified panel (i.e., parole board) evaluates the suitability of an offender to complete his or her sentence in the community based on the nature of the offense, the offender's relevant history (e.g., criminal and violent behavior, past legal involvement), behavior while incarcerated, objective measures and psychological evaluations, and victim input (Kinnevy & Caplan, 2008; Petersilia, 1998). In addition to directing offender management, conditions of parole also guide supervising officers in the community on whether

or not to recommend the revocation of release (Petersilia, 1998).

Furlough is an administrative form of community supervision that serves varying roles. Short-term furloughs excuse offenders from jails or prisons for a predetermined amount of time for a specific purpose. This may include medical treatment, daily work release, or familial reasons (e.g. the death of an immediate family member). Longer-term furloughs may be for an indeterminate amount of time. These furlough releases may focus more on the needs of the offender, as may be the case for long-term medical treatment, or the progress of the offender, such as in cases of halfway house or transitional supervision placements (Cheliotis, 2009; U.S. Department of Justice, 2010).

Finally, in contrast to other forms of community supervision, diversionary programs offer an alternative to sentencing altogether. Addressing needs like addictions or psychopathology in first-time offenders may help reduce future criminal behavior. Rather than focusing on punitive goals, diversion programs seek to reduce the burden on the criminal justice system and mitigate future criminal behavior by addressing problematic behavior through community-based programs (Bureau of Justice Statistics, 2010; Center for Health and Justice at TASC, 2013). However, community supervision professionals often play a front-line role in the management of individuals in diversion programs, despite the potential differences in professional objectives (Center for Health and Justice at TASC, 2013).

Criminological Theories and Perceptions of Behavior

An assumption underlying the practice of community supervision is that working with offenders in the community has advantages over incarceration. Probation and diversionary programs monitor offenders in the community while using community resources to affect behavior change (Center for Health and Justice at TASC, 2013; Kinnevy & Caplan, 2008;

Petersilia, 1997, 1998). Parole and furlough programs facilitate offenders' transition from prison

to community in recognition of benefits to both the offender and the public's interests (Cheliotis,

2009; Petersilia, 1998, 1999). A number of theoretical views have shaped criminal justice policy

and community supervision practices over the last 200 years (Wrightsman et al., 2002). Here, I

briefly summarize this evolution.

Reforms to criminal justice practice followed philosophical shifts in theories of criminal

behavior. During the 18th and 19th centuries, criminological theories suggested that criminal

behavior results from situational opportunities where the gains of criminal behavior outweigh the

consequences, or when alternatives are unattainable (Beccaria, 1764; Bentham, 1843).

Kohlberg's (1958, 1973) pre-conventional self-driven-interest stage of morality provides a

contemporary representation of this school of thought. For example, in the "Heinz Dilemma"

(Kohlberg, 1958), Heinz may choose to steal the medicine his wife needs because her well-being

is more important than the legal consequences, or not steal the medicine because the punishment

associated with the crime is too great to risk. In this sense, the subject is placed in a situation

where he may need to engage in criminal behavior, but it is his own preponderance of whether or

not the gains outweigh the risks of punishment that determine the outcome.

Many community supervision programs have their roots in juvenile justice initiatives

from this era. In the early 19th century, the first diversionary programs sought to incarcerate

delinquent children as a means of removal from criminal indoctrination in their families or

environments of origin (Patenaud, 2005). Less than 50 years later, the first parole program in the

United States rewarded compliant young offenders in reformatory schools with supervised

placement in the community (Petersilia, 1999). Concurrently, probation practices developed

from community volunteer efforts to provide alternatives to incarceration for non-violent adult

offenders (Petersilia, 1997). However, the practice of mitigating harsh sentences for juvenile offenders, rather than with adult offenders for whom it was originally designed, popularized the practice of probation (Harris, 1995). By the early 20th century, most states adopted community supervision practices borne from these early practices (Clear & Cole, 1997; Petersilia, 1997, 1999).

The contrasting perspective during community supervision's infancy in the United States emphasized the relationship between physiological characteristics and criminal behavior. For example, phrenology suggested that criminal behavior results from enlargements in brain "organs" associated with destructiveness, combativeness, covetousness, and secretiveness (Spurzheim, 1815). Later, atavism suggested that individuals with more primitive features were prone to savage, criminalistic tendencies (Lombroso, 1911), and constitutional theories suggested that certain body types, such as being athletic and muscular, predisposed individuals to criminal behavior (Sheldon, 1949; Wrightsman et al., 2002). These theories proposed that criminality is relatively stable characteristic, and not surprisingly, at this time neither criminal justice professionals nor the public readily embraced policies that placed offenders in the community (Petersilia, 1999).

Criminological theories in the mid-20th century refocused away from biological theories and towards sociological and social-psychological explanations of behavior (Wrightsman et al., 2002). These theories attributed criminal behavior to deficits in social systems, such as a lack of sufficient school or job opportunities (Cloward & Ohlin, 1960; Nettler, 1974), appraisals of how social bonds influence the perception of behavioral consequences (Hirschi, 1969), and the balance of internal and external controls in behavior regulation (Reckless, 1967). Public support for community supervision and offender rehabilitation peaked during this period, as community

supervision practices that focus on managing offenders' risk and utilize community service partnerships were believed to be well suited to address these sociological and social-psychological influences on criminal behavior (Bottom, 1990; Menninger, 1966; Petersilia, 1999). However, criminal justice professionals continued to emphasize external behavioral controls over rehabilitative efforts (Bottom, 1990; Rothman, 1980). Popular research discrediting rehabilitation in the 1970s reinforced this focus on external control (Martinson, 1974; Petersilia, 1999), while a growing emphasis on criminal sentencing stressing the need for punishment and "just deserts" for offenders (Andrews & Bonta, 2010a; Clear, 1994; von Hirsch, 1976) also arose.

Modern criminological research emphasizes the potential for behavior change (e.g. Andrews & Bonta, 2010b; Lipsey et al., 2007; Lipsey & Wilson, 1993). The suggested goal is targeting the changeable behaviors or situational factors associated with continued criminal behavior, or criminogenic needs, such as antisocial attitudes, family or marital problems, or employment problems (Andrews & Bonta, 2010b; Andrews et al., 1990). Nevertheless, community supervision practice continues to promote behavior management through external control (Haney, 1997; Gaes, 1998; Petersilia, 1998; Wrightsman et al., 2002).

Values and Goals of Community Supervision

While theories describing the etiology of criminal behavior continue to guide how criminal justice professionals view their roles, a major guiding force in United States criminal justice at a systems level is the President's Commission on Law Enforcement and Administration of Justice. Established in 1965 by President Lyndon B. Johnson to understand ineffectiveness or inefficiency in criminal justice system, their resulting report suggested a number of criminal justice reforms that have shaped current policy. The broad recommendations made in this report

have served as a guide to how the U.S. Federal Government can support local law enforcement departments in the prevention and management of crime, creating agencies such as the Office of Justice Programs and the National Institute of Justice (Feucht & Zedlewski, 2007; Walker, 1992).

The first of seven recommendations in this report notes that strengthening law enforcement capabilities while simultaneously reducing opportunities for criminal behavior will serve to prevent crime. The second recommendation states that devoting resources to higher risk offenders, reducing the emphasis on incarceration and punishment, and treating offenders differently based on their offenses and needs will similarly result in a reduction in overall crime (President's Commission on Law Enforcement and Administration of Justice, 1967). While the first recommendation emphasizes a sociological view of the etiology of criminal behavior, the second recommendation relies on a more individualistic explanation of criminal behavior and why it does or does not recur among known offenders.

Nearly a quarter-century later, the Risk-Need-Responsivity model (RNR; Andrews & Bonta, 2010b; Andrews, Bonta, & Hoge, 1990) gained traction as the internationally favored approach toward offender management (Looman & Abracen, 2013). In line with the second recommendation of the 1967 President's Commission Report, this model emphasizes a more individualistic focus through diverting greater resources to higher risk offenders and fewer resources to lower risk offenders, targeting dynamic factors associated with higher recidivism (i.e., criminogenic needs), and working with offenders in a way that promotes treatment responsiveness (Andrews & Bonta, 2010b).

Despite the modern popularity of the individualized approaches suggested by the RNR model, competing values hold a strong influence on criminal justice professionals' perspectives

of need. In line with the first recommendation of the 1967 President's Commission Report, the United States justice system favors a "crime control" model (Wrightsman et al., 2002), emphasizing the rights of society, the punishment of rule-breakers, and the containment of convicted criminals (Packer, 1964). Meanwhile, the "get tough" philosophy of crime management, which prescribes broad and increasingly punitive measures regardless of an individual's risk, continues to retain political popularity (Andrews & Bonta, 2010a).

Between the time of the 1967 President's Commission Report and the proliferation of the RNR model, community supervision practice adopted a risk management approach to supervising offenders (Cole, Smith, & DeJong, 2014). Risk management in this context focuses on minimizing the chance of reoffending (Cadigan, Johnson, & Lowenkamp, 2012) while maintaining the least restrictive and most cost-effective means of supervision. Consistent with the crime control model, this approach seeks first to enact punishments appropriate to the severity of the offense, while also matching the level of supervision to risk of reoffense (Cole et al., 2014). With this emphasis on crime control, four goals of community supervision can be identified (Schwalbe, 2012):

1. Deterrence: using punishment to foster an expectation that criminal behavior leads to consequences;

2. Control: using supportive interventions to increase an offender's involvement in prosocial activities;

3. Punishment: engaging in an act of retribution on behalf of a victim or society; and

4. Restoration: holding offenders responsible for the damage they caused to individuals and society.

The values of community supervision lean more toward control and punitive goals of the

criminal justice system, favoring societal safety and well-being (Cole et al., 2014; Packer, 1964; Schwalbe, 2012). While maintaining community safety may be accomplished through incarceration, reducing criminal behavior in the long-term may be more efficiently and cost-effectively accomplished by addressing the needs of offenders rather simply restricting opportunities for new offenses (Andrews & Bonta, 2010b; Latessa & Lowenkamp, 2005; McVay et al., 2004). How these goals are achieved is reflected through the emphasized roles and responsibilities adopted by community supervision professionals.

Roles and Responsibilities of Community Supervision Professionals

Community supervision professionals are, first and foremost, an arm of the criminal justice system, with goals of controlling and managing offender behavior (Cole et al., 2014; Packer, 1964; Schwalbe, 2012; Vera Institute of Justice, 2013). In the contemporary model of community supervision, officers accomplish their professional goals through two specific avenues (Klockars, 1972; Miller, 2015). First, offender management tasks focus on law enforcement responsibilities, consistent with the crime control model of criminal justice (Cole et al., 2014; Packer, 1964). Second, community supervision professionals often adopt case management responsibilities, connecting offenders in the community with resources to address their offense-related, or criminogenic, needs (Andrews & Bonta, 2010b; James, 2015; Latessa & Lowenkamp, 2005; Vera Institute of Justice, 2013).

In this contemporary community supervision model, the law enforcement agents have five primarily responsibilities: 1) helping an offender comply with court orders, 2) executing authority granted unto them by the court, 3) standing by decisions made despite an offender's attempts to negotiate or alter such decisions, 4) ensuring that the offender is not presenting a risk to public safety, and 5) conducting police duties (such as investigations and arrests) as necessary

with offenders on community supervision. Within this role, an officer is concerned about the welfare of an offender insofar as it ensures the safety of the community and adherence to rules, conditions, and laws (Klockars, 1972). This role has traditionally prevailed in many jurisdictions, particularly as a cost-efficient means of supervision in regions with ballooning probationer and parolee populations (Vera Institute of Justice, 2013) and those that may have limited resources for treatment or other needs (Colley, Cullbertson, & Latessa, 1986).

In contrast to the law enforcement role, the case management role focuses on five other responsibilities: 1) consistently demonstrating concern and respect for offenders, 2) facilitating a shared, problem-solving, and helping process with offenders, 3) addressing offenders' negative attitudes towards officers as authority figures, 4) helping an offender recognize the workable pieces of his or her "total life problem," and 5) helping the offender recognize that criminal behavior has and will result in negative outcomes (Klockars, 1972; Shireman, 1963). While this model highlights the polarization of law enforcement and case management roles, it does not view these positions as mutually exclusive. In fact, a third role-type, identified as the "synthetic" officer, takes on both roles of the community supervision professional (Klockars, 1972).

Functioning as a synthetic officer presents a potential role conflict – the officer encourages an open relationship while harboring the threat that an offender's openness may lead to revelations that warrant legal sanction. Despite the potential conflict, this archetype continues to endure today. For example, Miller's (2015) examination of the roles and responsibilities of contemporary community supervision professionals revealed that none of the professionals sampled could be classified as exclusively oriented towards law enforcement or case management roles. Instead, the analysis identified four different levels of synthetic officers on a continuum from law enforcement (low engagers) to case management orientations (high

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engagers). In between, medium engagers accounted for more than 60% of professionals, with some more weighted towards community collaboration and rehabilitation, and others leaning more towards traditional law enforcement roles.

Several characteristics determine to what degree community supervision professionals identify as law enforcers or case managers. These included ideological philosophy, caseload characteristics, officer demographics, and agency progressiveness. With regard to officers' personal characteristics, older and more experienced officers are more likely to integrate case management perspectives as part of their work (Allard et al., 2003; Miller, 2015). On the other hand, probation officers typically work with lower-risk individuals, such as first-time and non-violent offenders, as opposed to parole officers (Ruesink, 2015). Non-violent offenders and first-time offenders in general present a lower risk of continued crime and reduced risk to society, while violent and repeat offenders are more likely to engage in continued criminal activity (Andrews & Bonta, 1995). This may contribute to more of a case management perspective among probation officers and more of a law enforcement perspective among parole officers.

Community supervision best-practice responsibilities for reducing criminal behavior focus on successful reintegration (over punishing failures), utilizing a behavioral-management approach, supervising offenders differentially based on risk levels, and employing graduated sanctions for failing to adhere to conditions (Vera Institute of Justice, 2013). These best-practice goals reflect the synthetic officer role that utilizes a humanistic approach to effect offender change and promote community safety (Klokars, 1972). However, these goals are difficult to achieve in the current political and fiscal environment. Community supervision practice continues to be guided by the traditional principles of crime control and being "tough on crime" (Andrews & Bonta, 2010a; Packer, 1964; Wrightsman et al., 2002). These programs are

marketed as a more cost-effective alternative to incarceration (e.g. McVay et al., 2004), but this frugal focus often results in insufficient resources to maintain manageable caseloads and individualized services (Vera Institute of Justice, 2013). Not surprisingly, then, the contemporary, practical demands of community supervision tilt officers toward law enforcement roles (Holloway et al., 2013; Miller, 2015; Roskes et al., 1999; Turnbull & Beese, 2000). As such, community supervision practices often define success as the absence of reoffending, with specific intermediate goals including the quantity of contacts with offenders rather than the interpersonal quality of these contacts, focusing on "standard conditions" over individualized needs assessments, and using incarceration as a primary sanction (Vera Institute of Justice, 2013).

Mental Health Practice in a Criminal Justice Context

Modern community supervision professionals have integrated case management responsibilities in their typical duties. Nevertheless, the primary responsibilities held by these individuals focus on law enforcement and community safety (Allard et al., 2003; Miller, 2015; Schwalbe, 2012; Vera Institute of Justice, 2013; Wrightsman et al., 2002). Their case management responsibilities more often involve coordinating with other community services, including mental health resources (James, 2015). In the following section, I discuss the perspectives, goals, and responsibilities of mental health providers who partner with community supervision professionals.

Psychological Theories of Criminal Behavior

To understand the role of mental health practice in a criminal justice context, one must understand historical and current psychological conceptualizations of criminal behavior. As some of the first psychological theorists, psychoanalysts developed early explanations for

criminal behavior. Freud (1930) believed that individuals who hold unconscious guilt experience a compulsive need for punishment. Criminal behavior provides a concrete reason for punishment, which in turn resolves the individual's guilt. It is assumed within this conceptual framework that the desire for punishment, and thus the motivation for criminal behavior, resides in the unconscious; thus, an offender is not explicitly aware of such a drive. Later psychoanalysts suggested other developmental causes for criminal behavior, including the supposition that an underdeveloped ego ineffectively or insufficiently delays gratification (Alexander & Healy, 1935), and the impact of poor maternal attachment or parental rejection on the development of criminal behavior (Bowlby, 1949).

More recently, learning theories have played a major role in explaining crime. Differential association theory (Sutherland, 1947) is an early learning theory of criminal behavior suggesting that an individual behaves according to how he or she associates adhering to the law with favorable or unfavorable consequences. Similarly, operant conditioning theories explain criminal behavior as the result of rewards favoring breaking the law outweighing the imposed punishments (Burgess & Akers, 1966). Later, social learning theory explained criminal behavior not exclusively through direct operant contingencies, but through vicarious learning as well. In Bandura's (1973, 1976) explanation of aggressive behavior, familial aggression, cultural acceptance of aggression, and indirectly observed aggression (e.g., media depictions of violence) can contribute to an individual engaging in aggressive behavior.

Rather than focusing on how one learns to perform criminal behavior, cognitive theories instead examine the manner in which individuals interpret situational factors or events. A core component of cognitive theories is the A-B-C model (Ellis, 1961; Ellis & Ellis, 2011). Following an activating event (A), an individual's beliefs regarding the event (B) guide the

emotional reaction and/or behaviors of the individual (C). The belief component is crucial, as it guides how an individual interprets an event and prescribes responses to the event. Some beliefs may originate from learned experience, while others reflect heuristic biases that function to streamline cognitive activity (Tversky & Kahneman, 1974). Such biases may support criminal behavior. For example, according to the outcome bias (Baron & Hershey, 1988), an individual may evaluate his or her behavior as justified if he or she sees the outcome as favorable.

A number of theories apply cognitive concepts to criminal behavior. According to cognitive development theory, the decision to engage in criminal behavior is influenced by the individual's developmental goals (Piaget, 1952). These goals advance from punishment avoidance, to social expectations, to valuing the rules of society (Kohlberg, 1958). Rational choice theory includes how cognitions impact learned behaviors, proposing that an individual engages in criminal behavior based on the appraisal of competing rewards for criminal versus legal behavior (Cornish & Clarke, 1986). Empirical research describing the hostile attribution bias suggests that some individuals may interpret ambiguous situations as hostile or aggressive (Steinberg & Dodge, 1983), and such interpretations may forebear retaliatory behavior, defined as reactive aggression (Dodge & Coie, 1987). Information processing theories (Lachman, Lachman, & Butterfield, 1979) have also sought to explain criminal behavior. Here, individuals may misinterpret situations as threatening, search for an appropriate response to the threat, and behave in accordance with their chosen response (Dodge, 1986; Lochman, 1987).

Personality theories have also contributed to psychological explanations of criminal behavior. Trait theory (Allport, 1937), which suggests that personality characteristics cluster into relatively stable groups, has been used to highlight important personality correlates with criminal behavior. For example, one early personality theory suggested that criminal behavior is

correlated with aggressiveness, impulsivity, extraversion, and negative emotional reactions (Eysenck, 1964). Trait theory has also been applied in conjunction with behavioral learning theories. Specifically, the Big Five personality traits of extraversion and neuroticism, when elevated, may contribute to poor pro-social learning and in turn predispose an individual to criminal behavior (Eysenck & Gudjonsson, 1989). Other personality theorists have suggested a criminal personality type, most notably psychopathy (Cleckley, 1941; Hare, 2003). Contemporary characteristics of psychopathy include antisocial and disinhibited behavior, low empathy, and little remorse for one's deviant or harmful behavior (Hare, 2003). Diagnostically, psychopathy is highly correlated with Antisocial Personality Disorder (American Psychiatric Association, 2013; Skeem, Polaschek, Patrick, & Lilienfeld, 2011).

Whether the explanation focuses on development (e.g. Alexander & Healy, 1935; Kohlberg, 1958), cognition (e.g. Cornish & Clarke, 1986, Lachman et al., 1979), learning (e.g. Bandura, 1973; Sutherland, 1947), or personality (e.g. Eysenck, 1964; Hare, 2003), psychological theories of criminal behavior all describe the individual's internal processes in relation to their behavior. Criminological theories, in contrast, emphasize external influences on behavior (e.g. Cloward & Ohlin, 1960; Nettler, 1974). Therefore, psychology's focus provides an alternative perspective for criminal justice professionals, highlighting individuals' perspectives, values, and needs to better understand and change behavior (Wrightsman et al., 2002). This focus directs the goals of psychological service providers in the context of offender rehabilitation and the criminal justice system.

Goals of Mental Health Practice in the Criminal Justice System

As reflected in psychological theories of criminal behavior, mental health providers are concerned with the individual offender's perspectives, values, and needs. At the most basic

level, the goal of mental health practice in the criminal justice system is to address individuals'

cognitions and behaviors contributing to criminal behavior (Wrightsman et al., 2002). Goals of

treatment can be qualified as either clinically or legally motivated. Clinical goals focus on

reducing symptoms of pathology and improving overall psychological functioning. Legal goals

of treatment, on the other hand, address the need for legally-relevant behavioral change, such as

changing criminal thinking patterns or improving behavioral and impulse control (Heilbrun &

Griffin, 1999).

Specific goals of treatment may depend on the type of service being offered. Heilbrun

and Griffin (1999) identify three broad types of professional mental health service for offenders.

First, traditional treatment for offenders is typical mental health services that could be provided

to either forensic or non-forensic patients. This might include outpatient therapy for major

depression or bipolar disorder. Second, contemporary treatments usually focus on educating

offenders about offense-supportive thinking and behavior as well as encouraging pro-social

thinking and behavior. Third, targeted treatments are specialized interventions relevant to

specific legal concerns, such as sex offender treatment, violent offender treatment, or substance

abuse treatment.

Most treatment approaches, whether they are traditional, contemporary, or targeted, focus

on the abatement of symptoms or behaviors associated with criminal activity like impulsivity,

antisocial attitudes, or poor problem solving skills (Andrews & Bonta, 2010b; Bush, Glick, &

Taymans, 2011; Heilburn & Griffin, 1999). However, an alternate perspective is to encourage

healthy and pro-social thinking as a means of change. An example of this approach is the Good

Lives Model (Ward, 2002; Ward & Mann, 2004), which focuses on pro-social approaches to

obtaining primary human goods, such as a healthy life, knowledge, occupational excellence,

independence, relationships, community, happiness, and creativity (Ward & Gannon, 2006). Within this framework, an individual seeking to avoid or desist from criminal behaviors, either independently or via therapy, might seek to obtain such human goods by developing prosocial thinking, beliefs, and behaviors (Laws & Ward, 2011).

Where mental health and community supervision overlap, the RNR model prescribes the goal of treatment as addressing criminogenic needs among those most at risk of committing new offenses. There are several criminogenic needs which could potentially be addressed in a therapeutic setting, such as antisocial attitudes, substance abuse related issues, and family or marital relationship problems. Treatment approaches aligned with RNR have demonstrated reductions in general recidivism (Andrews, Zinger, et al., 1990), violent recidivism (Dowden & Andrews, 2000), and sexual offense recidivism (Hanson, Bourgon, Helmus, & Hodgins, 2009).

The goal of the RNR model is to address empirically-identified criminogenic needs because they are associated with continued criminal behavior (Andrews & Bonta, 2010). This model aims to reduce future criminal behavior; therefore addressing other non-criminogenic needs, such as mood disorders or history of victimization, is not a major focus (Andrews & Bonta, 2007; Latessa & Lowenkamp, 2005). Nevertheless, traditional treatments for offenders aim to abate psychopathology, not just reduce criminal behavior (Heilburn & Griffin, 1999). The American Psychological Association (2010) calls its members to "strive to benefit those with whom they work" (pp. 3), implying that beneficence is an active professional process. Therefore, the goals of mental health providers should be dictated by their respective professional institution rather than the criminal justice system and may extend beyond the reduction of criminal behavior.

Roles and Responsibilities of Mental Health Providers

Mental health providers who partner with community supervision professionals perform duties spanning two broad goals: serving the interests of the individual and considering the needs and safety of the public. Unlike a traditional mental health provider, they may develop treatment goals for offender-clients to facilitate pro-social change rather than focusing on only the goals identified by the individual (American Psychological Association, 2010; Association for the Treatment of Sexual Abusers, 2014). Mental health providers still have a professional obligation to the individual offender as a patient, though. There is not one uniform path to accomplish these goals, as the collective of mental health providers in this setting is drawn from a variety of backgrounds and practice in differing offender agencies and settings.

These roles and responsibilities are first dictated by the training of a specific professional. Psychiatrists train as doctors of medicine (M.D.) or osteopathy (D.O.), and also receive training in medical models of mental illness, psychodiagnostics and assessment, psychopharmacology, and psychotherapy. Psychiatric nurse practitioners (N.P.) train at a variety of post-secondary education levels. Often, these professionals focus on prescribing psychiatric medication and referring individuals to other professionals (e.g., psychologists, social workers, counselors) for psychotherapy (American Psychiatric Nurse Association, 2014; Lilienfeld, Lynn, Namy, & Woolf, 2013). Psychologists, on the other hand, typically train at the doctoral level as well (i.e., Ph.D., Ed.D, Psy.D.), most often in clinical or counseling specialties (Dittman, 2004; Lilienfeld et al., 2013). Psychologists may have previously trained at the master level (i.e., M.A., M.S.), though contemporary licensing requirements rarely allow for early career psychologists to practice with less than a doctoral degree.

Other professionals, specifically social workers and counselors, are typically trained at

the bachelor or master level (e.g., B.S.W., M.S.W., B.S., M.A.). Many of these professionals'

training and certification vary widely (Council on Social Work Education, 2009). Common

licensures and certifications include mental health counseling and substance abuse treatment.

Among counselors, most (70%) hold some credential such as Licensed Professional Counselor

(LPC), and while over one-third (34%) practice independently or as part of a private practice,

only seven percent work as part of a correctional facility or other government program

(American Counseling Association, 2014). Substance abuse treatment providers, while often

drawing from a similar educational background, have additional training and certification. The

specific certification can vary in title from state to state, including Alcohol and Drug Abuse

Counselor, Certified Alcohol and Drug Counselor, and Licensed Alcohol and Drug Counselor

(National Association of State Alcohol and Drug Abuse Directors, 2012).

The training and credentials of mental health providers specifically practicing in criminal

justice settings are rarely documented in research. One survey of providers engaging in

traditional mental health treatment in correctional facilities found that about one-third (35%) of

professionals were trained at the doctoral level, whereas more than half (53%) were trained at the

bachelor or master level (Bewley & Morgan, 2011). Another survey focusing on community sex

offender treatment providers in the United States found that about three-quarters (74%) of

providers were trained at the master level, while only 14% completed doctoral level degrees

(McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). As the majority of mental health

providers in this setting train at the bachelor or master level, these professionals' role is most

readily as applied scientists who provide treatment services to individuals involved in the

criminal justice system (Grisso, 1987; Nicholson, 1999; Wrightsman et al., 2002). For example,

the training of social workers often emphasizes research comprehension for providing

empirically-based treatments but not research practice as a standard competency (Council on Social Work Education, 2009).

Finally, mental health providers must often embrace flexibility in their practice. This is particularly true in rural areas, which typically have fewer specialized mental health services available. Mental health providers may need to assume roles of other professionals absent in one's region or community, as when psychologists engage in case management duties to address patient needs (Campbell & Gordon, 2003; Cates, Gunderson, & Keim, 2012; Jameson & Blank, 2007). This could include vertical integration, with mental health providers supervising or being supervised by professionals from other backgrounds (Roberts, Battaglia, & Epstein, 1999). Thus, many rural providers will function in capacities beyond their typical competence to address this gap (Gamm, Stone, & Pittman, 2010; Jameson & Blank, 2007; Schank, 1998). Additionally, the lack of mental health resources may contribute to greater stigma regarding mental health treatment, and thus decrease the willingness of those living in rural areas to utilize such services (Faver, Crawford, & Combs-Orme, 1999). However, a major contributor to the willingness to seek services may be whether professionals reflect the values and needs of the community (Weisheit & Donnermeyer, 2000).

In conclusion, mental health and community supervision professionals operating in rural areas are generally exclusive groups. Each profession is influenced by their limited resources addressing diverse needs. These mental health providers in particular come from a variety of training backgrounds (Grisso, 1987; Nicholson, 1999) and are often called upon to serve outside of their typical professional roles and responsibilities (Campbell & Gordon, 2003; Gamm et al., 2010; Jameson & Blank, 2007). Their work must balance professional obligation to the individual with the needs and safety of society (American Psychological Association, 2010;

Knapp & VandeCreek, 2012), as well as the needs of their relationships with community supervision professionals (Thom et al., 2013; Turnbell & Beese, 2000). Thus, partnerships between mental health and community supervision professionals are complicated.

Contemporary Community Supervision and Mental Health Partnerships

The criminal justice system concentrates its efforts on protecting society and punishing offenders (Packer, 1964; Schwalbe, 2012; Wrightsman et al., 2002). Community supervision works towards these goals via law enforcement duties and case management efforts (Klockars, 1972; Miller, 2015; Shireman, 1963). While the case management role more closely aligns with the roles of mental health providers, community supervision largely adopts the contemporary criminal justice system's authoritarian approach towards working with offenders (Holloway et al., 2013; Miller, 2015). Thus, perspectives on the role of offender treatment have largely paralleled the authoritarian approach for the last 40 years (Andrews & Bonta, 2010a; Vera Institute of Justice, 2013).

Mid-20th century society held positive views that offenders could desist from criminal behavior. For example, Menninger (1966) proposed that behavior change would be possible if offenders' environments were conducive to pro-social behavior. Not long after, though, research suggested that rehabilitation efforts were generally ineffective. In his seminal report on rehabilitative treatments, Martinson (1974) concluded that prison rehabilitation programs do not work. Furthermore, he noted that the primary benefit of community treatment programs is not their effectiveness, but rather their diminished cost in comparison with prison treatment programs. Despite even Martinson's own attempts to temper his conclusions (Martinson, 1979), the criminal justice field continues to lean towards the belief that offender treatment does not affect change (Haney, 1997; Gaes, 1998).

More recently, though, research has demonstrated that mental health treatment has substantive benefits for offenders. These findings have been summarized in a number of meta-analyses published in the last 25 years. One such meta-analysis examined outcome studies from the 1980s and early 1990s and found that while offender treatment has only a small effect, 90% of studies found that treatment resulted in significant behavioral change (Lipsey & Wilson, 1993). Another more recent meta-analysis of cognitive-behavioral treatment for offenders showed a 25% decrease in reoffense rates among offenders who participated in treatment. This meta-analysis further differentiated significantly more effective aspects of treatment, including anger management and cognitive restructuring (Landenberger & Lipsey, 2005). A third meta-analysis similarly found that offenders participating in mental health treatment were 25% less likely to commit new offenses, and those in cognitive-behavioral treatment were 50% more likely to succeed in the community. In this analysis, interpersonal problem solving and anger management produced significantly greater effects, while victim impact programs showed significantly poorer effects (Lipsey et al., 2007).

Specialized treatment programming has also been examined via meta-analysis, consistently demonstrating treatment benefit. In a review of court-ordered substance abuse treatment, nearly half of the outcome studies examined supported a positive effect of court-ordered treatment on outcomes, and more than a third of studies showed no worse outcomes when compared to voluntary treatment (Farabee, Prendergast, & Anglin, 1998). One finding specific to court-ordered substance abuse treatment is that individuals are significantly less likely to drop out of treatment prematurely (Loneck, Garrett, & Banks, 1996; Young, 2002). Sex offender treatment outcomes have also been examined, with a 37% decrease in new offenses among those who completed treatment, and the most significant gains originating from

community-based treatment (Schmucker & Lösel, 2008).

These meta-analyses suggest that mental health treatment can help criminal justice professionals achieve their goals of reducing recidivism and improving community re-entry. The majority of partnerships between treatment providers and criminal justice agents are built on agencies devoted to community supervision, but even among these there are a variety of different partnerships (Golden, Gatcehl, & Cahill, 2006; McGrath et al., 2002; Nishith, Mueser, Srsic, & Beck, 1997; Roskes et al., 1999; Turnbell & Beese, 2000; Watts, 2008). Other partnerships can be developed directly with the court (Boothroyd, Poythress, McGaha, & Petrila, 2003; McNiel & Binder, 2007; Steadman, Davidson, & Brown, 2001; Turnbell & Beese, 2000; Wolf, 2007). Ultimately, the form of these partnerships is based on the needs and resources of the associated community supervision agency.

Contemporary Partnership Modalities

When community supervision professionals partner with mental health providers, supervision officers are typically the gatekeepers for offenders to receive mental health services (Holloway et al., 2013). Those involved in ongoing court proceedings or supervised on probation or parole may seek out services on their own, though confidentiality standards (e.g. American Psychological Association, 2010) discourage mental health providers from initiating partnerships with criminal justice professionals associated with their clients. Thus, Holloway and colleagues (2013) describe community supervision professionals as "gateway providers" (p. 371) to mental health services. A probation or parole officer can draw on his or her familiarity and professional relationships to refer offenders to treatment resources, which implies utilizing those who are most supportive of, if not congruent with, community supervision goals. Because of this referral pattern, these partnerships often emphasize the goals of the criminal justice

system more than those of mental health providers (Boothroyd et al., 2003; Holloway et al., 2013; Goldkamp & Irons-Guynn, 2000; McGrath et al., 2002; Roskes et al., 1999; Wolf, 2007).

Mental health and community supervision partnerships vary significantly with regard to their degree of integration. These partnerships can be classified broadly as basic coordination, co-location, or co-facilitation. In addition, mental health courts provide another form of partnership at the judicial level. However, these partnerships should not be perceived as incrementally building on one other. For example, co-facilitation of treatment does not imply co-location of services, nor does participation in a mental health court imply either co-facilitation of treatment or co-location of services.

Coordinated supervision and treatment. Following a referral to mental health services, coordinated supervision and treatment is the most basic and broadly defined form of partnership (Evans, Jaffe, Urada, & Anglin, 2011; Holloway et al., 2013; Nishith et al., 1997; Roskes et al., 1999). Coordination refers to continued communication following a referral to treatment services (McGrath et al., 2002). In this form of partnership, treatment providers and community supervision professionals have the most clearly and exclusively defined roles, with those of mental health providers defined by their own agency or practice (McGrath et al., 2002, 2010; Nishith et al., 1997; Roskes et al., 1999), while community supervision professionals continue to engage in law enforcement or case management duties, partnering with substance abuse, community mental health, and crisis intervention treatment providers for specialized services (Hean et al., 2015).

In this model, probation or parole officers initiate referrals for mental health treatment, which may or may not be mandated by the conditions an offender's supervision. Following intake, the offender's treatment mirrors that of any other individual. This may include

psychotherapy, substance abuse treatment, or medication management. In the meantime, clinical staff engage in regular contacts with probation or parole officers. These contacts may occur at fixed intervals or may be dependent on treatment progress or changes in an offender's supervision status (Roskes et al., 1999; Nishith et al., 1997).

       Co-located supervision and treatment. Co-location expands beyond coordinated services in that mental health providers and community supervision professionals are placed in the same physical location. Thus, offenders can meet with mental health providers in the same location as their probation and parole appointments, or other services related to their community supervision (Golden et al., 2006; Turnbell & Beese, 2000; Watts, 2008). Therefore, while a community supervision officer may not be directly involved in providing treatment in a co-located office, treatment referrals can be more easily made, and progress reports can be more easily communicated to community supervision professionals (Golden et al., 2006; McGrath et al., 2002, 2010; Turnbell & Beese, 2000; Watts, 2008).

       Co-located treatment providers and programs vary based on the needs of the partnership. For example, Turnbell and Beese (2000) examined the experiences of mental health nurses in six different partnerships with criminal justice programs. One provider practiced within a magistrate's office for pre-court screenings and assessments, four worked in probation offices, and only one provided services in an independent office. Similarly, in a study of Vancouver parole officers, three of seven community corrections offices reported hosting sex offender treatment groups at their offices (Watts, 2008). Golden and colleagues (2006) describe the implementation of the *Thinking for a Change* program within "community supervision and corrections department" (p. 56) satellite offices. However, it should be noted that while the *Thinking for a Change* program suggests that facilitators possess skills generally associated with

practicing group therapy (e.g., empathy, facilitation techniques, and understanding group processes and interpersonal interactions), this program need not be facilitated by a mental health provider (Bush et al., 2011).

Co-facilitated treatment. The co-located model describes mental health practice within a community supervision office without probation and parole officers involved in actual treatment sessions (e.g. Turnbell & Beese, 2000). Co-facilitated treatment, on the other hand, actually places the community supervision professional in the treatment setting. Most often seen in group therapy settings, a mental health provider can practice co-therapy with a probation or parole officer who specializes in supervising offenders with psychosocial needs (Marino, 2009; McGrath et al., 2002, 2010).

Co-facilitated treatment is the least common form of mental health provider/criminal justice partnership. For example, a national survey of sex offender treatment programs found that only seven percent of community treatment programs used a co-facilitation model (McGrath et al., 2010). One program utilizing a co-facilitation model describes it as a response to insufficient coordination of resources. The suggested advantages of co-facilitation are that probation officers can better assess an offender's risk, observe subtle behaviors associated with attitudes about sexual and criminal behavior, and ensure knowledge of offenders' deviant fantasies and failures to avoid high-risk situations (Marino, 2009).

Co-facilitated treatment generally reflects the belief that treatment programs operate in service to the overall goals of the criminal justice system (Greenberg & Ruback, 1982; Marino, 2009; Schwalbe, 2012; Wrightsman et al., 2002). Thus, co-facilitation may not reflect the values and ethics of treatment providers. In a study of treatment provider attitudes, more than half (52%) of providers indicated that co-facilitation with a probation officer was either somewhat or

completely inappropriate, and more than two-thirds (68%) acknowledged this opinion when group members were supervised by the co-facilitating probation officer. Concerns of treatment providers included professional liability, differences in ethical standards, confidentiality concerns and differences in confidentiality practices, and probation officers' deficits in therapy training (McGrath et al., 2002).

Mental health courts. A variety of specialized courts emerged in the 1980s and 1990s that aimed to address specific problems in their communities. This reflected the philosophy that courts can promote change from a problem solving perspective rather than serving only as punishment or retribution. These courts attempt to address issues such as drug abuse, domestic violence, and mental illness among selected offenders. Special principles are typically adopted to further these efforts, including better and more specialized training for judges and other officers of the court, community engagement, individualized justice, collaboration with a wide range of professionals, and increased accountability of offenders and the professionals working with them (Wolf, 2007). Offenders referred to mental health courts show better treatment engagement (Boothroyd et al., 2003), decreased criminal behavior (McNiel & Binder, 2007), and improvements in quality of life (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003).

There is no current best practice standard for a mental health court (Steadman et al., 2001), though they typically employ several shared characteristics. These generally include a specific judge who works with non-violent offenders with mental health needs and aims to divert defendants away from the criminal justice system into treatment programs (Goldkamp & Irons-Guynn, 2000). During court proceedings, mental health providers are active participants, however, playing a quantitatively small role (Boothroyd et al., 2003). Thompson, Osher, and Tomasini-Joshi (2007) suggest ten essential elements of mental health courts: 1) specialized

planning and administration; 2) an identified target population; 3) timely participant identification and linkage to services; 4) established terms of participation; 5) the ability of defendants to make an informed choice; 6) identified treatment supports and services; 7) confidentiality; 8) identified members of a court team; 9) ongoing monitoring adherence to court requirements; and 10) ensuring the sustainability of the court.

Effective Service Allocation

Between basic coordinated services (McGrath et al., 2002, 2010; Nishith et al., 1997; Roskes et al., 1999), co-located programs (Golden et al., 2006; Turnbell & Beese, 2000; Watts, 2008), co-facilitated treatment (Marino, 2009; McGrath et al., 2002), and specialty courts (Boothroyd et al., 2003; Cosden et al., 2003; McNiel & Binder, 2007; Wolf, 2007), there are a variety of opportunities for offenders to benefit from interprofessional cooperation. Not all forms of interprofessional partnerships are available in all areas, however. Offender need, provider training, and program resources may all influence the design of interprofessional services in a given jurisdiction.

A major revolution in forensic treatment is consideration of resource allocation. Research on the application of the RNR model (Andrews & Bonta, 2010b) has shown that treatments are most likely to be effective when they treat higher risk offenders more intensely, target characteristics that are related to reoffending, and match treatment to the offenders' intellectual abilities and learning styles (Andrews & Bonta, 2006; French & Gendreau, 2006; Landenberger & Lipsey, 2005). For example, higher risk offenders with anger or other emotional regulation needs may benefit from working with a psychotherapist co-located in a probation or parole office, whereas a lower risk offender with substance abuse needs may benefit more from working with community-based substance abuse treatment services that operate

independently of supervisory control. This theory drives service provision, in that more intense services may not be necessary or beneficial for programs servicing lower-risk groups.

In addition to the degree of integration and intensity of service, an important consideration in effectively engaging offenders in treatment is the provider's training for working with this population. Research on treating offenders often focuses on specialist providers, though both entry-level and seasoned professionals may have some exposure to working with this population regardless of their specialties in treatment (Bersoff, 1995, 1999). For psychologists, there are many opportunities to gain graduate-level training in forensic psychology. Nearly 50 graduate programs offer non-specialist training in forensic psychology and nearly half of internships offer at least a minor rotation in forensic populations (DeMatteo, Marczyk, Krauss, & Burl, 2009). However, most psychology training in forensic populations occurs at the post-doctoral level (Otto & Heilbrun, 2002). Social work education often overlooks training in offender populations, offering instead a number of post-graduate certifications in forensic social work (National Organization of Forensic Social Work, 2015). For example, the American Board of Forensic Social Workers provides certificates for bachelor and master level social workers, focusing on ethical practice and knowledge of the legal system (American Board of Forensic Social Workers, 2011).

The need for effective service engagement based on provider training becomes further complicated in rural areas. Although heterogeneous in makeup, rural areas typically lack comprehensive mental health resources and specialty mental health care (Jameson & Blank, 2007), and the degree of rurality is negatively correlated with specialty mental health providers (Holzer, Goldsmith, & Ciarlo, 2000). Therefore, the lack of rural resources increases the need for forensic specialization. Such insufficient specialist training may hinder effective partnerships

between community supervision professionals and mental health providers, as they may not

understand one another's goals and perspectives (e.g. Schwalbe, 2012). This is further

complicated because many rural providers function beyond their typical competence or scope of

practice to overcome service deficits in their communities (Jameson & Blank, 2007; Schank,

1998).

General efforts to overcome rural mental healthcare deficits include the development of

multidisciplinary healthcare teams (Amundson, 2001; Office of Rural Health Policy, 2005),

though these efforts generally speak to the needs of general rural populations rather than rural

offenders. However, current models of community supervision and mental health partnerships

may be consistent with these suggestions. For example, several manifestations of co-located

treatment are documented within the literature (e.g. Golden et al., 2006; Turnbell & Beese, 2000;

Watts, 2008). Co-located forensic treatment in rural areas can reduce the demand on offenders

who are required to participate in both community supervision activities and mental health

treatment. For example, offenders can reduce time away from work by streamlining

appointments. Also, particularly in rural areas where offenders may have significant travel

burden associated with appointments (Wodahl, 2006), single-visit appointments can reduce the

financial cost of participating in treatment and meeting required probation or parole meetings.

Yet this requires community supervision agencies to embrace mental health treatment as part of

their culture. Again, the effectiveness of co-located services is impacted by specialized training,

as having a clear understanding of interprofessional roles and responsibilities is key to effective

partnerships (Edmondson & Roloff, 2009).

Issues Concerning Professional Relationships

Even though some community supervision professionals view their role as law

enforcement (Miller, 2015), the value of mental health and community supervision partnerships is generally accepted at the policy level (Thom et al., 2013). Several forms of partnerships between mental health and criminal justice systems have been developed. Typically, the coordination of resources often follows what resources are available and how much support there is for partnership. Unfortunately, these interprofessional programs rarely include a quality analysis or program evaluation component (Morrissey, Fagan, & Cocozza, 2009), and even fewer empirically or otherwise examine the functionality of mental health and community supervision partnerships.

Overall, research shows that mental health and community supervision professionals typically value their relationships (McGrath et al., 2002; Thom et al., 2013; Turnbell & Beese, 2000; Watts, 2008). Support of good relationships by senior staff members is an important component for successful interprofessional coordination (Holloway et al., 2013), though mandating interprofessional partnerships may deter from productive relationships (Mitchell & Shortell, 2000; Thom et al., 2013). Training students and early career professionals to function interprofessionally contributes to successful relationships (Hean et al., 2015), but again the quality of this training is only cursorily studied (e.g. Hrovat, Thompson, & Thaxton, 2013).

Still, mental health providers and community supervision professionals do not always agree on interprofessional issues. Two studies addressing co-facilitated treatment highlight this issue. McGrath and colleagues (2002) found that the majority of treatment providers responding to questions about interprofessional collaboration viewed treatment co-facilitation as inappropriate. Treatment providers viewed community supervision professionals as undertrained in group therapy techniques, and perceived their professional roles as too unbalanced for effective co-facilitation. On the other hand, Marino (2009) suggests that co-facilitation benefits

treatment outcomes by providing an alternative evaluation of an offender's treatment progress. Community supervision professionals based their evaluations largely on compliance with probation conditions and displays of remorse, only the former of which has been previously linked with a reduction in criminal recidivism (Hanson & Morton-Bourgon, 2004; Mann & Barnett, 2013; Mann, Hanson, & Thornton, 2010). Overall, Marino argues that co-facilitation contributes to positive outcomes for offenders. These findings highlight the value differences for the two sides of these professional relationships. The concerns raised by treatment providers emphasize competence and ethical concerns (McGrath et al., 2002), whereas community supervision professionals focus more on measurable outcomes associated with their own job responsibilities (Marino, 2009).

Questions remain regarding professional roles, responsibilities, values, training, and experience that highlight the deficits in our understanding of functional interprofessional relationships between mental health and community supervision providers. What little research is available suggests that these relationships are rarely problematic (Holloway et al., 2013; Thom et al., 2013; Turnbell & Beese, 2000, Watts, 2008), though the differing perspectives on co-facilitated treatment (Marino, 2009; McGrath et al., 2002) underscore the different values of treatment providers (American Psychological Association, 2010; Heilbrun & Griffin, 1999; Wrightsman et al., 2002) and community supervision professionals (Andrews & Bonta, 2010a; Packer, 1964; Schwalbe, 2012). This discrepancy between cursory interprofessional research and more substantial unilateral research highlights the need for a more in depth examination of these interprofessional relationships.

Interprofessional Practice Standards

Partnerships between mental health providers and community supervision professionals

take several forms, each reflecting available resources and agency or professional support. Although there are differences in the goals of each profession (Heilbrun & Griffin, 1999; Schwalbe, 2012; Wrightsman et al., 2002), both mental health providers and community supervision professionals generally value these partnerships (McGrath et al., 2002; Thom et al., 2013; Turnbell & Beese, 2000; Watts, 2008). Research on these partnerships has typically focused more on outcome improvement, such as reductions in recidivism (e.g. Hofmann et al., 2012; Lipsey et al., 2007), than the functionality of the professional relationship.

Other fields that partner with mental health providers have studied the qualities associated with successful interprofessional relationships more thoroughly. In particular, physical health care providers have paid significant attention to their partnerships with mental health practitioners. These partnerships occur in a variety of settings, including primary care (Byrd, O'Donohue, & Cummings, 2005; deGruy, 1997), healthcare centers (e.g. hospitals; Reeves & Lewin, 2004; Russakoff, 2003), hospice programs (Reese & Sontag, 2001), and psychiatric hospitals (Akhavain, Amaral, Murphy, Uehlinger, 1999).

Together, the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the Association of Schools of Public Health, the American Association of Colleges of Pharmacy, the American Dental Education Association, and the American Association of Medical Colleges have pooled their resources to develop the Interprofessional Education Collaborative (IPEC). The goal of IPEC is to advance interprofessional education, best practices, and practice innovations (IPEC, 2012). One of IPEC's key publications includes the four basic competencies identified for interprofessional practice: 1) values and ethics for interprofessional practice; 2) roles and responsibilities; 3) interprofessional communication; and 4) teams and teamwork (IPEC, 2011). While these

competencies primarily pertain to health care practices, they may be relevant to interprofessional practice between mental health and criminal justice professionals.

Values and Ethics for Interprofessional Practice

Underlying this area of competency is the belief that professionals should "work with individuals of other professions to maintain a climate of mutual respect and shared values" (IPEC, 2011, p. 18). Here, values and ethics concern professional standards of interprofessional practice. While the specific values of a medical partnership may not reflect the specific values of a criminal justice partnership (Dickie, 2008; Grisso, 1987; McGrath et al., 2002; Nicholson, 1999; Wettstein, 2002), defining the values of each are equally important. This includes the need to emphasize characteristics that support interprofessional relationships, relationships with clients, and the quality of interprofessional exchanges.

Some specific recommendations that might overlap with criminal justice partnerships include: 1) embracing the cultural diversity of clients; 2) respecting the backgrounds and responsibilities of other involved professionals; 3) developing a trusting relationship with clients, families, and other team members; 4) demonstrating high standards of ethical conduct; 5) acting with honesty and integrity; and 6) maintaining competence in one's practice appropriate to the scope of the setting (IPEC, 2011). A major difference between health care and criminal justice partnerships is that the needs or concerns identified by an offender may not be the focus of service delivery. Partnerships between mental health and criminal justice agencies also have the added responsibility to the community to ensure safety and control of offender behavior (Association for the Treatment of Sexual Abusers, 2014; Glaser, 2003; McGrath et al., 2002).

Roles and Responsibilities

Roles and responsibilities as an area of competency reflects the need to understand one's

own role and the roles of partners to appropriately address the needs of those whom you serve. This includes knowing partners' strengths and abilities, as well as continuous improvement of interprofessional partnerships. It also focuses on ensuring that one's specific role in an interprofessional setting is sufficiently communicated to the end-of-line consumer (IPEC, 2011), or here, offenders in community treatment. The Center for Sex Offender Management (2007) highlights several interprofessional tasks consistent with these needs. For example, early tasks should include establishing expectations and developing an understanding of other team members.

Communicating roles and responsibilities to clients in multi-disciplinary settings is also important (American Psychological Association, 2010). For example, offenders may view mental health providers as agents of the court instead of treatment providers (Roskes et al., 1999), thus limiting their disclosures in therapy out of fear that minor infractions may result in serious consequences.

Interprofessional Communication

The general competency of interprofessional communication states that interactions with clients should be done in a responsible manner that supports a team-based approach. The specific sub-areas of competency include the need to accurately and effectively communicate information while actively working to ensure that other parties involved correctly receive one's message. This competency builds on both the values and roles competencies discussed above - the belief in interprofessional values and understanding one's own professional roles both facilitate communication practices (IPEC, 2011).

In a study of mental health nurses partnered with a variety of community supervision agencies, treatment providers who adapted their language to accommodate the criminal justice

environment fostered stronger interprofessional relationships with their criminal justice

counterparts. Additionally, treatment providers promoted interprofessional communication by

adopting a professional image consistent with a criminal justice setting (Turnbell & Beese,

2000). Other similar research has examined the frequency of interprofessional communication

(e.g. McGrath et al., 2002; Watts, 2008), though the overall strengths, weaknesses, benefits, and

pitfalls of interprofessional communication between mental health providers and community

supervision professionals is insufficiently examined.

Teams and Teamwork

The final competency advises applying "relationship-building values and the principles of

team dynamics to perform effectively in different team roles to plan and deliver patient- or

population-centered care that is safe, timely, efficient, effective, and equitable" (IPEC, 2011, p.

25). The teamwork competency draws from the previous three, including cultivating roles as

part of team development, building consensus on guiding ethical principles, integrating

knowledge and experience of other professions in decision making, and using evidence to inform

team-based practices (IPEC, 2011).

Partnerships between mental health and community supervision professionals reflect a

dichotomous system of control and care (e.g. Hean et al., 2015; Holloway et al., 2013; McGrath

et al., 2002; Roskes et al., 1999; Thom et al., 2013; Turnbell & Beese, 2000; Watts, 2008), with

community supervision professionals leaning more towards the control/management side of this

dichotomy (Andrews & Bonta, 2010a; Miller, 2015). This does not discredit the importance of

teamwork as a valued competency, though. Rather, the guidelines advise flexibility in

relinquishing professional autonomy (IPEC, 2011). Thus, while it is important to build

functional teams, it is also important to recognize one's role on the team and retain values

specific to professional practice to better contribute to the team's broader goals. As the larger goals focus on the responsibility to the community as well as to the individual (Association for the Treatment of Sexual Abusers, 2014; Glaser, 2003; McGrath et al., 2002), mental health providers may need to defer to community supervision professionals' leadership in the overall management of offenders' needs (Holloway et al., 2013; Roskes et al., 1999; Turnbull & Beese, 2000), while still emphasizing individualized care.

Aims of the Current Study

Mental health providers and community supervision professionals share some values, roles, and responsibilities, but also have unique professional identities and mechanisms of practice. Community supervision professionals use a combination of law enforcement and case management strategies to punish offenders and deter them from future criminal behavior (Klockars, 1972; Schwalbe, 2012). Mental health providers who offer offender services seek to reduce offenders' pathology and improve psychological functioning, and also to facilitate legally-relevant behavior change (Heilbrun & Griffin, 1999) that is necessary to support community safety (American Psychological Association, 2010; Association for the Treatment of Sexual Abusers, 2014). These two professions interact and partner to achieve these goals in several ways, including coordinating treatment services following a probation (or court) referral (Evans et al., 2011; Holloway et al., 2013; Nishith et al., 1997; Roskes et al., 1999; Wrightsman et al., 2002), providing treatment services at a probation or parole office (Golden et al., 2006; Turnbell & Beese, 2000; Watts, 2008), or community supervision professionals co-facilitating treatment activities (Marino, 2009; McGrath et al., 2010). However, little research has examined the interprofessional experiences of these two disciplines.

Given the dearth of published research regarding these issues, it is difficult to infer

specific hypotheses. Therefore, this study is exploratory in nature, focusing on four major aims, which are displayed in Figure 1.
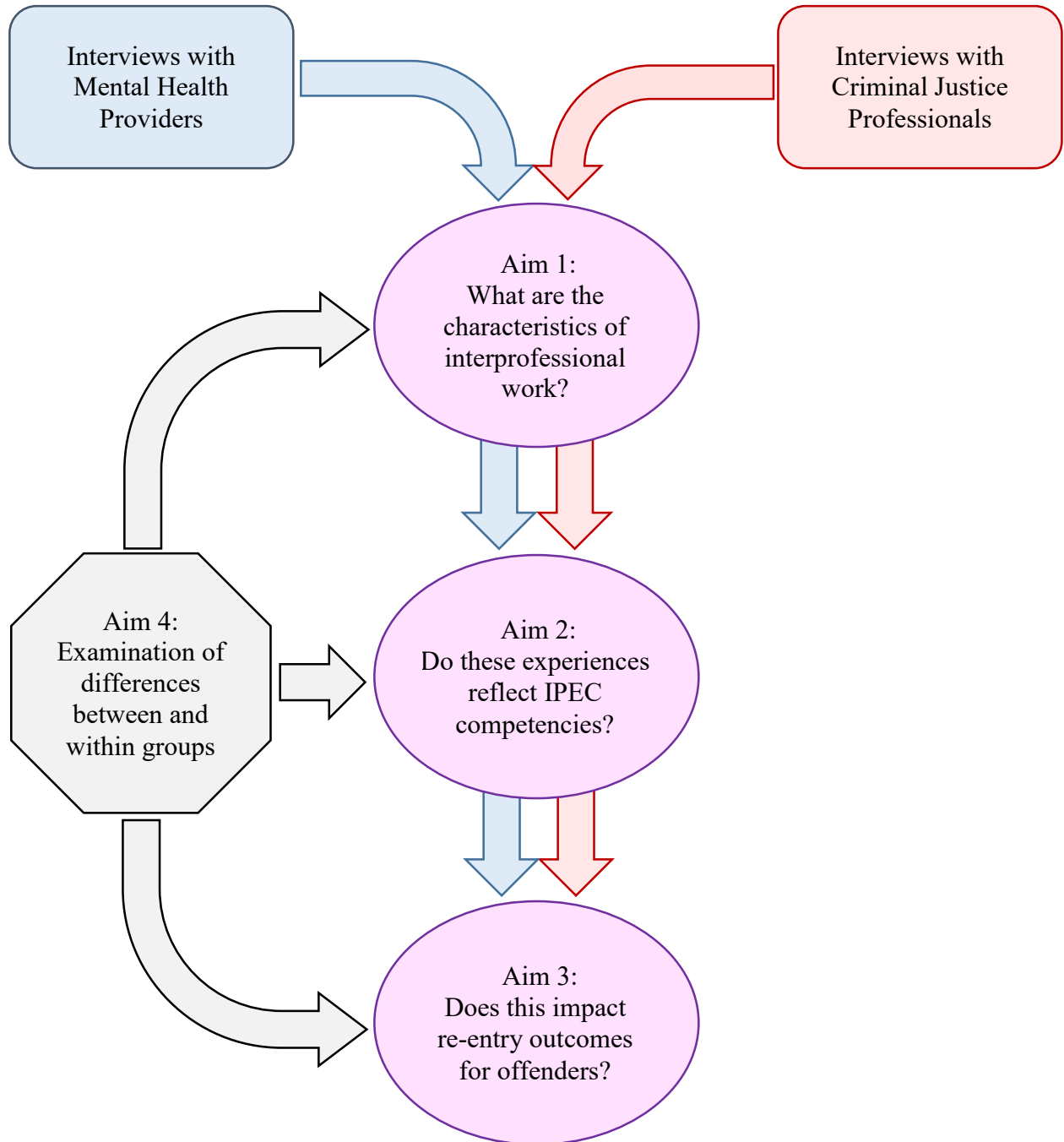
Figure 1. Outline of the present study's four aims

The first and primary aim of this study is to explore mental health and community supervision professionals' experiences with providing coordinated services or co-located or co-facilitated treatment. Past research in this area has either focused on single-question issues or included the study of interprofessional relationships as a secondary objective within a larger analysis (Holloway et al., 2013; McGrath et al., 2002; Thom et al., 2013; Turnbell & Beese, 2000; Watts, 2008). An open-ended approach to questions is used to reveal dynamics within these interprofessional relationships previously not documented in literature.

The second aim of this study is to explore if partnerships between probation or parole officers and mental health providers reflect these interprofessional best practice values. As health care research has an established infrastructure for interprofessional partnerships (Blount, 2003, Byrd et al., 2005; IPEC, 2011), the broad, core competencies they have previously identified (i.e., values and ethics, roles and responsibilities, interprofessional communication, teams and teamwork; IPEC, 2011) help guide the research of mental health and community justice supervision partnerships. However, there is no precedent in empirical literature that such standards apply in the partnerships examined here, and the differences between health care and criminal justice practices suggest issues beyond the IPEC competencies.

The third aim of this study is to explore the perceived impact of partnerships between probation or parole officers and mental health providers on offenders' success in the community. Both mental health and community supervision professionals aim to minimize problems faced by offenders in the community (Holloway et al., 2013; Roskes et al., 1999; Schwalbe, 2012; Turnbull & Beese, 2000). Although research supports that such partnerships contribute to reduced criminal recidivism (Boothroyd et al., 2003; Cosden et al., 2003; McNiel & Binder, 2007), professionals' beliefs about how interprofessional relationships contribute to these

successes are rarely documented.

Finally, a fourth aim of this study is to explore differences in themes identified within participant types in the primary analysis. In this set of analyses, differences considered are based on professionals' education, training, professional experience, and professionals' caseload characteristics.

CHAPTER 2

METHODS

The current study is a part of a larger examination entitled, "Barriers and facilitators to offender re-entry in rural communities. Part I: Perceptions of treatment and risk management personnel." The purpose of the parent study is to identify perceived challenges, needs, resources, and communication practices related to working with offenders living in rural communities, as viewed by groups of mental health providers and community supervision professionals. The ETSU Campus IRB approved the parent study on April 3, 2015. This portion of the parent study specifically addressed four major aims: 1) examining MHPs' and CSPs' experiences with providing coordinated services, 2) examining if partnerships between probation or parole officers and mental health providers reflect best practice values adopted by interprofessional healthcare practitioners, 3) examining the perceived impact of interprofessional partnerships on offenders' success in the community, and 4) quantitatively testing for intragroup differences within the qualitative data described in the first three aims.

Participants

The principal investigator and a graduate research assistant identified individual mental health providers (MHPs) and agencies who provide a variety of court-ordered treatment services. This included providers listed with the Tennessee Sex Offender Treatment Board and licensed providers registered with the Tennessee Department of Mental Health and Substance Abuse Services, as well as community supervision professionals (CSPs) associated with area mental health and case management agencies who routinely perform court-ordered services. The principal investigator of the parent study recruited participants by emailing requests for participation in focus groups or individual interviews, and provided informed consent

documentation and video authorization to those who indicated interest in participating in the research study (see Appendix B).

MHPs interviewed for this study participated either individually or within focus groups. In total, 38 MHPs participated in this study. Two MHPs interviewed individually and 36 interviewed in five focus groups. Five MHPs were excluded from the current analyses for not contributing to discussions relevant to the present analyses during focus groups. MHPs included 45% males and 55% females. Four CSPs consented to participation in this study, and were each interviewed individually. Among CSP participants, 25% were male and 75% were female. Table 1 details participants' education and training demographics, and Table 2 details participants' professional demographics. Table 3 includes further information regarding the participants' caseloads.

Table 1.

Education and Training Demographics

	MHPs ($n = 33$)	CSPs ($n = 4$)
Highest Degree Attained		
Bachelor's Degree	21.2%	75.0%
Master's Degree	63.6%	25.0%
Doctoral Degree	12.1%	0%
Other	3.0%	0%
Highest Degree Field of Study		
Criminal Justice	0%	50.0%
Education	18.2%	0%
Marriage and Family Therapy	12.1%	0%
Psychology	12.1%	25%
Social Work	48.5%	25%
Other	9.1%	0%
Specialized Training		
Annual Agency Training	6.1%	0%
Conference Attendance	6.1%	0%
Formal Courses Related to Offenders	12.1%	0%
Multiple	12.1%	0%

Table 1 (continued).

Other	9.1%	0%
None	54.5%	100%
Certifications		
ABPP Forensic Certification	3.0%	0%
Level of Service/Case Management Inventory Certification	0%	50.0%
National Certified Counselor	3.0%	0%
Sex Offender Treatment Board Approved Provider	15.2%	0%
Suicide Prevention	0%	25.0%
Multiple	21.2%	25.0%
Other	15.2%	0%
None	42.4%	0%

Table 2.

Professional Experience Demographics

	MHPs ($n = 33$)	CSPs ($n = 4$)
Mean Years of Professional Experience (SD)	11.8 (10.3)	3.3 (1.3)
State Licensure		
Yes	30.3%	0%
No	60.6%	0%
Not Reported	9.1%	100%
Member of a Professional Association		
Yes	54.5%	25.0%
No	42.4%	75.0%
Not Reported	3.0%	0%
Type of Agency		
Community Corrections	6.1%	50.0%
Community Counseling Center	69.7%	0%
Court System	3.0%	25.0%
Residential Treatment Facility	12.1%	0%
Sheriff's Office	0%	25.0%
University	9.1%	0%
Mean Monthly Caseload (SD)	55.5 (44.5)	105.7 (74.5)

Table 3.

Reported Caseload Demographics

	MHPs (*n* = 33)	CSPs (*n* = 4)
Mean Percent Types of Convictions (SD)		
Misdemeanor	21.6% (24.7)	42.5% (50.6)
Felony	26.2% (37.5)	82.5% (35.0)
Non-Violent	30.4% (35.5)	68.8% (17.5)
Violent	8.4% (13.2)	31.3% (17.5)
Substance Abuse	19.0% (30.5)	72.5% (23.6)
Parole Only	4.5% (13.8)	25.0% (50.0)
Probation Only	26.5% (29.7)	75.0% (50.0)
Client Data (Mean Reported Percent)		
Domestic Violence Offenders	11.2% (13.4)	15.0% (12.9)
Sexual Abuse Offenders	18.3% (35.3)	2.0% (4.0)
Substance Abuse Offenders	45.5% (33.2)	79.5% (27.8)
Local Referral	74.3% (40.4)	96.0% (4.5)
Court Ordered Offender	56.6% (34.8)	[a]
Non-Offenders	19.8% (27.9)	[a]

[a] CSPs not queried in this area.

Materials

Participants completed a brief survey prior to participating in focus groups or interviews. One survey examined the demographics and professional characteristics (e.g. experience, training, job activities) of MHPs (see Appendix A). Another survey examined the demographics and job activities of CSPs (see Appendix B). These surveys were written for the parent study and designed to be completed in approximately 10 to 15 minutes.

Specific focus group questions developed for the parent study inquired about training, workload, services in the community, impressions of what does and does not work in community reintegration, and policy. Seven questions, which had minor variations between the MHP and

CSP interviews, target the primary aims of this study (see Appendices A and B):

1. How important to you is communication with other providers or people who are supervising your clients?

2. How often do you discuss specific offenders with other people? How often do you have to report anything? Does this make your work easier, or is it more complicated?

3. What kinds of rules do you have to follow in contacting others about your clients?

4. What kinds of things help you communicate with others about your clients?

5. What kinds of things get in the way of communicating with others about your clients?

6. What is your responsibility in comparison with other people or agencies who work with your clients? How well are roles and responsibilities between agencies clarified?

7. Do you ever disagree with people in other agencies about the client? If so, how does that work out?

Participants also provided relevant information in the context of larger discussions, therefore material pursuant to the aims of this project noted during other portions of the discussion may also be used in the proposed analyses.

Procedure

All participants consenting to this study engaged in focus groups or individual interviews conducted either at the Department of Psychology's facilities or at participants' offices. Participants completed the discipline-appropriate survey prior to their focus group or individual meeting. Focus groups and individuals met with interviewers for approximately 60 minutes. At least two research staff, including the parent study's principal investigator and trained graduate research assistants, facilitated each of the interviews. Questions developed for the parent study guided the discussion, including those seven questions listed above that are specific to the

research aims of this proposed dissertation. All focus groups were video-recorded for later transcription, coding, interpretation, and reference during analyses. Interview data were coded inductively, without using an a priori approach to defining themes, due to the lack of sufficient source material to develop a priori themes. The exception to this was the examination of responses associated with IPEC best practice values.

These focus groups and interviews of MHPs were conducted between September 2015 and December 2015. The interviews of CSPs were conducted between September 2016 and August 2017. Under the supervision of the parent study's principal investigator, graduate and undergraduate research assistants reviewed and coded videos of focus groups and individual interviews. Videos and transcripts were used to identify major themes by thematic analysis. The recommendations of Boyatzis (1998) and Braun and Clark (2006) guided the thematic analyses.

Data relevant to the first and third aims of the study were defined using inductive coding. This is an open-ended process to establish themes within the data instead of approaching data with pre-determined themes. Data relevant to the second aim of the study, to examine if partnerships between community supervision professionals and mental health providers reflect interprofessional best practice values in healthcare research, used theory-based, deductive coding (Boyatzis, 1998). Thematic analyses involved five phases (Braun & Clark, 2006). First, the thematic analysis team reviewed videos and transcriptions of interviews (i.e., the research data). This team consisted of graduate and undergraduate research assistants assigned to the parent study. Second, the analysis team identified notable excerpts from a random subset of the data to generate initial codes. Two team members were assigned to review the interviews of each research participant at this phase. The third step involved consolidating initial codes into major themes and subthemes. Fourth, the team reviewed the themes developed from the initial subset

of data against the whole dataset. Finally, the fifth step involved defining and naming the major themes and refining the specifics of each.

Quantitative analyses addressed the fourth aim of the study: to examine differences in identified themes based on participant characteristics. Coded data from the earlier analyses classified participants as either endorsing or not endorsing identified themes. Participant characteristics surveyed using the questionnaires presented in Appendix B and examined significant differences in identified themes. Themes identified during the thematic analysis portion of the study were defined as independent dichotomous variables. Responses were coded "1" for specific responses consistent with identified themes, "0" for specific responses inconsistent with identified themes, and missing if the participant did not make any theme-relevant statements. For participant characteristics classified as ratio scale variables (i.e., years of experience, caseload size, cost of services, percent of offense types, percent of supervision types, and time in treatment), univariate analysis of variance (ANOVA) identified statistically significant differences in responses by characteristic. For nominal participant characteristics (i.e., educational level and background, specialized trainings, professional association affiliation, confidentiality restrictions, and degree of treatment provider integration with community supervision programs), a Kruskal-Wallis ANOVA identified significant differences in responses between groups. The Kruskal-Wallis test is a non-parametric examination of statistical differences appropriate when analyzing nominal data.

CHAPTER 3

RESULTS

The current study addressed four major aims: 1) examining MHPs' and CSPs' experiences with providing coordinated or overlapping services, 2) examining if partnerships between probation or parole officers and mental health providers reflect best practice values adopted by interprofessional healthcare practitioners, 3) examining the perceived impact of interprofessional partnerships on offenders' success in the community, and 4) quantitatively testing for intragroup differences within the qualitative data described in the first three aims.

Aim 1: Experiences of MHPs and CSPs Providing Interprofessional Services

MHPs' Experiences with Interprofessional Services

Thematic analysis identified seven major themes associated with communication and collaboration:

1) value of and challenges to communication,

2) individual characteristics and roles,

3) characteristics of communication,

4) elements of effective communication,

5) role of technology,

6) court's role in offender treatment, and

7) contribution of MHPs

In the course of identifying subthemes, considerable overlap was apparent in both source and context of multiple themes. Specifically, there were evident similarities between the "individual characteristics and roles" and "contribution of MHPs" themes, and the "role of technology" theme bore similarity to a segment of the "characteristics of communication" theme.

To provide a more objective examination of correlations among themes, a factor analysis quantitatively identified commonalities among the themes. Each quote from MHP interviews was entered in SPSS, and the seven themes were dummy-coded for each interview quote. Table 4 presents the results of the factor analysis following Varimax rotation, illustrating four major factors.

Table 4.

Factor Analysis of MHP Interview Initial Codes

	New MHP Theme Number			
Initial Thematic Analysis Theme	1	2	3	4
Appreciation for and process of collaboration	**0.91**	-0.11	0.04	0.04
Individual characteristics and roles	0.08	**0.80**	0.06	-0.03
Characteristics of communication	-0.13	-0.18	**0.82**	-0.07
Elements of effective collaboration	0.27	0.12	-0.09	**0.80**
Role of technology	-0.26	-0.29	**0.72**	0.21
Involvement of the courts	-0.25	-0.20	-0.23	-0.67
Value of contribution as a mental health treatment provider	-0.20	**0.78**	-0.15	0.00

The "individual characteristics and roles" and "contribution of MHPs" themes both showed best loading on factor 1, and the "role of technology" and "characteristics of communication" themes best loaded together on factor 3. Factors 2 and 4 each contained one theme, "elements of effective communication" and "value of and challenges to communication," respectively. The final theme, "courts' role in offender treatment," did not load to any factor in this analysis, suggesting this theme draws on a significantly different set of sources from the interviews than other data pertaining to communication and collaboration. This factor analysis confirms the use of five themes, rather than seven. These five themes are presented in Table 5 along with their definitions.

Table 5.

Major Themes and Definitions for MHP Interviews

Theme	Definition
Appreciation for and process of collaboration	This theme describes the importance of communication with others about the client as well as relationships (or lack thereof) with people from other agencies who also work with the client. It additionally includes some barriers and challenges to effective communication.
Individual characteristics and roles	This theme involves the treatment providers' perceptions of their roles & responsibilities. It also includes discussion of personality characteristics or features of the provider & others that are essential to these roles or that may hinder effective service provision.
Characteristics of communication	This theme includes elements like frequency of communication, rules about communication (e.g., confidentiality, who initiates it), mandatory reporting rules, manner of communicating with others (e.g., in-person, written, phone calls), and documentation. This theme also includes how technology affects treatment providers performing their jobs & communicating with others.
Elements of effective collaboration	This theme highlights both positive & negative factors that can impact communication, including personality characteristics, relationships, agency differences, differences in roles & responsibilities, perceptions of others, technology & manner of communication, rules, etc.
Involvement of the courts	This theme describes how treatment providers perceive courts' understanding of mental health treatment, how sanctions are given, individual variability across courts/jurisdictions, and what the court expects from mental health treatment providers.

MHP 1.0 Appreciation for and process of collaboration. MHPs readily discussed their

appreciation of relationships with their community supervision counterparts. Participants

provided examples of the value of interprofessional services, including the link between valuing

collaboration and the resulting quality of relationships, or the impact on service efficiency.

MHPs also discussed factors that hinder their appreciation of interprofessional service. Six subthemes are presented here.

MHP 1.1 Interprofessional collaboration is important when providing offender treatment. The first interview question pertaining to communication and service collaboration within the parent study (see Appendix E) was, "How important to you is communication with other providers or people who are supervising your clients?" All responses to this question affirmed the importance of MHPs maintaining relationships with CSPs. This opinion was evident from a number of similar examples:

> "I think it's very important to communicate with providers that are treating your clients. Communication varies from texts, to e-mail, to phone calls, sometimes nothing. Sometimes you get nothing. But it's very important to…see what services they are getting, how they are doing in those services. You can use that as part of your service with the clients." (MHP 11)

> "I think it's definitely important because everyone has a piece of the puzzle and us coming together is more effective." (MHP 22)

MHP 1.2 Appreciating interprofessional service motivates MHPs to have better relationships with CSPs. MHPs shared concerns about their differences with CSPs regarding professional values and roles, and that these differences can lead to disagreements or frustration. However, when discussing the value of service collaboration, MHPs often noted how this is related to improved professional relationships, such as improving their understanding of others' work goals, increasing their ability or willingness to take the perspective of their CSP counterpart, and developing professional empathy that reduced their frustration with CSPs. For example,

"DCS and the court, I know they have their roles to play...but often times they come at us in a way that makes us feel like they're commanding us or …we work for them in some way or another, which we don't. And that is often off-putting. …They're good people that are in this field, they just have their roles to play and we have our roles to play, and it's just finding that balance…between what we do for our community and what they are…our provider-partners…our referral partners. It's that balance in what we're able to do as a service and what they're doing as…a necessity." (MHP 10)

MHP 1.3 Appreciating interprofessional service is associated with efficiency. MHPs supplied examples illustrating how embracing relationships with their CSP counterparts has contributed to more effectively working with court-ordered clients. One example of this is an aspiration of MHP 9 with regards to an ideal system of service collaboration:

"I've dreamt…a long time about having a true continuum of service care where everyone would be in-house so that we could coordinate. So I could tell my probation officer who's doing the management, and their work would be collaborative and consistent and complementary to the treatment, and we have a true containment model. I think that would be a dream."

In general, though, MHPs described how valuing interprofessional service actively increased the efficiency of their work. As described by MHP 31:

"I think as far as…therapy…goes, the only two things that I…relied on…from other professionals…was substance history or records, and context, because sometimes I would get better context of the patient's problems from the case officer than I would from the clients themselves. Either because they couldn't trust me yet or they didn't

want to tell me, or they couldn't verbalize it as well as the case officer could. So

that really helped me put their struggles in perspective contextually."

Several providers discussed how collaboration with their CSP counterparts can be instrumental

in overcoming a client's motivation deficits. This is particularly relevant given that many clients

receiving services are mandated by the court (or other legal body) to complete treatment

programs. For example:

"There are many times that I have to…email…the referral source…and let them

know, 'Hey, this person's cancelled two appointments with me. And now I can't

reach them.' And [they] will email me back and say, 'Okay, give me a couple of

days.' Sure enough, in a couple of days I get a phone call from the client to schedule

the appointment. So, without [them] as that muscle, motivation is pretty limited."

(MHP 17)

MHP 1.4 Challenges emerge from different systems. While MHPs identified many

reasons to value interprofessional collaboration, they also acknowledged several factors that

interfere with maintaining the focus on treatment. Most notably, MHPs discussed how the

differences between treatment and supervision frustrate MHPs and blur perspective. This

includes how CSPs may have different professional goals, priorities for their clients, and rules

about communication. For example, this can occur when interacting with individual CSPs:

"I think we, in each county, we have a PO or someone in another agency…[who is]

not going to accept your referral or they don't believe. 'No - he's not mentally ill,

he's just bad. You know? He's just this, he's just a drunk, he's just a druggie, he's

just a whatever.' And sometimes they're so hardcore…they won't allow you to

work with…the individual because they put a blockade up. So…the good thing is

that's few and far between. But there's usually one in every county, and if you

happen to have that one, you're going, 'Oh no.'" (MHP 32)

This can also occur on a systemic level:

"How they utilized us in the last many years as well has changed. Twenty years ago

when the courts were referring clientele to us, it felt much more that they were

expecting results and wanted to see results and now they're expecting us to be part

of their philosophy. So, it's no longer they're expecting us to do treatment, they're

expecting us to help them be part of the punitive schema." (MHP 10)

MHP 1.5 Motivation to collaborate is heterogeneous among CSPs. A common thread

is the inconsistency among CSPs in the value of interprofessional collaboration. This

inconsistency is a major source of frustration among many MHPs, as highlighted by MHP 16:

"And then [CSP] workers, some of them…are very proactive. They will call you

every week with some type of update….They'll be very proactive. Some of them,

you will not hear from until the day before court….So it's not consistent…it all

depends on the DCS worker or referral source and their preference and how

proactive they are in terms of the communication."

MHP 1.6 Not all systems are sufficiently connected. Many services which could

collaborate do not. This often concerns services beyond the typical MHP/CSP dyad, such as

additional psychiatric treatment or employment assistance. While this reflects a systemic barrier,

it also reduces MHPs' emphasis on interprofessional service collaboration.

"There's very little communication between agencies, whether it's healthcare or

providing services like job help or anything like that. They exist, but there's little to

no communication between them. And that was really frustrating. But I don't think

it's uncommon…at all." (MHP 31)

MHP 2.0 Individual characteristics and roles. This theme details the professional roles MHPs see as part of their regular duties. These are associated with direct service to clients, working alongside CSPs, and interprofessional responsibilities. Five subthemes were identified:

MHP 2.1 Clinical service role. MHPs most identified their role as clinical service providers, conducting assessments, facilitating psychoeducational programs, and providing group or individual therapy to clients. For MHPs with a social work background, this included case management duties as well. As described by MHP 10: "I think our role is to treat, to identify the risk factors, develop a course of action, try to lower those risk factors, and then give that information to the other members of the team who have a different job to do."

MHP 2.2 Providing a service to community supervision programs. The above excerpt from MHP 10 highlights not only the primary clinical duties described by several MHP participants but also that their role is to provide a service to the courts, probation and parole offices, and child and family welfare programs. Thus, the needs of the professional partnership can shape the MHPs' responsibilities and work product. In the case of court ordered evaluations:

> "Communication…is controlled by the parameters of court order referral, so we
> follow whatever the court order is. Sometimes the court will send a family to us
> and say, just do what you can to help them, we don't want to hear anything back.
> Sometimes the court will say, we want a report…" (MHP 24)

Therapy services typically involve a longer time period than evaluations, and consequently require in a more balanced relationship between MHPs and CSPs. Nevertheless, therapy is still often considered a greater component of an individual's social and behavioral rehabilitation, as managed by CSPs. For example:

"A lot of the time I just ended up deferring to the system because…I'm not going to fight a battle for somebody because they messed up and relapsed, unless I think it's a really extenuating circumstance….For the most part, I'm there as a supplement to the program. The program is not a supplement to me." (MHP 31)

MHP 2.3 Advocacy. MHPs and CSPs interact with offenders in different ways. The client -provider relationship is by nature more conducive to the open exchange of information than is true of the relationship between CSPs and their supervisees. Offenders may be more willing to share information with a therapist, and the training and professional objectives of MHPs lend better to the exploration of etiology of behavior. Thus, MHPs are in a position to counsel their CSP counterparts on mechanisms of improving offender success in the community. MHP 21 described how this was evident in a multidisciplinary team setting:

"One of the biggest things that came up for me was clients were reporting…struggles…and it would come out in treatment team that everybody just thought it was a lie, that they were making it up, that they were trying to get out of something or it was an excuse. Whereas for me, I had had a lot more face to face time with that person, or I was aware of things that other people…weren't because of the nature of the therapeutic relationship."

MHP 2.4 Assuring clients of professional boundaries. While the professional triad of MHP, CSP, and client provides opportunities for MHPs' advocacy, many clients struggle with the preconception that MHPs are "part of the system." They fear that therapists cannot be trusted, and that openness and honesty are a threat to their freedom rather than a step toward growth and change. Thus, those referred from the court are more resistant to building productive therapeutic relationships than the average self-referred client. Several MHPs discussed their

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increased effort to develop therapeutic relationships, most commonly accomplished through education about their professional responsibilities and differentiation from CSPs. For example:

> "A lot of times…they think because they're referred to us, we are…a more disciplinary force, and I just kind of reassure them that we're here to help them and whatever their needs are that need to be met…that we're not going to take any kids away. We're not going to do any drug tests. We're just here to counsel. That's our main job." (MHP 12)

MHP 2.5 Maintaining the professional relationship. MHPs additionally noted their responsibility for ensuring that professional relationships are healthy and functional. MHPs believe that if they do not make efforts to foster a relationship on a personal level, then CSPs are more likely to maintain a basic, utilitarian relationship. MHP 33 discusses this in the context of providing clinical supervision to a team of student therapists working alongside a community corrections program:

> "With our students who have been placed....there are some [who] communicate with the [CSPs] and the other providers….The ones who have communicated more have…been more effective…in terms of more referrals happening and more work with the offenders happening. We've had a couple students there that…were good therapists, were more reserved, more introverted, and maybe less adaptive in terms of their introversion, and so…by the end of the training year, the [CSPs]…maybe not tired really, but given up on (sic)…active interaction referring people."

MHP 3.0 Characteristics of communication. How collaborative relationships function is often governed by professional standards on both sides of the relationship. MHPs expressed less concern about formal professional rules and more concern with their interprofessional

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expectations and the unofficial means through which the flow of information occurs within the relationship. A wide variety of topics were discussed within this theme, which were ultimately reduced to three broad subthemes.

MHP 3.1 Who wants information drives communication. A primary characteristic of interprofessional collaboration is the motivation for information exchange. Regarding relationships between MHPs and CSPs examined here, this motivation often occurs as needed, rather than resulting from a desire for equal and balanced collaboration. In discussing the dynamics of information exchange with their associated CSPs, MHP 25 described the nature of communication exchange with his/her CSP counterpart, echoing the MHP role as providing a service to community supervision agencies, stating, "The general understanding is that it's…a one-way street with communication, where the [CSPs] can tell us…all they want, but (they're) not really going to get much coming back."

In some cases, this results in a breakdown in collaboration, as some parties may not prioritize communication until their counterpart is seeking information. For example, with regard to MHPs learning of a failure to meet community supervision expectations:

"It seems to be months later…we have this conversation - alright you've completed your…assessment. Congrats, your recommendations is....(sic) Then you never see them for, like, three months. And now…you get a call or email from somebody and they say, 'What happened? So-and-so said they've been working with you and haven't seen you in three months.' ….And I'm like, 'Gosh I don't know. I met them once, I didn't know I was working with them all this time.'" (MHP 21)

Thus, communication may become a function of the CSPs' motivation to collaborate with MHPs. The degree to which communication is used may be mediated by the quality of the

relationship between the MHP and CSP. As described by MHP 25:

> "I feel like that depends on the relationship with the case officer, because there
>
> are some of my clients, if they violate, I know that day when they violate. Just to
>
> keep me in the loop to make sure I'm keeping up with scheduling, keeping up
>
> with their care. Other cases, though, when someone maybe fails a drug test and
>
> then they abscond, I don't know that until weeks down the road, or never find out
>
> what happens to that person until I'm like, 'Wait, whatever happened to them?'
>
> And they're like, 'Oh yeah, they absconded.'"

This issue is even more salient for MHPs who interact directly with the courts. As described by

MHP 24: "Contacting the court is something you have to be careful about if there is not a court

order for that because it's considered ex parte communication and you can get in trouble for that.

So unless the court has said, we want to hear back, generally you don't unless there's a

compelling sort of report kind of situation."

> ### MHP 3.2 Formal standards regarding interprofessional communication.

Confidentiality is one of the hallmarks of modern healthcare, especially with regard to behavioral

health services. This was not mentioned by a majority of MHP participants, though those who

did discuss confidentiality and formal releases of information did so with the utmost seriousness.

For example: "The release is the main thing, it's a large part of what we do…of what our case

manager does." (MHP 12)

More commonly, MHPs discussed the formal expectations about the frequency of

communication with their CSP counterparts. This varied, with some providers describing near-

daily contact with their counterparts, as noted by MHP 17:

> "In my role, I'm emailing [CSPs] multiple times a day because they want to know

- did this person comply, did they get their assessment completed, what are the

results, what would you recommend? So it's daily. My phone, yesterday I had my

office and cell phone ringing simultaneously. Right now I have seven missed calls

on my office phone and three new voicemails."

Other MHPs described less frequently required contact with their CSP counterparts. Participants

7 and 11 briefly discussed the monthly formal contacts they receive from CSPs:

"The [CSPs] come...they visit here…twice a month or monthly." (MHP 2)

"It's typically supposed to be monthly. But depending on where the worker's from,

they could be on the other side of the state. And then depending on…the supervisor

of the county…they can Skype to do one or two sessions for two months." (MHP

5)

MHP 3.3 Impact of communication technology on collaborative relationships. The

excerpts in the subtheme above highlight the multimodal nature of modern collaboration.

Several MHPs commented on how technology provides greater opportunity for communication

and collaboration. Information can be shared more readily thanks to e-mail and text messages,

and improvements in telephone technology allow for increased participation in meetings. This is

notable in rural areas where scarce resources are available across wide geographical areas, as

described by MHP 5 above. MHP 11 summarizes the current state of interprofessional

communication modalities: "It would be great if we could talk on the phone to all of them, but

that's highly unusual. It's more in the form of e-mails or texts – mostly e-mails."

While the use of technology addresses logistical barriers to maintaining interprofessional

relationships, several participants highlighted that this also can create additional barriers. While

modern communication increases the frequency of contacts, this may not increase the quality of

the information exchanged. This concern is best highlighted by MHP 9:

> "Some of the things that make the communication easier…also have…weaknesses
> that…interfere with relationships. So e-mails, texts, things like that that make it
> easier to get information from other people often times…created not the kind of
> relationship that we really need to share information."

Relying on modern modes of communication also appears to complicate information exchange, as they are not utilized uniformly. As noted by MHP 10:

> "[CSPs] [use] these little flip phones; they can't use their regular phones…for
> clients. And their voicemails fill up very quickly. They'll text you, but they'll text
> you from a personal phone, so [you've]…got to make sure your phone numbers
> work. …You have to know their preference, and some will text books to you;
> others will e-mail at one o'clock in the morning."

MHP 4.0 Elements of effective collaboration. This theme highlights MHPs' perspectives on their efforts to help grow and maintain collaborative relationships with their CSP counterparts. Five subthemes were identified within this theme.

MHP 4.1 Nurturing positive and active relationships. Across multiple interviews, participants shared their opinions about how a positive relationship increases collaboration. When explicitly asked what helps with communication, MHP 9 simply stated, "Relationships," which was affirmed by three other participants in the same focus group. MHP 15 highlights the importance of MHPs' personal efforts to demonstrate commitment to the relationship: "I think personable, and being there, and being available for calls or texts….what I'll do is make a phone call first and I'll say, 'What is your preference? How would you like to communicate?' And then that's the way I communicate with them."

The above excerpt demonstrates that one must not only want to foster nurturing positive relationships but also make efforts to promote such relationships. MHP 22 discusses the magnitude of effort made by some MHPs to actively engage in their interprofessional relationships: "If you do it the way [name omitted] does, I mean you are working non-stop. I mean non-stop. Like phone calls in the middle of the night. And she's not the only one I've heard this from…multiple people…really put that effort in to make…contact."

Not devoting effort to these relationships was identified as a barrier to collaboration. When explicitly asked about barriers to communication, issues such as "wrong phone numbers" (MHP 12 and 13) and "not knowing who the [assigned CSP] is" (MHP 22) were identified as problems that impede effective interprofessional collaboration.

MHP 4.2 Professionalism. Building a positive relationship is important. Professionalism within these relationships is also viewed as part of maintaining successful collaborations. A loss of professional objectivity is described as a risk for MHPs:

> "Treating clinicians also have strange ideas about what they're treating…The most common one that I encounter is…where somebody has really just either lost or abandoned...a stance of…neutral objectivity…and they'll either become an advocate, very strongly for someone, or...put themselves in the position of judging matters that they have incomplete information about." (MHP 24)

Other MHPs discussed the dangers of being overly familiar with their counterparts. MHP 9 (with MHP 4 in agreement) shared an example of how lack of professionalism may be an interfering factor: "…The other thing that is a barrier is irrelevant information. Gossip, what I call clinical gossip. It's nice to hear, but…it's not necessary. It wastes a lot of…time."

MHP 4.3 Mutually defined roles. Multiple MHPs described the importance of focusing

on the roles defined previously (i.e., "Individual Characteristics and Roles"), much of which concerns their traditional role as clinical service providers. Many MHPs endorsed a view that the court and CSPs strive to make MHPs another form of legal enforcement, which MHPs resist. Similarly, while MHPs acknowledge their role in advocating for their clients, they recognize the importance of respecting their CSP counterparts' authority and decisions.

"…For me it was helpful to have a clear differentiation on roles. I'm not going to tell a [CSP] how to do their job. I'm not going to punish people. That's their job, not mine. I don't want them telling me what…I should be focused on in treatment…or something like that. I'm happy to listen to their input, but I'm the final say on that, and they're the final say on the punitive side of things." (MHP 31)

A notable discussion related to this topic centered on challenges to effective collaboration in rural communities. Specifically, the lack of specialized resources can contribute to blurring of defined roles. MHP 9 summarizes this issue:

"If we could all follow the Clint Eastwood rule of, 'a good man knows his limitations' and we stay focused within what we know and stay out of what we don't know…I think that would be better. But the problem in rural areas…is that…most of these people are trying, and including providers…often left to do multiple jobs that aren't always consistent. In other words, they have different purposes and procedures, but they're asked to do them and…they get blended. 'Well that's supervision issues. (sic) That's a clinical issue. This is a family issue. This is a personal choice.' …I think that poses difficulty."

MHP 4.4 Perspective taking. MHPs endorse the importance of role delineation between themselves and their CSP counterparts. They also acknowledge that differences in roles and

professional goals can lead to disagreements and frustration. Several MHPs described managing

interprofessional differences by considering the perspective of CSPs and negotiating

collaborative goals appropriately. For example:

"…One of the things we have to recognize is that…different agencies have different

goals and objectives and purposes, and they're not always mutually,

collaboratively, cooperatively directed. So when you've got…different goals and

objectives that have to be met, there's going to be disagreement. …A relationship

built on respect and good honest communication…is...the most successful." (MHP

9)

"…What I try be mindful of is that we're…all in the best interest of the client,

and…we might have differing beliefs about their treatment, but…our hope is…to

help the client…even if we're on different pages. So I have to…keep that in my

mind so I don't become overly frustrated." (MHP 2)

MHP 4.5 Having multiple modes of communication is good, though direct

communication is better. As noted above in the "Characteristics of Communication" theme,

contemporary interprofessional relationships must navigate the benefits and costs of integrating

modern technology. While using technology increases connection between two professionals,

communication modes which are more direct (i.e., face-to-face contact or telephone

conversations) can provide MHPs and CSPs with more and nuanced information. This was

highlighted in a focus group discussion between three participants:

"Some of the things that make the communication easier have also…interfere[d]

with relationships. So e-mails, texts, things like that that make it easier to get

information from other people…[but have] created not the kind of relationship that

we really need to share information." (MHP 9)

"I would agree with that, because even if you can't even have them in person, just talking to them on the phone creates tons…more information than it would be if you're sending an e-mail." (MHP 3)

"Yeah, because you can explain situation in more detail." (MHP 5)

MHP 5.0 Involvement of the Courts. The majority of collaborations discussed by MHPs occur at the community supervision agency level (e.g., child welfare). On several occasions, however, participants discussed their experiences of direct or indirect collaboration with the courts as part of their interprofessional duties. Here, the dynamics of working with the courts are illustrated, with consideration of how community supervision agencies are involved.

MHP 5.1 Courts retain a superior role. The structure of the legal system engenders the courts with a defined authority that supersedes the power of treatment providers. Thus, the relationship between the courts and MHPs is functionally imbalanced, with MHPs in defined service to the courts. Several MHPs discussed their frustration with this power imbalance, as highlighted by MHP 10:

> "How they utilized us…has changed. Twenty years ago when the courts were referring clientele to us, it felt much more that they were expecting results and wanted to see results, and now they're expecting us to be part of their philosophy. So, it's no longer they're expecting us to do treatment, they're expecting us to help them be part of the punitive schema. …So now I think it's become more and more that they're looking for partners that adapt their philosophy…. If we don't have a certain court's attention or we don't have a certain relationship with the court, then we're not part of their system and they think they're better."

At other times, MHPs are placed in the position of balancing the orders of the court with the practical demands of healthcare service, such as reimbursement. MHPs sometimes must be creative in their duties because they are not in a position to negotiate certain court recommendations. For example:

> "…Some of the things that are court ordered…insurance won't cover. Like the difference between case management and outpatient therapy. You know we're not supposed to do outpatient therapy in the home, and so we do case management. But they really don't need the case management, they need the skills…. Well, we can help them with that but insurance won't cover it." (MHP 6)

MHP 5.2 Courts provide specific mandates for MHPs to follow. As a function of the power of the court, MHPs are expected to provide defined services to referred clients. Often, this concerns providing a specific service within a delineated timeframe. This may be a challenge given the circumstances of the case. For example:

> "…At times with the courts…the judge will have…a 60 or 90 day review; so they will…bring it back in 60-90 days because they want to find out what kind of progress has this person made. Have they completed? Are they being compliant? Or are they not being compliant? And…there is that window…." (MHP 19)

> "If a judge is telling a parent that they have to do parenting education in order to get their kids back at a certain time, do we have enough time to be effective in it? I don't know that the answer…is yes, not before the next court date. And perhaps we can let it roll over; people don't…want to see that. They've given multiple tries, attempts, to this family already, and…their frustration levels are probably a little slim…. And the expectation is that they are starting to follow through after six

months and trying to pursue it. They expect them to…get it done." (MHP 22)

MHP 5.3 Expectations vary by court. Many MHPs or agencies interact with multiple courts, particularly in rural areas where there are fewer specialized healthcare services. Thus, MHPs must interact with the courts on an individual basis, based on the characteristics of the presiding judge. This is best described by MHP 11:

> "Depending on [the] judge…certain judges have…their own advocacies. So certain individuals might be more heavily against drunk driving or might be bigger advocates for recovery in a treatment program versus jail time. And so, I think that it becomes...I don't necessarily say subjective…but the law allows for a big difference in many cases of…getting sentenced."

Furthermore, MHPs may have to interact with the same court on a case by case basis. MHP 24 highlights this: "Sometimes the court will send a family to us and say, just do what you can to help them. …It just varies from case to case."

MHP 5.4 Courts may have a limited understanding of mental health services. As noted above, MHPs express some frustration when courts mandate specific time frames or services that do not fit their model of service reimbursement. More broadly, though, MHPs discussed their struggles with matching services to mandates. They expressed that judges often do not understand the dynamics of mental health treatment. It then requires MHPs, from their perspective, to provide services that not only meet the mandates of the court but are understood by the court as well.

One such example of this is the use of specific curricula to address court-ordered treatment targets. MHP 22 describes this process of supplementing individualized treatment services for the sake of the courts:

"If there is a specific recommendation that is court ordered, like anger management, [alcohol and drug treatment]…there is…a set curriculum that we go by because we've got to give the court something….[You] have to…back up what you've done with your client. …Sometimes as mental health professionals it's hard to convey to the court, because they don't understand mental health, what you were working on…in session."

A separate dynamic is how the courts may fail to recognize the workflow and priorities of MHPs. Courts may hold expectations of MHPs that are beyond the range of their capability given the breadth of their duties. Unfortunately, this may cause discord between MHPs and the courts. MHP 10 outlines this issue in detail:

"One big hardship we've had is…the court's expectations about us being present at court to give our input about how clients are doing. We have a difficult time being physically present because we don't know…how long we're going to have sit there. And again, we don't work for the court; the court doesn't fund us. …Sitting there for eight hours because our client's at the end of the docket is very unfair…because [we're] paid to see clients and do work, not sit…and wait for court. And that put us in a bad scenario with some courts that have had other providers do that service…so we found that communication breaks down when we're not going to court…the whole day just to give our report. …We found that some courts have not liked that."

MHPs' comments highlight disconnect between court orders and reasonably available services. Particularly in rural areas, specialized services are of limited availability, and judges may have preconceptions of treatment needs that result in orders that are difficult to fulfill in a timely fashion.

"[In this region]…there's 20 beds…detox space, and there's 10…male beds, residential. There's 15 or 18 female beds after detox. And the judges have...this concept that…he's gotta (sic) go into a 28-day program. I'm not going to let him out of jail until he gets a bed in a 28-day program.' Right. …We know that may be four to five months…and where's the funding source…coming from jail? It's very…limited…what we can do." (MHP 32)

MHP 5.5 CSPs can mediate the division between the courts and MHPs. MHPs are not always able to interact with the court on the court's terms. Certain community supervision agencies, as a matter of standard operating procedure, place greater emphasis on interacting with the courts and the schedule or expectations of the court. Thus, CSPs can act as go-between for MHPs when dealing with the court. This is described by MHP 31: "The [CSP] had a little more say because [they] would go in, the judge would say, 'How are they doing?' and the [CSP] would say, 'They're all better!' or, 'They still have some work to do,' or things like that. And the judge would just go off of that."

A more specific example is provided by MHP 25, from the perspective of a therapist-in-training:

"…One individual…was mandated to treatment…for substance use related problems, and the judge…said he had to go to group and individual, but they didn't specify any sort of time. Well, with this individual, he couldn't afford both group and individual, so his probation officer made an addendum or change and submitted to the judge so that he could still be mandated to treatment but still be able to see me."

CSPs' Experiences with Interprofessional Services

Thematic analysis of CSP interviews yielded four major themes associated with communication and collaboration: 1) collaboration and service coordination, 2) recognizing roles, 3) when conflict occurs, and 4) lack of knowledge about other professionals. Table 6 summarizes the definitions of these four themes.

Table 6:

Major Themes and Definitions for CSP Interviews

Theme	Definition
Collaboration and service coordination	This theme refers to the extent to which CSPs either within the same agency or within differing agencies collaborate and work together, as well as how well services are coordinated within and across agencies. This includes how well (or not) different parties communicate with one another, barriers or facilitators to collaboration and communication, and whether or not communication and collaboration are achieving desired goals.
Professional roles	This theme describes the recognition of differing roles or responsibilities associated with being a CSP. Important elements of this include how well (or not) those roles are defined, how they are communicated, and how people feel about their ability to do their jobs within those defined roles.
When conflict occurs	Here, CSPs describe the experience of conflict with other agencies or other professionals within their own agency that they attribute to differences in priorities, roles and/or responsibilities, or approaches to offender management. This theme may also include discussion of how those conflicts are resolved or their impact on offender outcomes.
Lack of knowledge about other professionals	This theme includes recognition on the part of the CSPs that they lack education about treatment providers' work, mental health needs of offenders, or available services in the community. It may also reflect that people working in probation may lack basic understanding of what to ask other agencies or providers about an offenders' treatment or mental health needs.

CSP 1.0 Collaboration and service coordination. CSPs identified several aspects of collaboration with MHPs that highlight their appreciation for these relationships. They also discussed some of the dynamics of the collaborative process, as well as ways their relationships are functionally challenged. Four subthemes are identified here.

CSP 1.1 Communication is valued. CSPs uniformly acknowledged the importance of communication with their MHP counterparts. Their comments varied in detail across interviews according to the type of contact and administrative restrictions placed on collaboration. Nevertheless, these interviews highlighted how CSPs viewed collaborating with MHPs as beneficial to their work goals. For example, in the case of CSPs with more autonomy in their professional relationship:

> "So we would have a little bit of back and forth when it came to [the priorities for the client]. But we were always able to come to some kind of conclusion together… there was definitely some…little blurred lines when it came to deciding which one was more important in that moment." (CSP 2)

In contrast, another comment highlights valuing communication in light of more restrictive operating practices:

> "…I would like the [mental health staff] to actually tell us, 'Hey, you know, this person has an anger management problems,' or, 'This person needs this.' You know, we have a lot of mentally ill people, like I said, and if she told us a little bit more of how to treat them, and if we had a little bit more training on how to treat them, then that'd be better." (CSP 1).

CSP 1.2 CSPs are the gateway to mental health services. Regardless of setting, CSPs saw their role as initiating mental health services for offenders. This appears to be, in part, a

function of ensuring that CSPs focus on supervision and utilize other services already available in the community. CSP 4 notes this in the context of direction from the office supervisor:

"Sometimes [supervisors] want us to talk to [MHPs], and sometimes they didn't. …You're not [the clients'] babysitters. You need to find out if they're going, but other than that…you get them where they need to go and then it's none of your business. So…we would communicate just to make sure that they are actually going after they said that they were."

Some CSPs expressed frustration with their limited role in the communication process:

"Our roles are so defined, having a little bit more leeway with being able to… work with them on our end instead of just… saying, 'Sorry, can't do anything. You need to go to this other agency.' I think being able to communicate between their case worker there and…our probation officer or something, you know being able to work together instead of just sending them back and forth, I think that would have helped a lot more." (CSP 2)

CSP 1.3 Confidentiality standards as a barrier to collaboration. A recurrent topic across interviews was how CSPs must navigate the confidentiality standards of healthcare professionals. Generally, CSPs appeared frustrated but accepting of confidentiality rules healthcare professionals are required to follow. For example:

"There is a part of me that wishes that…we could communicate more with agencies and families to kind of see what everybody needs, but at the same time, it was really difficult just to figure out what could be said without breaking confidentiality." (CSP 2)

While confidentiality rules were acknowledged as a global barrier to open information exchange,

CSPs suggested that healthcare providers' attitudes towards confidentiality standards can impact the quality of the professional relationship as well. For instance, CSP 3 notes that providers with stricter interpretations of confidentiality standards may be more resistant to collaboration:

> "The facilities and probation need to talk about [treatments] because if you're failing on mental health level, you're gonna (sic) fail on probation, and if you're failing probation you're probably failing in mental health…. And sometimes that's hard because even when you communicate [through]…a release of information, they get angry because they feel like you're accusing them of doing something when more you're trying to confirm it."

CSP 1.4 Apathy as a barrier to collaboration. Finally, some CSPs described their colleagues as being disinterested in collaborating with other professionals. Whereas some CSP supervisors were noted above to limit their subordinates' work duties in favor of efficiency, this particular subtheme speaks to front-line professionals' burnout and subsequent loss of compassion when working with offender populations. As noted by CSP 1:

> "A lot of people don't care. They think…, 'Well, I'm just going to do my eight and hit the gate,' and, 'It's just, it's not my problem.' …A lot more [CSPs] feel like that than most…and I think the long-timers…have just lost all compassion. It's really easy to lose your compassion in that type of environment."

CSP 2.0 Professional roles. This theme focuses on CSPs' roles and responsibilities, including perceptions of primary duties, roles relative to MHPs, and the relationship to the courts in light of interprofessional collaborations. Some of these professional roles are internalized, while others appear more driven by the CSP supervisory structure.

CSP 2.1 Enforcing conditions. A primary responsibility of community supervision is

law enforcement, as well as managing the behavior of the offender in the community (Klockars, 1972; Schwalbe, 2012). Consistent with the theoretical expectations of probation and parole, CSPs have a duty to ensure that offenders are complying with conditions imposed on them by the courts or other related agencies. CSPs here discussed the importance of maintaining order for their clients, which often needed to be placed ahead of their desire to act on compassionate impulses. For example:

"I…establish the rules so they knew what the rules [are], and they [have] to do it. There wasn't any ifs, ands, or buts. And I think that's how every probationer is… Seeing somebody struggle and not being able to help or try to help I think was the hardest for me. But…I was like, 'I have a job to do and I can't lose my job so I have to follow the rules because I expect them to follow the rules.' So how am I going to tell them, "You have to follow these rules, but here I am gonna go (sic) break these rules, but it's okay." (CSP 3)

CSP 2.2 Making appropriate referrals. Similar to how CSPs view their primary function in the collaborative process as a gateway to treatment, CSPs discussed a major professional role as identifying clients' needs as well as appropriate resources in the community. As described by CSP 4, this compliments their law enforcement role:

"Just because I knew what they were talking about didn't mean that I could actually be in [the treatment provider] role. There was (sic) a lot of times I could have conducted a therapy session in my office with a client but I couldn't because I wasn't being paid for that. …So I would have to say, you need to go see [one MHP] or you need to go see [another MHP]... I would just have to send them off."

CSP 2.3 Informing courts of offenders' progress. CSPs discussed how they are able to

relay status updates from collaborating treatment providers when their clients are evaluated by the courts.   As described by CSP 3: "I think our opinions matter, and…the criminal court judges…do take our opinion into account because we do see them so often… I do think they really give us credit and it does play a role."

CSP 2.4 Maintain professional role boundaries. CSPs described their responsibility to maintain professional identities and roles. This was discussed primarily as a duty of the CSPs' supervisor in prescribing defined boundaries of their duties. For example:

> "I can sit there and say [to the MHP], 'Hey…so-and-so's not having a very good day. This is what they said to me,' and all this stuff. And they'll go talk to [the client]. But, when it comes to like treatment [recommendations], I really don't have any freedom at all. It has to go through the [MHP], and that's one thing that [supervisors] don't want us touching on." (CSP 1)

CSPs did note occasions necessitating firm professional role boundaries as a means of minimizing conflicts with MHPs. In these cases, CSPs described their responsibility to maintain role boundaries in reaction to more aggressive MHPs rather than a supervisory order. As described by CSP 4:

> "I got into it a lot with the treatment facilitator because she would always try to overstep her boundaries in a sense. Like, 'You're the treatment facilitator and I'm the [CSP], and I…know what I'm talking about... You can't tell me how to conduct my office visits or house visits to treat this one client.'"

CSP 3.0 When conflict occurs. CSPs discussed conflict with other agencies. Primarily, they emphasized two major sources of conflict when interacting with MHPs.

CSP 3.1 Overemphasizing role boundaries and identity contributes to conflict. In each

of the previous two themes, CSPs discussed the importance of maintaining role boundaries when

engaged in interprofessional practice. In contrast with these earlier themes, CSPs noted that

taking such delineation of roles too far can impede collaboration. This was manifested as

conflict when professional boundaries are not respected; for example:

> "I would say that [the professional roles] were pretty clear. We kind of knew what
>
> we were required and what other agencies required, to the point where each agency
>
> would kind of get a little miffed if you stepped on toes or you crossed that line a
>
> little bit. You know, like, 'That's my job, don't do my job,' you know, that kind of
>
> thing. So they were almost that clearly defined, that people would get a little upset."
>
> (CSP 2)

Furthermore, CSPs described instances when MHPs' professional identity is as challenging as

having strict role boundaries:

> "I think we all need to work together – it doesn't matter who you work for, who you
>
> are, what degree you have. And that's for anywhere. I just feel like there are some
>
> people who have all these degrees who don't care about communicating." (CSP 3)

> *CSP 3.2 Different priorities contribute to conflict.* CSPs have a dual responsibility to

provide structure and support to their clients (Klockars, 1972). In contrast, MHPs in this context

primarily focus on behavior change and addressing pathology relevant to community stability

(Heilbrun & Griffin, 1999). The differential focus of CSPs and MHPs can generate

disagreements. As highlighted by CSP 2:

> "We had… completely different ideas about what was important…. Where I might
>
> have thought [the clients'] sticking to the rules of…[the Department of Corrections]
>
> is more important than getting what [the MHPs] might require, just because if [the

clients] don't do what…they're supposed to do…, they're gonna (sic) go back to prison. Whereas there is a little bit more leeway when it comes to [MHPs] because they're not going to go back to prison."

CSP 3.3 Working collaboratively can resolve conflict. CSPs identified the solution to these conflicts as building healthy and professional relationships between CSPs and MHPs, where each respects the experience and roles of the other. Functional professional relationships are described as non-competitive and acknowledge the contribution each professional makes to the service of the client. CSP 3 best elaborates on this:

"I think people just need to lose who they are…and focus on the client and help them. Talking with [each other] and brainstorming…because sometimes they can bounce ideas off of you or they can be like, 'Well, I don't know if I want to do that, maybe I'll do this route or talk to [someone else] and maybe do this.' So that was really helpful… and I think sometimes people get caught up in who they're working for and are like, 'I can't discuss with you because you don't work here, you don't understand what we're doing,' and they'll get defensive. It's not about being defensive, it's about helping the…clientele."

CSP 4.0 Lack of knowledge about other professionals. Finally, several CSPs acknowledged that they or their supervisors lack education about the nature of MHPs' work, or the general availability of services within the community beyond their typical interprofessional partners. This includes the impact on the functionality of collaborative relationships.

CSPs who lack training about serious mental health conditions like personality disorders or psychotic disorders may fail to recognize important symptoms and thus misattribute behavior as being willfully oppositional. As a result, CSPs may be less invested in involving mental

health systems in the management of their clients. As discussed by CSP 4:

> "I had a lot of clients [with] borderline personality disorder, and I had a few clients
>
> that had been diagnosed with schizophrenia so I knew how to approach them… but
>
> a lot of [CSPs] don't know that there's a mental health aspect to it, and so they don't
>
> know what to do. But there were a few trainings that they allowed us to go to. There
>
> was…a mental health CPR…but only me, my supervisor, and one other [CSP] even
>
> wanted to go - so it was 3 out of 9. Nobody else wanted to go."

In other cases, training is simply unavailable, as it is deemed outside of the professional scope of
the CSP role. Thus, CSPs may attempt to engage clients with significant mental health
symptoms without sufficient understanding of their needs. For example:

> "I only have a bachelor's degree in psychology, but when I have [a client] in a room
>
> and he thinks there's a dog in there with him… and I know there's no dog, I know
>
> that I'm not supposed to feed in to it. But, you'll have other [CSPs] that will. That
>
> will be like, 'Oh, you know, what's the dog's name?' and all this stuff. You don't
>
> need to be doing that, and we don't get training on that at all." (CSP 1).

Aim 2: Comparison of MHP and CSP Partnerships with Interprofessional Healthcare Best
Practice Standards

At present, interprofessional best practice standards have not been adopted by
MHPs and CSPs. Interprofessional standards adopted by healthcare systems (see IPEC,
2011) are a baseline from which to examine the aspects of interprofessional practice
discussed thus far that meet a best practice standard. Here, I examine how the themes
and subthemes overlap with the four major competencies of IPEC best practice standards
(IPEC, 2011). Findings regarding the overlap between subthemes identified in Aim 1

and specific subcompetencies within each major IPEC category are presented below. Subthemes associated with each IPEC category were aggregated to form a composite theme.

IPEC Competency 1: Values and Ethics (VE)

This competency emphasizes the values associated with effective interprofessional practice within the context of healthcare, involving relationships with other professionals as well as clients. As seen from Aim 1, several of the specific aspects of VE overlap between MHPs and CSPs, though the differential objectives of the healthcare system versus community supervision are evident from the focus on how the client is involved in the interprofessional relationship. Of the ten VE subcompetencies identified in the IPEC guidelines (IPEC, 2011), nine share commonalities with MHP interview themes and six overlap CSP interview themes.

VE subcompetency 1 does not appear to have significant association with any subthemes from the initial thematic analysis. This subcompetency advises that clients should be placed at the center of interprofessional collaborations. The initial thematic analyses of both MHP and CSP interviews demonstrated more focus on the interprofessional relationships than on the relationships with clients. This may be due to the demand characteristics of pre-determined interview questions, as well as differences in how healthcare goals drive IPEC competency, rather than the differentially aligned goals of MHPs and CSPs. A major, recurrent theme within the interview data is that MHPs and CSPs have roles to play in relation to their clients, though in these cases interprofessional practice strives to supplement one's own professional goals. This contradicts the focus of traditional healthcare relationships, where multiple providers

collaborate to promote shared client-driven outcomes.

Subcompetency 2 concerns the issues of patient dignity and privacy in the context of interprofessional care. Privacy guidelines are strongly emphasized in mental health practice but were not as strongly represented in the current MHP interviews. Nevertheless, privacy practices were discussed as a component of formal communication standards (MHP 3.2). However, this subcompetency was most associated with the second subtheme identified among the elements of effective interprofessional relationships, that being professionalism (MHP 4.2). MHPs discussed the importance of maintaining an objective focus on clients as a component of healthy professional relationships. One interview highlighted the issue of gossip within professional relationships, a practice that represents a threat not only to respecting clients' dignity but also to maintaining confidentiality.

Subcompetency 3 advises the importance of both cultural and individual differences of other professionals and patients, and similarly, subcompetency 4 concerns respect for professionals' values and roles. The first three subthemes of "Appreciation for and process of collaboration" (MHP 1.0) involve valuing professional diversity in MHP/CSP partnerships (MHP 1.1), as well as recognizing that valuing this professional diversity can actually improve these relationships (MHP 1.2) and increase the efficiency of treatment services (MHP 1.3). This is also seen in the chief subtheme of the "Elements of effective interprofessional relationships" theme – nurturing positive and active relationships (MHP 4.1) – with the importance of embracing professional diversity as a means of promoting the interprofessional relationship. Elements of these subcompetencies are also evident within one of MHPs' identified roles, maintaining

professional relationships (MHP 2.5). Here, MHPs recognize the need to adapt to the professional culture of CSPs for the sake of promoting interprofessional relationships.

In contrast, CSPs did not reciprocate with a similar focus on subcompetency 3. CSP interviews did elicit overlap with subcompetency 4, however. CSPs expressed this first in the "communication is valued" subtheme (CSP 1.1). Conversely, in fourth major CSP theme, "Lack of knowledge about other professionals," CSPs expressed that while many of their peers lack a basic understanding of mental health practice, an improved understanding could lead to greater interprofessional respect.

Subcompetency 5 emphasizes the importance of cooperative practice with other professionals, as well as patients. Again, collaborating with clients was not emphasized in MHP or CSP interviews. Instead, cooperative practice is reflected in the roles MHPs play to provide a service to the court (MHP 2.2) and maintaining the relationship with CSPs (MHP 2.5), and how CSPs facilitate clients' entry into mental health services (CSP 1.2, CSP 2.2). This subcompetency is also reflected in MHPs' discussion of their relationship with the courts, in that MHPs acknowledge the need to cooperate with the courts due to their power differential (MHP 5.1) and the subsequent court directives that MHPs are required to follow (MHP 5.2).

Subcompetency 6 primarily concerns developing relationships with both clients and other team members. This is clearly connected to the subtheme of nurturing positive and active relationships (MHP 4.1) as MHPs noted that actively working to build a healthy partnership with CSPs was a key component in maintaining these relationships. CSPs similarly described the importance of the interprofessional relationship as a key component of resolving disagreements with their MHP counterparts (CSP 3.3). MHPs

identify maintaining these relationships as one of their main roles in interprofessional practice (MHP 2.5). MHPs also discussed the role of ensuring clients of professional boundaries (MHP 2.4) as a key component of ensuring positive relationships with clients. However, MHPs described this less often as a core duty and more in terms of their reaction to the problems faced by clients within community supervision structures.

Subcompetency 7 focuses on maintaining high ethical standards when collaborating with other professionals. This directly overlaps onto the professionalism subtheme of elements of effective relationships (MHP 4.2), which highlights the importance of maintaining one's professional standards while nurturing a professional relationship. This may include maintaining professional boundaries, such as confidentiality (MHP 2.4, 3.2), while working to minimize barriers. Also, this subcompetency overlaps with MHPs' advocacy role (MHP 2.3). MHPs recognize that, at times, they may need to provide context and perspective to their CSP counterparts on behalf of their clients. The goal is to ensure the best possible outcomes for their clients, recognizing that this perspective is not similarly embraced by CSPs.

Subcompetency 8 addresses the management of ethical dilemmas in an interprofessional context. Ethical dilemmas were not explicitly discussed by MHP participants, and CSP participants discussed ethical issues only in the context of either MHPs or CSPs encroaching on the others' professional autonomy. Specifically, CSPs discussed how participants or their supervisors held a responsibility for enforcing interprofessional role exclusivity (CSP 2.4). In contrast, MHPs discussed interprofessional priorities that can guide ethical decision making in light of their professional code of conduct. Specifically, MHPs identified duties to clients in the form

of clinical service (MHP 2.1), advocacy (MHP 2.3), and assuring clients of their interprofessional boundaries (MHP 2.4), and duties to CSPs through their focus on providing a service to the court (MHP 2.5) and their self-adopted responsibility to maintaining these relationships (MHP 2.5). Relatedly, MHPs discussed the importance of professionalism (MHP 4.2), and providers who value professionalism ideally will be aware of and address ethical issues as they arise.

Subcompetency 9 focuses on the importance of acting with honesty and integrity. Again, this overlaps strongly with the subtheme of professionalism (MHP 4.2) with regard to MHPs' interactions with CSPs. This is also relevant to maintaining professional relationships (MHP 2.5), in that honesty and integrity may facilitate healthy interprofessional collaboration. In addition, efforts to communicate professional boundaries to clients (MHP 2.4) are also noted as a means of demonstrating honesty and conveying integrity. CSPs' role of enforcing supervision conditions (CSP 2.1) is discussed frequently, emphasizing genuineness when interacting with clients. Similarly, CSPs discussed their role related to MHPs and the courts as one based in the courts' trust of CSPs (CSP 2.3), a role requiring the honesty and integrity directly discussed in this subcompetency to be effective.

Subcompetency 10 advises the maintenance of competency within one's own profession. This is not directly reflected in either the MHP or CSP themes for Aim 1. However, as clinical service is a major role for MHPs working in interprofessional settings (MHP 2.1), this may be indirectly related to this subcompetency. Ideally, MHPs maintain their practice standards at least to licensing standards, though this is not fully guaranteed. CSPs also indirectly discussed the role of maintaining professional

standards. This was highlighted by how CSP supervisors provide structure to participants

to ensure they are correctly engaging in the professional functions (CSP 2.4) versus

engaging in activities delegated to other professionals (e.g., providing therapy services).

IPEC Competency 2: Roles and Responsibilities (RR)

This competency involves an individual professional's role in relation to the roles

of partnering professionals. This includes both one's own service delivery as well as how

one's own practice is interdependent on the roles and responsibilities of partner

professionals (IPEC, 2012). IPEC (2012) advises not only the recognition of one's

professional skill but also the limits of expertise and the need for collaboration in

addressing complex problems. This competency was strongly reflected in MHP as well

as CSP interviews.

Subcompetency 1 considers the communication of one's role to both clients and

to other professionals. CSPs gave considerable attention to the need to communicate and

maintain role boundaries between their officers and the MHP counterparts (CSP 2.4).

Conversely, MHPs discussed their role as providing a service to community supervision

programs (MHP 2.2) and mutually defined roles between MHPs and CSPs (MHP 4.3);

thus MHPs must explicitly outline the services they provide as well as the expectations of

community supervision programs that they are unable meet (e.g., functioning as an

additional arm of supervision over therapeutic service). Additionally, MHPs

communicate their interprofessional roles to clients by providing assurances to clients of

their professional boundaries (MHP 2.4).

Subcompetency 2 concerns acknowledging one's own limitations. MHPs

acknowledge the benefit and need of having CSPs provide a supervisory role in the

mutually defined roles subtheme (MHP 4.3). CSPs did not discuss the importance of defined roles in the context of maintaining boundaries, but this subcompetency is reflected in the theme "Lack of knowledge about others" (CSP 4.0). CSPs discussed how their training in mental health issues is often limited, and how they could benefit from improved cross-training.

Subcompetency 3 advises drawing on diverse resources in interprofessional collaborations to meet clients' needs. This is reflected in two roles identified by MHPs as most relevant to interprofessional practice – providing a service to community supervision programs (MHP 2.2) and maintaining these relationships (MHP 2.5). CSPs mirror the MHP roles here, as they describe themselves as the gateway for many clients to enter into treatment services (CSP 1.2). Additionally, both MHPs and CSPs view interprofessional collaboration as contributing to services they provide, either by increasing the efficiency of their services (MHP 1.3) or by reducing conflict between service goals (CSP 3.3).

Subcompetency 4 recommends communicating roles and responsibilities among collaborating professionals. MHPs discussed a major role is to discuss with clients how they are differentiated from their CSP counterparts (MHP 2.4).

Subcompetency 5 directs the use of the "full scope of knowledge, skills, and abilities available to healthcare professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable" (IPEC, 2011, pp. 21). In the spirit of the "full scope" standard, this applies to all five subthemes of the "Individual characteristics and roles theme" (MHP 2.0) and the four subthemes of the "Professional roles" theme (CSP 2.0). These themes encompass the clinical skills MHPs apply to their

interprofessional practice, the supervisory guidelines CSPs apply in their typical work, and ability and need to manage interprofessional interactions by both parties.

Subcompetency 6 advises the identification of each team members' roles and responsibilities. CSPs do acknowledge the importance of communicating with their MHP counterparts the limits of each party's role in interprofessional practice (CSP 2.4). In contrast, MHPs' described work showed several similarities to this subcompetency. The mutually defined roles subtheme (MHP 4.3) is related to this subcompetency. In contrast, though, the relationship of MHPs to the courts (MHP 5.1) complicates the implementation of this subcompetency. The power differential between the courts and MHPs results in a more prescriptive dialogue, where MHPs are directed to provide services (MHP 5.7), and the deficits in the courts' understanding of mental health practice (MHP 5.4) complicates how MHPs provide these services. With regard to how this subcompetency is successfully implemented, MHPs appear to be most able to communicate their duty to the court through the mediation of CSPs (MHP 5.5), who have a more direct relationship with the courts.

Subcompetency 7 concerns the development of interprofessional relationships. The interdependent aspect of this subcompetency can be seen in the first three subthemes of the "Appreciation for and process of collaboration" theme (MHP 1.0). Here, MHPs discuss the impact of an interdependent focus on the quality of their services (MHP 1.1), relationships with CSPs (MHP 1.2), and the impact on providing services (MHP 1.3). Similarly, CSPs discussed the importance of communication, primarily as a resource for increasing the opportunities for clients to receive services (CSP 1.1) and improving the efficacy of service provision by reducing conflict (CSP 3.3). MHPs' duty to maintain

these relationships (MHP 2.5) is also associated with this subcompetency. The
application of this subcompetency is evident from the role CSPs play as mediators
between MHPs and the courts (MHP 5.5).

Subcompetency 8 was not represented in the thematic analysis of MHP or CSP
interviews. This subcompetency advises the participation in collaborative professional
development. Although both MHPs and CSPs acknowledged the importance of nurturing
their relationships, there appeared to be greater emphasis on maintaining professional role
delineation than the interprofessional development of skills. CSPs did discuss the
perceived benefits of cross-training as suggested by subcompetency 8, but in the context
of the absence of such interprofessional development.

Subcompetency 9 directs professionals to use their unique skills to provide best
practice patient care. At the core of this subcompetency is, again, the realization of
mutually defined roles. Thus, there is an obvious association here with the MHP and
CSP subthemes emphasizing mutually defined roles (MHP 4.3, CSP 2.4). Additionally,
this would include specific roles, including the clinical service (MHP 2.2), advocacy
(MHP 2.3), providing structure to enforce supervision conditions (CSP 2.1), and making
referrals to appropriate services (CSP 1.2, CSP 2.2).

IPEC Competency 3: Interprofessional Communication (IPC)

The interprofessional communication competency emphasizes the importance of
effective communication among professionals as well as patients receiving care.
Differences between traditional healthcare partnerships (for which the IPEC guidelines
are designed) and mental health and community supervision partnerships are more
evident. Current results demonstrate more deviation from this competency than the

previous two. Additionally, the IPEC guidelines begin to show an increasing emphasis on patient inclusion in the team process, which is not strongly reflected in the current findings.

The first subcompetency advises use of efficient communication modalities. This is primarily evident from discussions of the role of technology in interprofessional collaborations (MHP 3.3, MHP 4.5). MHPs made comments regarding how use of technology such as e-mail or text messages can increase the frequency of communication but noted that direct communication (e.g., telephone calls or face-to-face contact) provided a greater quality of contact. Additionally, MHPs discussed formal standards of communication. This broadly concerned the expectations placed on MHPs about communication with CSPs (MHP 3.2), such as the required frequency of contact and expected reports.

Subcompetencies 2 and 3 focus on maximizing communication efficiency and ensuring effective information sharing. These subcompetencies are reflected in the many comments made with regard to the importance of maintaining positive relationships (MHP 4.1, CSP 1.1, CSP 3.3) and MHPs' role in maintaining these relationships (MHP 2.5). An element of maintaining effective relationships included how direct communication (i.e., face-to-face or telephone contact) provides higher quality interactions (MHP 4.5), which is associated with these subcompetencies' focus on effective modes of communication. Further, subcompetency 3 includes special focus on communicating with "confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions" (IPEC, 2012, pp. 23), which strongly resembles the MHP subtheme of professionalism (MHP 4.2) and the CSP

focus on using relationships to reduce professional conflict (CSP 3.3).

Subcompetencies 4 and 5 were not represented within the results of the current analysis. Subcompetency 4 advises professionals to, "Listen actively, and encourage ideas and opinions of other team members" (IPEC, 2012, pp. 23). Competency 5 concerns the importance of feedback provided to other team members. Neither MHPs or CSPs discussed issues related to these subcompetencies in their interviews.

Subcompetency 6 encourages use of respectful language in interprofessional conflict resolution. This most directly relates to the subtheme of professionalism in interprofessional collaboration (MHP 4.2). It also reflects the impact of positive relationships on effective collaboration (MHP 4.1), the importance of collaboration to resolve conflict (CSP 3.3), as well as MHPs adopting a relationship maintenance role when collaborating with CSPs (MHP 2.5).

Subcompetency 7 includes a number of factors the provider must consider regarding the interprofessional team, including professional contribution, experience, and hierarchical relationships. Several MHPs discussed their professional role in relation to the larger collaborative system (MHP 2.0), and CSPs highlighted the importance of discriminating between their work and therapeutic services (CSP 2.4). Notably, MHPs acknowledge providing a service to community supervision programs (MHP 2.5). In this sense, MHPs recognize a role secondary to the services provided by CSPs in the collaborative hierarchy.

The eighth subcompetency here focuses on the role of maintaining a collaborative structure in the provision of interprofessional care. This almost fully correlates with the MHP role of maintaining the professional relationship (MHP 2.5), and similarly the CSP

focus on collaboration to reduce interprofessional conflict (CSP 3.3). The major difference between typical healthcare relationships IPEC competencies target and MHP/CSP relationships is that this IPEC subcompetency focuses on patient-centered care, whereas the collaborative relationships discussed in this study are more commonly driven by community safety concerns.

IPEC Competency 4: Teams and Teamwork (TT)

The teams and teamwork competency provides direction on the maintenance of interprofessional collaborations. As with the IPC competency, there is an emphasis on patient inclusion that is not evidenced in the current study. Furthermore, many of the subcompetencies reflect how healthcare teams work in conjunction with more closely shared goals than the mental health and community supervision partnerships examined presently. Thus, this competency demonstrates the least overlap with identified themes overall.

Subcompetency 1 advises the explicit description of team development, including team roles. This subcompetency aligns with three MHP subthemes: the role of maintaining relationships (MHP 2.5), nurturing positive relationships (MHP 4.1), and mutually defining roles between MHPs and CSPs (MHP 4.3). Together, this represents a constellation of interprofessional structure shared both by collaborative healthcare providers as well as the interprofessional relationships discussed here. CSPs, in contrast, focused more on interprofessional differentiation in collaborative activities (CSP 2.4).

Subcompetency 2 focuses on developing ethical guidelines appropriate to interprofessional practice. Neither MHPs or CSPs discussed the process of developing team-focused ethical standards.

Subcompetency 3 advises the importance of engaging other healthcare professionals to address clients' needs. This is central to how CSPs view their relationship with MHPs - making appropriate referrals as the gateway to community services (CSP 1.2, CSP 2.2). MHPs do not describe "engaging" with CSPs, as they view their role as secondary to CSPs.

Similar to subcompetency 2, subcompetency 4 focuses heavily on the structure of team development, emphasizing patient-centered procedures. This reflects a greater focus on placing patient-centered care at the core of team goals. As previously noted, MHPs and CSPs have goals that are partially exclusive from one another, some of which expand beyond the client-centered focus.

Subcompetency 5 suggests a need for leadership within the interprofessional relationship. MHPs discussed how they, in general, follow the lead of the CSPs with whom they collaborate. This is most reflected in the MHPs' role of providing services to community supervision programs (MHP 2.2). It is also reflected in subthemes regarding the court's superior role (MHP 5.2) and the mandates provided by the court (MHP 5.1), though to a lesser degree since MHPs more directly provide a service to the court than collaborate with them. Although they directly manage the treatment plan for their clients, MHPs recognize that the larger management plan is driven by the CSP and the courts.

Subcompetency 6 directs providers to proactively address conflicts with others. This aligns with three MHP subthemes: the role of maintaining relationships (MHP 2.5), nurturing positive relationships (MHP 4.1), and the perspective taking subtheme (MHP 4.4). CSPs do not discuss issues related to managing relationships in the same detail as MHPs, though CSPs do explicitly acknowledge that conflicts occur, and collaborative

relationships mitigate the severity of these conflicts (CSP 3.3).

Subcompetency 7 advises sharing responsibility for client outcomes. Similar to subcompetency 3, this is associated with how CSPs make appropriate referrals as the gateway to community services (CSP 1.2, CSP 2.2). Furthermore, CSPs actively work to not take responsibility for clients' behaviors, emphasizing the importance of delegating clients' needs to MHPs where appropriate (CSP 2.4).

Subcompetencies 8, 9, and 10 focus on process analysis and improvement. While MHPs discussed their role in managing the professional relationship, there was no mechanism identified by either CSPs or MHPs to evaluate and improve functioning.

Subcompetency 11 directs collaborative providers to perform efficiently, regardless of setting. This only loosely matches the current descriptive data. The best fit for this subtheme relates to MHPs who work with multiple courts, noting how they are required to meet mandates (MHP 5.2) that can vary widely (MHP 5.3).

Aim 3: Perceived Impact of MHP/CSP Partnerships on Offenders' Success in the Community

Broadly, success is discussed as a lack of new charges or violations of conditions of supervision. The interview guidelines for MHPs (see Appendix E) and CSPs (see Appendix F) do not explicitly query participants' beliefs about the impact of interprofessional relationships on offenders' success in the community. However, the characteristics of the interview data assist in defining success as related to other criteria. Here, elements of collaboration contributing to improved outcomes are discussed in relation to specific indicators of success associated with reduced recidivism. These factors are also discussed in relation to the IPEC competencies discussed above.

MHPs did not discuss any direct impact of partnerships on their clients' success in

the community, as defined by successful reintegration and avoiding probation or parole violations. MHPs did indicate that their partnerships maximized treatment services and their outcomes. As prior research has established the benefit of treatment on offenders' success in the community (as defined by reduced recidivism; e.g., Landenberger & Lipsey, 2005; Lipsey et al., 2007; Schmucker & Lösel, 2008), this section focuses on how collaborations benefit treatment as a proxy for community success. Three major dimensions are evident with regard to MHPs' perception of the benefit of collaboration on treatment.

First, as observed from discussions of the clinical service provider role (MHP 2.1), several MHPs describe their duties as a therapist, evaluator, or case manager as the most effective service they provide to their clients. In some cases this was described as direct client service, but some MHPs felt that the therapeutic relationship was beneficial for modeling skills needed for forming appropriate interpersonal relationships. Three subthemes describe aspects of the collaborative relationship that support how MHPs conduct their therapeutic duties.

MHPs indicated that valuing interprofessional collaboration improves the efficiency of their work (MHP 1.3) and makes them more likely to interact with CSPs (MHP 1.2). MHPs describe this as crucial for engaging their clients, particularly those who lack motivation. Thus, CSPs become the enforcement arm of treatment services for clients who would otherwise be unlikely to follow through with clinical referrals. MHPs receive information from CSPs that they would otherwise be unable to access, which in turn can inform targets for ongoing evaluation and treatment planning.

Associated with this subtheme is how technology has impacted collaborative

relationships (MHP 3.3). While relying on indirect communication methods is not optimal for maintaining the professional relationship, utilizing modern communication methods increases the flow of information from CSPs to MHPs. Additionally, MHPs who are willing to use communication method(s) preferred by their CSP counterparts are more likely to receive information necessary for effective treatment.

The second major benefit to clients is that collaborative relationships allow MHPs to serve as advocates in the context of community supervision (MHP 2.3). MHPs have a different professional perspective that provides insight into clients' behaviors, and the therapeutic relationship may provide a better opportunity for clients to discuss their problems than a supervisory relationship with CSPs permits. While the differential professional training and disposition of MHPs versus CSPs contributes to the potency of advocacy, having exclusively defined roles and responsibilities (MHP 4.3) provides greater opportunity for MHPs to gain the trust of clients (MHP 2.4).

Finally, MHPs view their efforts to maintain collaborative relationships with CSPs as a key component in maximizing the benefits of these partnerships (MHP 2.5). Again, MHPs draw an association between coordinating services with CSPs and how low client motivation interferes with participating in treatment. Additionally, maintaining the collaborative relationship can assist with effective service allocation, both in terms of understanding the client's needs and avoiding redundant services (MHP 1.3).

Consistent with maximizing the benefits of treatment-related relationships, MHPs described how working towards healthy, positive, and active relationships promotes effective collaborations (MHP 4.1). Further, MHPs described the need to maintain professional boundaries, both with regard to adhering to professional standards and limits

on communication (MHP 3.2) and a general sense of professionalism (MHP 4.2), as key in creating an atmosphere of safety for clients. As discussed in MHP 2.4, a major role of MHPs is ensuring that clients feel that they can be open and honest in treatment.

In contrast, CSPs did discuss the impact of collaboration on clients' success more directly and concisely than MHPs. This manifests primarily as differential roles in the professional dyad. CSPs view their primary role as providing clients structure in light of supervision conditions imposed by the courts (CSP 2.1). In multiple interviews, CSPs noted the importance of their clients adhering to such rules and the importance of modeling rule-adherence so that they are not re-incarcerated. The secondary role identified focuses on how CSPs provide referrals to appropriate services as an adjunct to the expectations set by probation and parole conditions (CSP 1.2, CSP 2.2). This perspective is consistent with the MHP role of providing a service to community supervision programs, as described above (MHP 2.2).

A tertiary CSP role, maintaining role discrimination between CSPs and MHPs (CSP 2.4), also contributes directly to clients' success in the community. MHPs discussed similar aspects of their interprofessional relationships and duties (MHP 2.4, MHP 4.3), though MHPs focused more on professional differentiation as a means of maintaining professional fidelity. CSPs and their supervisors also focused on the importance of professional boundaries in the service of their primary duty (CSP 1.1), yet here presented it less as a matter of contamination and more an issue of efficient service provision.

These subthemes identified as key to providing effective mental health treatment demonstrated significant overlap with IPEC (2012) standards of best interprofessional

practice. There are, however, certain related subcompetencies identified for Aim 2 that stand out with regard to their repeated association with the subthemes discussed here. The focus of Aim 3 greatly overlaps with the values and ethics principle advising diversity in the professional team (VE 3) and developing a trusting relationship with clients and collaborators (VE 6). For the roles and responsibilities competency, these subthemes overlap with forging collaborations conducive to treatment (RR 7) and defining the exclusive roles and responsibilities of professionals (RR 6). A primary interface with the IPC competency involves maintaining professionalism in interactions (IPC 3, IPC 6). Finally, the subthemes referenced here exclusively overlap with two of the teams and teamwork subcompetencies: the need to engage in and maintain team development (TT 1) as well as providing professional insights to resolve differences in managing clients/offenders (TT 6).

Aim 4: Mixed Methods Analyses

This section examines the endorsement of themes, subthemes, and theme composites (i.e., subthemes associated with Aim 2 or Aim 3 results) within groups based on demographic information obtained from participant surveys (see Appendices B and C). MHP and CSP data are presented in four categories corresponding with Tables 1, 2, and 3: participant education and training, professional experience, caseload conviction data, and caseload client data.

Professional Training

Table 7 provides Kruskall-Wallis *H* statistics for theme endorsement by MHP professional training. Differences were seen by highest degree attained in subthemes MHP 1.1 (interprofessional collaboration is important when providing offender treatment) and MHP 1.5 (motivation to collaborate is heterogeneous among CSPs). Post hoc examination showed greater endorsement of subtheme MHP 1.1 by doctoral level providers, while subtheme MHP 1.5 was

endorsed almost exclusively by MHPs identifying their educational level as other. Differences

across specialized training were present in subtheme MHP 3.1 (who wants information drives

communication). The modal response here indicated multiple training opportunities accessed,

followed by training through conferences or no specialized training, with few receiving training

exclusively through their agency, through formal courses, or other training.

Table 7.

MHP Professional Training

Themes	Highest Degree Attained [a]	Field of Education [b]	Specialized Training [b]	Certifications [b]
1.0	1.02	6.94	3.73	4.18
1.1	9.97 *	3.04	3.90	7.88
1.2	1.58	1.99	1.88	2.09
1.3	1.74	5.95	8.17	3.39
1.4	1.88	2.37	2.91	4.60
1.5	10.77 *	3.64	2.75	1.71
1.6	1.50	7.51	5.92	2.12
2.0	6.18	8.88	5.64	3.84
2.1	1.83	7.89	4.76	5.06
2.2	5.43	4.38	4.00	7.90
2.3	2.20	2.63	3.79	6.27
2.4	1.83	3.40	5.92	3.34
2.5	1.86	3.32	5.31	6.47
3.0	3.18	2.40	4.23	1.90
3.1	7.71	7.03	10.74 *	3.76
3.2	2.56	3.70	2.24	3.25
3.3	1.14	4.08	6.22	1.56
4.0	1.70	2.95	4.29	1.15
4.1	1.92	4.03	1.65	2.14
4.2	3.88	7.49	6.50	9.45
4.3	0.94	3.46	6.90	7.89
4.4	6.42	3.74	6.50	9.45
4.5	1.79	2.32	6.75	1.23
5.0	6.60	3.10	2.29	2.97
5.1	1.18	4.96	0.00	1.71
5.2	1.70	3.10	2.75	9.11
5.3	4.12	2.56	3.66	3.20
5.4	5.35	5.28	1.61	2.57
5.5	1.18	2.19	0.00	0.00

Table 7 (continued).

IPEC Competencies

VE	3.22	5.83	5.55	3.39
RR	3.65	6.89	5.51	4.11
IPC	1.77	3.57	4.98	2.19
TT	2.13	2.78	3.98	1.54
Effectiveness	6.79	1.52	3.63	3.90

p < .05. **p* < .01. ***p* < .001
[a] Kruskall-Wallis *H, df* = 3
[b] Kruskall-Wallis *H, df* = 4

Table 8 highlights Kruskall-Wallis *H* statistics for CSP professional training. These variables did not significantly moderate response patterns among CSPs.

Table 8.

CSP Professional Training

	Highest Degree Attained [a]	Field of Education [b]	Certifications [b]
Themes			
1.0	0.89	2.25	2.25
1.1	0.00	2.25	2.25
1.2	0.00	0.00	0.00
1.3	0.20	1.80	1.80
1.4	0.33	3.00	3.00
2.0	3.00	3.00	3.00
2.1	0.22	0.92	0.92
2.2	1.00	1.50	1.50
2.3	0.33	1.00	1.00
2.4	0.33	1.00	1.00
3.0	1.80	2.70	2.70
3.1	2.00	3.00	3.00
3.2	1.00	1.50	1.50
3.3	0.33	3.00	3.00
4.0	0.22	3.00	3.00
IPEC Competencies			
VE	2.00	2.25	2.25
RR	2.00	2.25	2.25
IPC	0.33	3.00	3.00
TT	0.89	0.92	0.92
Effectiveness	2.00	3.00	3.00

p < .05. **p* < .01. ***p* < .001
[a] Kruskall-Wallis *H, df* = 1
[b] Kruskall-Wallis *H, df* = 2

Professional Experience

Table 9 describes MHPs' professional experience. Several differences were indicated here.

Table 9.

MHP Professional Experience

	Years in Field [a]	Licensure [b]	Professional Association [c]	Agency Type [d]	Mean Caseload [e]
Themes					
1.0	0.94	0.66	3.87	7.72	0.58
1.1	0.67	0.17	5.18 *	12.59 *	1.24
1.2	0.79	0.90	0.31	1.60	1.04
1.3	0.94	0.76	3.60	3.51	0.51
1.4	2.48	3.60	1.38	9.44	0.49
1.5	0.73	1.65	0.68	2.75	0.71
1.6	0.42	2.77	0.73	15.90 **	1.95
2.0	2.44	8.72 **	4.13	1.72	0.30
2.1	1.01	0.14	2.12	4.15	0.80
2.2	5.03 **	12.28 ***	1.22	3.71	0.63
2.3	0.26	0.03	0.80	4.66	0.82
2.4	0.57	0.00	0.14	1.39	0.30
2.5	6.02 **	12.61 ***	2.45	1.50	0.41
3.0	0.75	4.37 *	3.37	4.93	0.21
3.1	1.18	1.85	3.46	6.93	0.28
3.2	0.72	3.78	0.02	1.35	0.36
3.3	0.74	0.93	1.91	4.91	1.57
4.0	1.97	3.73	0.90	3.67	0.35
4.1	1.76	1.81	0.00	1.70	0.28
4.2	0.63	0.05	5.53 *	16.07 **	4.08
4.3	1.60	4.74 *	3.29	2.74	1.49
4.4	3.30 *	3.83	0.63	8.25	1.04
4.5	0.96	1.42	0.09	3.64	3.89
5.0	1.73	1.36	1.06	5.76	10.93 *
5.1	4.64 **	0.92	1.46	4.06	-
5.2	2.87 *	1.27	2.63	11.71 *	-
5.3	0.97	0.32	0.16	9.20	-
5.4	6.86 ***	2.73	0.02	2.74	1.18
5.5	0.48	1.04	1.64	12.13 *	-
IPEC Competencies					
VE	3.66 *	8.86 **	3.53	4.56	0.29
RR	2.04	6.80 *	4.21 *	3.62	0.36
IPC	3.37 *	9.35 **	2.04	4.10	0.31
TT	5.65 **	10.41 **	1.63	2.87	0.29

Table 9 (continued).

Effectiveness	1.24	4.99*	1.14	1.02	0.54

p < .05. **p* < .01. ***p* < .001
[a] Univariate ANOVA, *df* = 20, 11
[b] Univariate ANOVA, *df* = 1, 28
[c] Univariate ANOVA, *df* = 1, 30
[d] Kruskall-Wallis *H, df* = 4
[e] Univariate ANOVA, *df* = 4, 16

Years in field predict significant differences in the endorsement of subthemes MHP 2.2 (providing a service to community supervision programs), MHP 2.5 (maintaining the professional relationship), MHP 4.4 (perspective taking), MHP 5.1 (courts retain a superior role), MHP 5.2 (courts provide specific mandates to follow), and MHP 5.4 (courts may have a poor understanding of mental health services). Differences in experience were seen in items endorsed associated with IPEC competencies, including values and ethics, interprofessional communication, and teams and teamwork. Half of these subthemes (MHP 2.2, MHP 2.5, and MHP 5.4) and the three highlighted IPEC competencies showed higher-than-average endorsement starting at 16 years' experience. Other subthemes (MHP 4.4, MHP 5.1, and MHP 5.2) showed intermittent patterns, with most participants not endorsing these items.

Differences in licensure moderated two themes, three subthemes, and five theme composites. Such differences included theme MHP 2.0 (individual characteristics and roles), and associated subthemes MHP 2.2 (providing a service to community supervision programs) and MHP 2.5 (maintaining the professional relationship). Differences were also present in theme MHP 3.0 (characteristics of communication) and subtheme MHP 4.3 (mutually defined roles). All four IPEC competency composites showed differences by licensure, as did the Aim 3: Effectiveness composite. All themes, subthemes, and theme composites showed elevations among licensed MHPs in post hoc examinations.

Differences by professional association membership were evident in two subthemes: MHP 1.1 (interprofessional collaboration is important when providing offending treatment) and MHP 4.2 (professionalism). Differences were also present in the IPEC roles and responsibilities competency. Again, elevations were seen among MHPs reporting membership in professional associations.

Differences by agency type were present in five subthemes: MHP 1.1 (interprofessional collaboration is important when providing offending treatment), MHP 1.6 (not all systems are sufficiently connected), MHP 4.2 (professionalism), MHP 5.2 (courts provide specific mandates), and MHP 5.5 (CSPs can mediate the division between the courts and MHPs). Subthemes MHP 1.1, MHP 4.2, and MHP 5.2 showed the greatest elevations from providers working directly with the courts followed by providers from community corrections, whereas subthemes MHP 1.6 and MHP 5.5 showed similarly high endorsements from university and community corrections.

Elevations by mean caseload were significant for MHP 5.0 (involvement of the courts). Decreased endorsement of items related to this theme were seen as average caseloads increased. Of note, four of five subthemes associated with this (MHP 5.1, MHP 5.2, MHP 5.3, and MHP 5.4) contained insufficient variability to conduct these analyses.

Table 10 presents Kruskall-Wallis *H* and univariate ANOVA statistics for CSP professional experience. These variables did not significantly moderate response patterns among CSPs.

Table 10.

CSP Professional Experience

	Years in Field [a]	Professional Association [a]	Agency Type [b]	Mean Caseload [a]
Themes				
1.0	1.62	0.57	3.20	7.22
1.1	6.82	0.04	1.25	0.03
1.2	0.15	0.04	0.45	1.47
1.3	0.10	0.14	3.20	0.68
1.4	1.60	0.25	0.45	-
2.0	0.23	-	0.45	1.46
2.1	0.02	0.25	4.05	0.30
2.2	0.07	1.00	0.80	0.03
2.3	0.02	0.25	0.05	7.22
2.4	0.02	0.25	0.45	7.22
3.0	0.54	1.75	6.05	35.06
3.1	0.09	4.00	1.80	1.46
3.2	0.61	1.00	0.20	7.22
3.3	1.60	0.25	0.45	-
4.0	5.87	0.06	0.45	1.46
IPEC Competencies				
VE	0.03	6.25	5.00	35.06
RR	0.03	6.25	5.00	35.06
IPC	1.60	0.25	0.45	-
TT	0.12	0.75	0.05	7.22
Effectiveness	0.61	1.00	7.20	1.46

*p < .05. **p < .01. ***p < .001
[a] Univariate ANOVA, *df* = 1, 2
[b] Kruskall-Wallis *H, df* = 3

Conviction Information

Table 11 details differences by conviction and sentencing type for MHPs' clients. These are reported by the percent of the MHP's caseload for each category. Among clients with misdemeanor convictions, variation in responding was seen only in subtheme MHP 5.2 (courts provide specific mandates to follow). Here, increased endorsement was seen primarily in the 70% misdemeanor range, with a small elevation in the 0% misdemeanor range. No other MHPs indicating statistics regarding misdemeanor convictions endorsed this subtheme.

Table 11.

MHP Conviction Information

	% Misdemeanor Convictions [a]	% Felony Convictions [b]	% Non-Violent Offenses [c]	% Violent Convictions [d]	% Substance Abuse Convictions [e]	% Probation Only [f]	% Parole Only [g]
Themes							
1.0	.53	6.80***	8.17***	3.08 *	7.90 ***	1.44	2.62*
1.1	.53	2.14	1.52	0.42	1.62	0.77	0.63
1.2	.61	1.11	1.16	1.10	1.38	1.39	1.53
1.3	.51	3.33**	4.40**	3.39 **	3.63 **	1.33	2.64*
1.4	1.39	6.01***	6.44***	1.76	5.41 ***	2.30	0.73
1.5	.25	.16	1.12	2.26	1.02	1.10	9.97***
1.6	.41	1.14	6.08***	0.77	7.88 ***	0.60	13.62***
2.0	.71	2.85*	7.19***	2.39 *	3.12 *	3.35 *	1.05
2.1	1.78	3.21*	1.83	1.83	1.63	1.14	6.11***
2.2	1.24	1.54	5.12**	2.33	2.21	1.80	2.18
2.3	.20	1.00	1.60	0.48	9.44 ***	0.34	0.34
2.4	.18	.57	1.64	0.68	4.17 **	0.71	2.98*
2.5	.55	1.86	15.88***	1.40	2.99 *	7.46 ***	1.23
3.0	.80	2.68*	2.32*	1.72	1.62	1.20	0.42
3.1	.93	3.58**	2.08	0.95	2.11	1.13	1.36
3.2	1.57	1.91	1.65	1.66	2.06	1.64	0.44
3.3	1.23	1.99	1.71	2.51	0.91	1.16	0.67
4.0	1.02	4.08**	8.07***	3.81 **	2.81 *	5.88 ***	1.44
4.1	.51	1.28	4.34**	1.98	3.43 **	3.29 *	0.29
4.2	.73	4.38**	11.65***	1.66	9.44 ***	1.93	3.72*
4.3	2.14	4.81**	10.33***	1.62	1.50	3.75 **	0.92
4.4	1.17	1.23	2.00	1.47	1.15	1.59	1.83
4.5	2.12	3.59**	2.05	3.95 **	0.67	3.30 *	0.98
5.0	.59	.88	1.57	0.70	1.17	0.70	0.86
5.1	.10	.30	1.48	0.36	0.72	0.28	2.58*

Table 11 (continued).

5.2	3.56*	5.01**	11.09***	0.22	2.17	3.60**	0.92
5.3	1.11	.54	.74	2.08	1.04	0.98	0.88
5.4	.65	1.04	1.46	0.87	0.46	0.55	1.89
5.5	.46	1.45	-	1.23	.	2.76*	5.19**
IPEC Competencies							
VE	.63	3.22*	18.23***	2.39*	4.11**	6.28***	1.00
RR	.71	3.38**	9.31***	2.79*	3.38**	2.94*	1.34
IPC	.67	2.83*	17.16***	2.14	3.04*	8.22***	1.08
TT	.71	2.43*	23.95***	1.94	3.83**	9.50***	0.99
Effectiveness	.39	.24	1.69	0.24	2.38*	3.96**	0.36

*$p < .05$. **$p < .01$. ***$p < .001$

[a] Univariate ANOVA, *df* = 13, 19

[b] Univariate ANOVA, *df* = 9, 23

[c] Univariate ANOVA, *df* = 11, 21

[d] Univariate ANOVA, *df* = 8, 24

[e] Univariate ANOVA, *df* = 11, 21

[f] Univariate ANOVA, *df* = 16, 16

[g] Univariate ANOVA, *df* = 5, 27

In contrast, several differences by the proportion of caseloads with felony conviction were present. Four of five themes showed significant differences, specifically themes MHP 1.0 (appreciation for and process of collaboration), MHP 2.0 (individual characteristics and roles), MHP 3.0 (characteristics of collaboration), and MHP 4.0 (Elements of effective collaboration). Several subthemes showed differential endorsement by felony conviction rates, including MHP 1.3 (valuing interprofessional service is associated with providing services efficiently), MHP 1.4 (challenges emerging from different systems), MHP 2.1 (clinical service role), MHP 3.1 (who wants information drives communication), MHP 4.2 (professionalism), MHP 4.3 (mutually defined roles), and MHP 4.5 (having multiple modes of communication is good, though direct communication is better). Differences were also seen in the four IPEC competencies. The majority of themes, subthemes, and theme composites showed a general trend towards increasing endorsement of these items with increasing rates of felony convictions among clients. Subtheme MHP 2.1 exhibited an inverse relationship with felony conviction rates. Subthemes MHP 4.3 and MHP 5.2 showed modal endorsement at 30% felony rates. Theme MHP 2.0 and IPEC roles and responsibilities had bimodal endorsements at 30% and 95-100% felony rates.

Non-violent conviction rates also contributed to significant variability in themes endorsed, including themes MHP 1.0 (appreciation for and process of collaboration), MHP 2.0 (individual characteristics and roles), MHP 3.0 (characteristics of collaboration), and MHP 4.0 (Elements of effective collaboration). Differences in subthemes were seen among MHP 1.3 (valuing interprofessional service is correlated with providing services efficiently), MHP 1.4 challenges emerge from different systems), MHP 1.6 (not all systems are sufficiently connected), MHP 2.2 (providing a service to community supervision programs), MHP 2.5 (maintaining the professional relationship), MHP 4.1 (nurturing positive and active relationships), MHP 4.2

(professionalism), MHP 4.3 (mutually defined roles), and MHP 5.2 (courts provide specific mandates to follow). Differences by non-violent offense rate were seen in the four IPEC competencies. The majority of these themes, subthemes, and theme composites demonstrated a modal non-violent conviction rate of 45%, with a normal distribution of endorsement extending from the mode. Exceptions to this included two subthemes (MHP 1.3 and MHP 1.4) with bimodal distribution at 45% and 90%, subtheme 4.3 showing low variation outside of the 90% mode, and a positive correlation between non-violent conviction rate and the endorsement of subthemes MHP 1.6, MHP 4.2, and MHP 5.2.

Endorsement patterns showed significantly less variation by violent conviction rates. Three themes were significantly different by this statistic: MHP 1.0 (appreciation for and process of collaboration), MHP 2.0 (individual characteristics and roles), and MHP 4.0 (elements of effective collaboration). Two subthemes also showed differences on this item: MHP 1.3 (valuing interpersonal service is correlated with providing services) and MHP 4.5 (having multiple modes of communication is good, though direct communication is better). IPEC values and ethics and roles and responsibilities also showed differences by violent conviction rate. Most of these themes, subthemes, and theme composites also displayed a normal distribution centered upon a 15% violent conviction rate, with the only exception being theme MHP 4.0, which was positively correlated with violent conviction rate.

Rates of substance abuse convictions also showed differences in the endorsement of three themes: MHP 1.0 (appreciation for and process of collaboration), MHP 2.0 (individual characteristics and roles), and MHP 4.0 (elements of effective collaboration). Additionally, several subthemes showed differential endorsement by substance abuse conviction rates, including MHP 1.3 (valuing interprofessional collaboration is correlated with providing services

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efficiently), MHP 1.4 (challenges emerge from different systems), MHP 1.6 (not all systems are sufficiently connected), MHP 2.3 (advocacy), MHP 2.4 (assuring clients of professional boundaries), MHP 2.5 (maintaining the professional relationship), MHP 4.1 (nurturing positive and active relationship), and MHP 4.2 (professionalism). All IPEC competency composites showed variability by substance abuse rate as well as the Aim 3 Effectiveness composite. Most of these significantly different themes, subthemes, and theme composites featured significantly elevated modal conviction rates of 40% (MHP 2.0, MHP 2.4, MHP 2.5, MHP 4.0, MHP 4.1, IPEC VE, IPEC RR, IPEC IPC, and IPEC TT) or 65% (MHP 1.6). The Aim 3 Effectiveness composite showed a normal distribution around the modal conviction rate of 40%. Endorsement of the remaining themes and subthemes (MHP 1.0, MHP 1.3, MHP 1.4, MHP 2.3, and MHP 4.2) was positively correlated with the substance abuse conviction rate.

Rates of probation sentencing affected the endorsement of two themes: MHP 2.0 (individual characteristics and roles) and MHP 4.0 (elements of effective communication). Among subthemes, rates of probation sentencing impacted subthemes MHP 2.5 (maintaining the professional relationship), MHP 4.1 (maintaining positive and active relationships), MHP 4.3 (mutually defined roles), MHP 4.5 (having multiple modes of communication is good, though direct communication is better), MHP 5.2 (courts provide specific mandates to follow), and MHP 5.5 (CSPs can mediate the division between the courts and MHPs). All five theme composites showed significant differences by probation rates as well. Most themes, subthemes, and theme composites showed a positive association by probation rates (MHP 2.0, MHP 2.5, MHP 4.0, MHP 4.1, MHP 4.3, IPEC VE, IPEC RR, IPEC IPC, IPEC TT, and Aim 3 Effectiveness). Two subthemes exhibited a normal distribution centered upon the mode of 40% (MHP 4.5) or 80% (MHP 5.2). Subtheme MHP 5.5 showed marked elevations at 30% and 80% probation rates

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only; no participants reporting other rates of probation sentencing endorsed this subtheme.

Rates of parole sentencing showed less impact on theme endorsement. Theme MHP 1.0 (appreciation for and process of collaboration) was the only theme significantly impacted by parole rates. Several subthemes were affected by parole rates, though, including MHP 1.3 (valuing interprofessional collaboration is correlated with providing services efficiently), MHP 1.5 (motivation to collaborate is heterogeneous among CSPs), MHP 1.6 (not all systems are adequately connected), MHP 2.1 (clinical service role), MHP 2.4 (assuring clients of professional boundaries), MHP 4.2 (professionalism), MHP 5.1 (courts retain a superior role), and MHP 5.5 (CSPs can mediate the division between the courts and MHPs). Theme MHP 1.0 and subtheme MHP 2.1 showed a generally positive correlation between endorsement and parole rates, while subtheme MHP 4.2 demonstrated a positive correlation amid sparse overall endorsement of this item. Other significant subthemes showed a notable elevation of endorsement at parole rates of 10% (MHP 2.4), 70% (MHP 1.3, MHP 1.6, MHP 5.2, and MHP 5.5), or both (MHP 1.5) amid generally sparse endorsement at other parole rates.

Table 12 details differences by conviction and sentencing type for CSPs' clients. Variation by percent of misdemeanors was seen only in subtheme CSP 3.2 (different priorities contributes to conflict) and the IPEC teams and teamwork competency. Increased endorsement in CSP 3.2 was seen exclusively among those endorsing the 0% misdemeanor range. Endorsement of issues related to IPEC teams and teamwork was negatively correlated with the percent of misdemeanor cases.

Table 12.

CSP Conviction Information

	% Misdemeanor Convictions [a]	% Felony Convictions [a]	% Non-Violent Offenses [a]	% Violent Convictions [a]	% Substance Abuse Convictions [a]	% Probation Only [a]	% Parole Only [a]
Themes							
1.0	.53	6.80***	8.17***	3.08 *	7.90***	1.44	2.62*
1.1	.53	2.14	1.52	0.42	1.62	0.77	0.63
1.2	.61	1.11	1.16	1.10	1.38	1.39	1.53
1.3	.51	3.33**	4.40**	3.39 **	3.63**	1.33	2.64*
1.4	1.39	6.01***	6.44***	1.76	5.41***	2.30	0.73
2.0	.71	2.85*	7.19***	2.39 *	3.12*	3.35*	1.05
2.1	1.78	3.21*	1.83	1.83	1.63	1.14	6.11***
2.2	1.24	1.54	5.12**	2.33	2.21	1.80	2.18
2.3	.20	1.00	1.60	0.48	9.44***	0.34	0.34
2.4	.18	.57	1.64	0.68	4.17**	0.71	2.98*
3.0	.80	2.68*	2.32*	1.72	1.62	1.20	0.42
3.1	.93	3.58**	2.08	0.95	2.11	1.13	1.36
3.2	1.57	1.91	1.65	1.66	2.06	1.64	0.44
3.3	1.23	1.99	1.71	2.51	0.91	1.16	0.67
4.0	1.02	4.08**	8.07***	3.81 **	2.81 *	5.88***	1.44
IPEC Competencies							
VE	.63	3.22*	18.23***	2.39 *	4.11 **	6.28***	1.00
RR	.71	3.38**	9.31***	2.79 *	3.38 **	2.94*	1.34
IPC	.67	2.83*	17.16***	2.14	3.04 *	8.22***	1.08
TT	.71	2.43*	23.95***	1.94	3.83 **	9.50***	0.99
Effectiveness	.39	.24	1.69	0.24	2.38 *	3.96**	0.36

*p < .05. **p < .01. ***p < .001

[a] Univariate ANOVA, *df* = 1, 2

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Percent of felony cases was influenced by subthemes CSP 1.4 (apathy as a barrier) and CSP 3.3 (working collaboratively can resolve conflict), as well as the Aim 3 Effectiveness composite. CSPs with lower rates of felony clients on their caseload showed greater endorsement of CSP 1.4, whereas higher rates of felony clients were associated with CSP 3.3 and items associated with Aim 3. Percent of probation only cases demonstrated these same effects as well.

Percent of non-violent conviction cases impacted two subthemes: CSP 2.3 (informing courts of offenders' progress) and CSP 2.4 (maintaining professional role boundaries). Greater rates of non-violent cases were associated with endorsing CSP 2.3. Lower rates of clients with non-violent convictions were associated with CSP 2.4. Percent of violent conviction cases also affected these two subthemes, except here lower rates of felony convictions was associated with endorsing CSP 2.3, and higher rates of felony convictions was associated with CSP 2.4.

Caseload Client Data

Table 13 details the differences in MHPs' thematic responses dependent on client characteristics. Five categories were included in MHP analyses: percent of domestic violence offenders, percent of sexual offenders, percent of substance abusers, percent of clients in treatment from regional area, and percent of clients who are not in the criminal justice system. Of note, no significant differences in thematic responses were seen by percent of domestic violence offenders and percent of clients who are not in the criminal justice system.

Table 13.

MHP Patient Data

	% Domestic Offenders [a]	% Sexual Offenders [b]	% Substance Abusers [a]	% Local Offenders [a]	% Non-Offenders [a]
Themes					
1.0	0.57	2.95 *	1.78	1.85	0.56
1.1	0.42	1.68	1.86	0.71	1.09
1.2	0.95	3.03 *	0.95	0.39	0.98
1.3	0.80	2.88 *	1.33	1.99	0.90
1.4	1.16	2.82 *	4.29 **	2.55 *	0.45
1.5	0.79	0.59	0.79	0.16	1.34
1.6	1.48	1.34	0.58	1.04	0.33
2.0	0.35	6.33 ***	1.94	4.18 **	0.85
2.1	1.74	3.14 *	1.12	1.66	2.27
2.2	0.33	14.83 ***	2.84 *	2.23	0.76
2.3	1.68	0.39	0.93	0.58	0.30
2.4	0.79	3.14 *	0.71	0.96	0.92
2.5	0.26	7.95 ***	1.88	3.41 *	0.71
3.0	0.69	2.60 *	1.60	1.91	0.99
3.1	0.77	3.55 **	1.12	2.08	1.40
3.2	0.76	1.73	1.95	1.09	1.33
3.3	0.77	1.64	1.14	1.45	1.10
4.0	0.50	10.78 ***	1.82	1.94	0.90
4.1	0.41	7.97 ***	1.92	0.98	0.45
4.2	0.78	3.04 *	1.69	0.51	0.57
4.3	0.96	1.05	1.69	6.45 ***	0.51
4.4	0.71	4.30 **	3.32 *	0.69	0.88
4.5	0.77	4.61 **	0.89	0.94	1.50
5.0	0.31	0.95	0.93	1.02	0.59
5.1	1.26	0.70	0.16	0.32	0.30
5.2	0.42	1.16	3.38 *	5.94 **	0.34
5.3	0.88	0.72	1.65	1.34	1.10
5.4	0.85	0.99	0.39	1.17	1.04
5.5	0.83	0.90	2.15	0.36	0.16
IPEC Competencies					
VE	0.27	9.60 ***	2.81 *	3.21 *	0.71
RR	0.36	5.87 ***	1.95	3.93 **	0.73
IPC	0.37	9.06 ***	2.07	3.30 *	0.75
TT	0.29	9.38 ***	2.92 *	3.12 *	0.61
Effectiveness	0.67	2.02	3.01 *	1.49	1.34

*$p < .05$. **$p < .01$. ***$p < .001$
[a] Univariate ANOVA, $df = 9, 23$
[b] Univariate ANOVA, $df = 8, 24$

Percent of sexual offenders affected responses more than other variables in this category. Four of five themes were impacted by this variable: MHP 1.0 (appreciation for and process of collaboration), MHP 2.0 individual characteristics and roles), MHP 3.0 (characteristics of collaboration), and MHP 4.0 (elements of effective collaboration). Among subthemes, percent of sexual offenders influenced endorsement of MHP 1.2 (valuing interprofessional service motivates MHPs to have better relationships with CSPs), MHP 1.3 (valuing interprofessional service is correlated with providing services efficiently), MHP 1.4 (challenges emerge from different systems), MHP 2.1 (clinical service role), MHP 2.2 (providing a service to community supervision programs), MHP 2.4 (assuring clients of professional boundaries), MHP 2.5 (maintaining professional boundaries), MHP 3.1 (who wants information drives communication), MHP 4.1 (nurturing positive and active relationships), MHP 4.2 (professionalism), MHP 4.4 (perspective taking), and MHP 4.5 (having multiple modes of communication is good, though direct communication is better). Additionally, all four IPEC competency theme composites varied by this variable. Most themes, subthemes, and theme composites showed positive correlative relationships with the rate of sexual offender clients. Three subthemes (MHP 2.1, MHP 4.2, and MHP 4.4) showed bimodal distributions centered upon 4-5% and 99-100% of sexual offenders in their caseload. Subthemes MHP 2.4 and MHP 4.5 showed notably higher endorsement among participants working with higher rates (80-100%) of sex offender clients. Subtheme MHP 2.2 showed sporadic elevated endorsements with no clear pattern related to the number of sexual offenders.

Rates of substance abusers affected four subthemes: MHP 1.4 (challenges emerge from different systems, MHP 2.2 (providing a service to community supervision programs), MHP 4.4 (perspective taking), and MHP 5.2 (courts provide specific mandates to follow). Theme

composites were impacted for IPEC values and ethics, IPEC teams and teamwork, and Aim 3 Effectiveness. Most subthemes and the two IPEC theme composites showed large differences in the modal substance abusing population rate of 80% compared to the rest of the sample. Subtheme MHP 1.4 showed a modest positive association with rates of substance abusing clients. Subtheme MHP 4.4 showed endorsement clusters discreetly around 0%, 35%, and 80% rates of substance abusing clients. Subtheme MHP 5.2 showed a modal cluster of endorsement in rates of 95% and higher.

Rates of local clients influenced endorsement of MHP 2.0 (individual characteristics and roles). Four subthemes were additionally impacted by this variable as well: MHP 1.4 (challenges emerge from different systems), MHP 2.5 (maintaining the professional relationship), MHP 4.3 (mutually defined roles), and MHP 5.2 (courts provide specific mandates to follow). All four IPEC competency theme composites were affected by this variable. The percent of local clients variable features two major clusters: 0-30% and 80-100%. In each theme, subtheme, and theme composite, greater endorsement was seen among the higher local percentage. Additionally, modal endorsement was consistently seen between 80-90% of local clients.

Table 14 presents CSP client data that interacts with interview responses. Percent of domestic offenders was related to endorsement of subtheme CSP 1.3 (confidentiality standards as a barrier to collaboration). Working with clients with a history of domestic violence was negatively correlated with this subtheme. Increasing amounts of sexual offenders on a caseload influenced CSP 1.4 (apathy as a barrier) and the Aim 3 Effectiveness composite. CSPs who reported not working with sexual offenders did not endorse subtheme CSP 1.4, and working with sexual offenders was negatively correlated with endorsing issues associated with effectiveness. The percentage of local clients impacted endorsement of subtheme CSP 1.3 (confidentiality

standards as a barrier to collaboration). Working with local clients was positively correlated

with this subtheme.

Table 14.

CSP Client Data

	% Domestic Offenders [a]	% Sexual Offenders [a]	% Substance Abusers [a]	% Local Offenders [a]
Themes				
1.0	0.86	16.00	4.46	2.29
1.1	0.71	12.25	2.69	1.41
1.2	2.13	0.04	0.35	0.73
1.3	3.61×10^{32} ***	3.00	10.72	25.68 *
1.4	3.00	2.60×10^{33} ***	17.23	7.00
2.0	0.14	0.25	0.49	0.50
2.1	17.29	0.89	3.23	6.66
2.2	8.00	1.00	3.78	7.49
2.3	3.00	0.25	0.63	1.01
2.4	3.00	0.25	0.63	1.01
3.0	0.78	6.75	4.05	2.36
3.1	1.33	4.00	5.28	3.91
3.2	0.00	1.00	0.37	0.15
3.3	3.00	-	17.23	7.00
4.0	1.67	6.25	2.68	1.80
IPEC Competencies				
VE	0.04	0.75	0.57	0.36
RR	0.04	0.75	0.57	0.36
IPC	3.00	-	17.23	7.00
TT	0.39	0.06	0.00	0.04
Effectiveness	2.50	25.00 *	17.74	7.84

*p < .05. **p < .01. ***p < .001
[a] Univariate ANOVA, $df = 1, 2$

CHAPTER 4

DISCUSSION

Although mental health programs and community supervision agencies often collaborate to address the needs of their clients, very few studies have attempted to empirically study these professional relationships. The current research provides greater understanding of these professional collaborations by systematically reviewing structured interviews with both mental health providers and community supervision professionals and comparing their experiences with established standards of collaboration from the healthcare field. Results illuminate several aspects of the collaborative relationships between mental health and community supervision partners rarely documented in the empirical literature.

Foremost, MHPs and CSPs both acknowledge the benefits of interprofessional collaboration. MHPs see collaboration as beneficial to providing services efficiently, both in addressing motivation and having more complete information about clients. As their caseloads increase regarding felony convictions, substance use, and violent and non-violent crimes, their perceptions of the importance of collaboration increases as well. CSPs view MHPs as helping to address clients' complex behavioral needs appropriately, assisting with the coordination of services, and providing accurate information regarding how offenders are doing. This was particularly salient for CSPs working with high numbers of probationers or those convicted of felonies.

MHPs describe their primary role as being clinical service providers. This includes evaluating clients' needs, facilitating psychoeducational classes, and providing group and individual psychotherapy. These services are directly enhanced by collaboration, as CSPs can provide external motivation to clients to both attend and participate in clinical services. MHPs

who work with increasing numbers of non-violent clients, substance abusers, and felony-level offenders are most likely to acknowledge this benefit.

MHPs also described roles exclusive to these collaborative settings. Some focused on their perceived responsibilities within the professional relationship. MHPs, especially those who are more experienced and credentialed, acknowledged that they are providing a service to their referring agency (i.e., community supervision agencies) or the courts. These MHPs in particular also see themselves as increasingly responsible for maintaining positive and functional relationships with their CSP counterparts. Another role places them in the middle of the client-supervision-treatment triad. Although MHPs see themselves as providing a service to community supervision, they also describe a responsibility to advocate on behalf of their clients with regards to supervision issues. Nevertheless, MHPs recognize that their collaborative relationships with CSPs can impede the development of a therapeutic relationship. Assuring clients of adherence to ethics, confidentiality standards, and other professional boundaries becomes a major responsibility in itself.

CSPs delineated their major roles consistent with probation and parole theory: law enforcement and case management (Klockars, 1972; Schwalbe, 2012). CSPs discussed the importance of enforcing their clients' conditions of supervision, and they also expressed their belief in the importance of following these conditions for clients to successfully remain in the community. Consistent with previous research (Holloway et al., 2013), CSPs also viewed themselves as the pathway for their clients to enter into mental health services – they do not conduct the treatment but instead direct clients to the appropriate service to address their needs. Additionally, CSPs can serve as mediators between mental health treatment and the courts. Similar to MHPs, CSPs also identify a role pertaining to their professional relationships. In this

case, though, CSPs discussed the importance of restricting their work to the major roles of probation and parole rather than drifting into therapeutic service. This was most apparent among CSPs working with higher proportions of violent offenders.

Although communication may be limited by necessity, both CSPs and MHPs describe a responsibility for maintaining professional boundaries. MHPs described how the courts and community supervision push treatment providers to take on an enforcement role. Conversely, CSPs described how treatment providers can be critical of their enforcement duties. Thus, both acknowledged in their interviews that it is necessary and beneficial to ensure professional role boundaries, particularly when working with less violent clients and those sentenced directly to probation.

Current interviews do not suggest a best-practice standard for how often communication should occur. Instead, the current practice when working alongside community supervision appears to focus on as-needed communication rather than proactive information exchange. Sometimes this takes the form of mandatory reports, but more substantive collaborations occur in response to specific questions or concerns. This opinion was more frequently endorsed by treatment providers who reported greater engagement in ongoing training, perhaps as a function of more collegial experiences among providers engaged in continuing education. In the case of court-ordered services, communication with mental health services is often limited. With court-ordered assessments, MHPs only provide an answer to the court's referral question; ongoing communication rarely occurs and may complicate the relationship. For treatment referrals, CSPs more often serve as the coordinator between the treatment provider and the court. Again, communication with the courts is minimal – CSPs can provide case management with regards to treatment and provide an as-needed summary to the courts.

These interviews elicited several elements of effective collaborative relationships. Ensuring role boundaries are maintained is one, but these relationships require active engagement on a personal level. Included here is the ability to take the other's perspective on their professional opinions, especially when each have different professional priorities. Communicating directly (i.e., in person or by telephone rather than by written report or by e-mail) is also important to ensuring the quality of professional relationship. This serves two functions – first, having multiple modes of communication can increase opportunities to share information but also creates more work to ensure that information reaches its intended recipient, and second, direct communication provides opportunities to develop stronger, active, and respectful relationships. This impact of direct communication is evident from broader research of human interaction (e.g. Hall & Pennington, 2013). Additionally, MHPs identified the risk of being overly familiar as personal relationships are developed. Thus, maintaining professionalism in collaboration is equally paramount.

The importance of putting effort into valued relationships is underscored by the challenges identified by both parties. Not surprisingly, mental health and community supervision have different priorities. Treatment in criminal justice settings focuses on addressing individuals' cognitions and behaviors that contribute to criminal behavior, reducing symptoms of pathology, and improving overall psychological functioning (Heilbrun & Griffin, 1999; Wrightsman et al., 2002), whereas probation, parole, and similar agencies must balance enforcing adherence to court orders with facilitating access to community resources relevant to clients' criminogenic needs (Klockars, 1972; Schwalbe, 2012; Shireman, 1963). Thus, there is a risk of professional tribalism, where both CSPs and MHPs risk failing to consider the priorities and goals of the other. Both parties could thus potentially impede collaboration. With regard to

healthcare providers, some may devalue CSPs for their less complicated education and training, failing to consider the power dynamics of CSPs as referral sources and representatives of the legal system. On the other hand, both CSPs and MHPs identified the potential for many supervision agents, especially those with many years of experiences, to be less invested in collaboration overall. CSPs viewed this either as a function of disinterest, such as in the case of CSPs who are too focused on law enforcement duties (e.g., Klockars, 1972), or burnout.

Systemic challenges were also evident from these interviews. Confidentiality requirements are one such barrier. Due to the nature of healthcare ethics and law, this is one area of client control in forensic treatment services – they can refuse to allow treatment information to be disclosed (albeit with consequences associated with such refusals). CSPs who are more exclusively involved in local cases reported this concern most. The other broad, systemic challenge arises from the natural division of healthcare and the legal system from as early as training to supervision. This includes how both the courts and community supervision may have a poor understanding of healthcare practice, or they may not be aware of available services because the system, by nature, is disconnected.

These interviews advance our understanding of collaborative relationships between mental health care and community supervisions programs, though this is a minor achievement in comparison to the vast body of research studying interprofessional healthcare. Thus, it is helpful to compare the current findings to a standard of care from the healthcare field. Here, the Interprofessional Education Collaborative best practice standards (IPEC, 2011) are relevant. The IPEC standards include four major competencies: values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork. These competencies can be used to identify specific areas of overlap between current findings and the IPEC standards, as well as to

identify areas of potential improvement.

Nearly all dimensions of the values and ethics competency, which concerns working with professionals and clients for a common goal, were represented in this study's interviews. MHPs' interviews in particular reflected almost every aspect of this competency. This includes discussions of the benefit of working collaboratively with CSPs and the courts and the need for high standards of professionalism and commitment to one's own ethical guidelines. The importance of their exclusive roles when providing a service to clients referred from the criminal justice system is also consistent with the values and ethics competency, in that some of their responsibilities blend the commitment to the client with that to the courts and community supervision. Other professional responsibilities are specific to ethically placing the client's needs at the forefront, such as advocating to community supervision programs on behalf of clients or working to ensure their clinical services are perceived by clients to be of the same standard of care as voluntary mental health treatment.

CSPs' discussions also demonstrated notable inclusivity of many aspects of the values and ethics competency. In contrast to MHPs, CSPs' discussions overlapped this competency pertaining to their professional relationships with treatment providers and less so concerning placing the needs of clients first. While CSPs do see their work as partly in service to their clients, they described their relationships with them as more hierarchical than collaborative. Therefore, discussions of collaboration were generally in the context of how it is important for CSPs to find a productive middle ground with their treatment provider partners when developing a plan of care to address clients' behavioral needs.

Similarly, the roles and responsibilities competency, which advises using one's own expertise and an understanding of collaborators' strengths to best serve clients, was well

represented in the current interviews. Both MHPs and CSPs described the importance of their

exclusive primary roles, either as providing treatment services or enforcing orders and rules

mandated by the courts, as well as their perception of collaborative responsibility. Treatment

providers serve primarily in a front-line capacity as both clinicians and advisors to the criminal

justice system, while the duty of probation and parole is blended between serving different front-

line responsibilities with offenders, coordinating referrals between the community and the courts

to meet the needs of clients. Again, treatment providers echoed the IPEC competency by more

often placing their clients' needs as a priority when serving as an advocate and working to assure

clients they will provide the same professional fidelity as any other healthcare provider.

The interprofessional communication competency, concerning responsive and

responsible approaches to sharing information between professionals and with clients, shows

show less concordance with the current interview data. MHPs shared several experiences that

involve modes of effective communication, such as what has worked in light of technological

advances, the importance of putting effort into these relationships, and the necessity of

maintaining professionalism in the midst of growing familiarity. CSPs shared similar but limited

opinions, with their focus on the importance of finding middle ground amid differing priorities

while maintaining professional roles.

The teams and teamwork subcompetencies, which broadly involve team dynamics,

resulted in the least overlap within the current interviews. MHPs and CSPs discussed the

importance of defining roles and responsibilities within the collaboration and the importance of

having a mechanism to address disagreement. Treatment providers also focused on the

importance of flexibility given the differences in their respective systems (e.g., different courts

with different expectations), whereas probation and parole officers described the importance of

engaging community services to meet their clients' needs and to appropriately delegate responsibility based on these referrals.

The priorities emphasized in the current interviews unavoidably differ from the IPEC competencies given that healthcare-only collaborations may exhibit more consistent priorities than those examined here. An example of differing priorities is the additional responsibility to community safety. The concern for community safety is good example how the current partnerships differ from traditional healthcare, as community safety concerns generally do not motivate individuals involved in the criminal justice system to enter mental health treatment. Thus, while the services provided still concern the interests of clients, they place the community's needs above the autonomy of the client. Some areas in which current findings suggest a failure to meet IPEC standards imply areas of potential improvement in the examined interprofessional relationships, though.

Foremost, improved interprofessional training may provide a better understanding and appreciation of how both MHPs' and CSPs' work products complement the other. This was identified as a need for growth in CSP interviews, in that a poor understanding of mental health standards and practice was evident. This includes both how best to support mental health treatments as well as the importance of confidentiality. The current interviews also suggest that having structured conflict resolution practices and performance improvement strategies, grounded by ethics-driven consensus and evidence-based practice, may increase the benefits of collaborative practice for both clients and professionals.

Limitations and Future Directions

These conclusions are tempered by several limitations of this study. The two samples here are not matched based on collaboration. While both MHPs and CSPs in this study have

experience with interprofessional practice, they did not necessarily directly collaborate with each other. Thus, the experiences of their actual professional counterparts may not be reflected, and thus we cannot infer that findings fully represent collaborative issues. Furthermore, a relatively wide variety of mental health professionals consented to participation in this study, but significantly fewer representatives of community supervision practice contributed to the current data. This was, in part, due to the Tennessee Department of Corrections' resistance to supporting the larger research project with which this study is affiliated. In their reply to our request for participation, the Department of Corrections stated they do not believe this research (i.e., improving re-entry practices in rural Appalachia) is consistent with their current goals. Therefore, this study presents a limited scope of community supervision experiences, and the quantitative analyses of CSP data do not contain a large enough sample for valid inferences.

Three major limitations also concern the design of the study. In addition to limitations in sample recruitment, this study focuses on practices in mostly rural areas of the Appalachian region and therefore may not represent the experiences of more urbanized locations or regions outside of Appalachia in general (such as the Pacific Coast or New England regions, or those outside the United States). The exploratory and open-ended nature of this study also presents a limitation, in that some issues may not have uniformly received attention or response, particularly in larger focus groups. Thus, gaps in thematic responses may be present between interviews. Finally, the complexity of the inductively-coded qualitative data complicated the quantitative component of this study. The high number of analyses conducted here increases the likelihood of experiment-wise error, further tempering conclusions drawn from these data.

In light of these limitations, several avenues of future study in this area are possible. First, future research on these interprofessional collaborations may benefit from greater structure

in examining specific areas of interest. This may include greater examination of teamwork-related processes like conflict resolution, the prioritization of services, or resource coordination in the community. Additionally, hypothesis-driven, rather than exploratory, questions developed from the present findings can uniformly examine interprofessional relationships across a variety of settings and among a variety of professionals. Future research may also benefit from improved collaboration with government agencies, including the Department of Corrections, to ensure that greater response rates are obtained from community supervision professionals about their experiences. Once improved recruitment and data collection are achieved, expanding this research to a wider variety of regions will help improve the generalizability of findings. For example, previous research has established that rural professionals may be more susceptible to role drift due to the lack of resources (Gamm et al., 2010; Jameson & Blank, 2007; Schank, 1998). Ensuring professional roles was a major area of discussion among both MHPs and CSPs in the current study, and it is possible that less emphasis on this issue is present in areas with greater resources.

Conclusion

The exploratory and qualitative nature of this research has provided significantly more structured understanding of the interprofessional dynamics of these collaborations. Past research in this area has typically focused on single issues and often as an adjunct to larger research questions (Holloway et al., 2013; McGrath et al., 2002, Thom et al., 2013; Turnbell & Beese, 2000; Watts, 2008). Here, a variety of interprofessional issues between mental health and community supervision have been detailed, including perspectives on collaboration, perceived roles, dynamics of collaboration, and elements of effective relationships. Several of the elements presented in this study mirror how interprofessionalism is manifested in more thoroughly

researched healthcare settings. Despite the inevitable differences between mental healthcare and community supervision, potential areas for improvement in collaboration can be informed by examining solutions from exclusively healthcare experiences. Most importantly, these collaborations are seen as being crucial to meeting ultimate goal of all involved: addressing the criminogenic needs of clients and maximizing their quality of life by improving outcomes in the community.

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APPENDICES

Appendix A

Pre-Interview Survey for Community Treatment Providers

1. Name: _____

2. Number of years in mental health: _____

3. Current agency: _____
   ☐ Primarily state-funded
   ☐ Primarily grant-funded
   ☐ Primarily private/insurance funded
   ☐ Other: _____

4. Educational background:
   ☐ Bachelor's degree (major: _____)
   ☐ Master's degree (field: _____)
   ☐ Doctoral degree (field: _____)
   ☐ Other educational attainment: _____
   ☐ Special certifications/licensure: _____

5. Please describe any specialized training or certifications you have related to offender treatment.

   _____
   _____
   _____
   _____
   _____

6. Do you belong to any professional associations? Yes   No   If yes, please list:
   _____
   _____
   _____
   _____

7. Average caseload, by week _____, by month _____

8. What percentage of your clients are court-ordered? _____

9. What percentage of your clients are:

Misdemeanor convictions _____
Felony convictions _____
Multiple convictions _____
Violent convictions _____
Non-violent convictions _____
Substance abusers _____
Substance use convictions _____
Domestic or family violence offenders _____
Sex offenders _____
Regional offenders (i.e., they're from this area) _____
First-time offenders _____
Repeat offenders _____
Probation only _____
On parole _____
Non-offenders _____

10. What is the standard cost of your services for the offenders referred to you?
    a. Cost per group: _____
    b. Cost per individual therapy session: _____
    c. Are costs different for different offender types (e.g., substance abuse vs. sex offender treatment)? If so, please describe: _____
    _____
    _____
    _____

11. What is the standard frequency and length of treatment recommended and/or provided for:
    a. Substance abuse: _____
    b. Domestic violence: _____
    c. Anger management: _____
    d. Sex offenders: _____
    e. Other court-ordered counseling: _____

12. What other types of treatment or services do you provide for offenders? Please check all that apply.
    a. Couples counseling ____
    b. Family counseling ____
    c. Family reunification ____
    d. Trauma therapy ____
    e. Crisis services ____
    f. Medication management ____
    g. Resource referral ____
    h. Case management ____

    i.   Risk assessment ____

13. Do you use waivers of confidentiality with court-mandated clients, or those under probation/parole supervision? Yes   No   If yes, are these: Required   Requested

14. Do treatment services ever occur in probation or other supervision agency offices? If yes, please describe:

_____

_____

_____

15. Do probation/parole officers ever visit or participate in treatment appointments/groups? How often? Are there any special rules or procedures in place for this?

_____

_____

_____

_____

16. Please briefly describe your role in the continuum of offender services, or your goals for offender clients.

_____

_____

_____

_____

_____

_____

_____

_____

Appendix B

Pre-Interview Survey for Probation and Parole Officers

1. Name: _____

2. Number of years in probation/parole: _____

3. Current agency: _____

4. Educational background:
   - ☐ High school diploma
   - ☐ Some college (major: _____)
   - ☐ Associates degree
   - ☐ Bachelor's degree (major: _____)
   - ☐ Post-graduate training (field: _____, highest degree earned _____)

5. Average caseload, by week _____, by month _____

6. What percentage of your supervisees are:
   Misdemeanor convictions _____
   Felony convictions _____
   Multiple convictions _____
   Violent convictions _____
   Non-violent convictions _____
   Substance abusers _____
   Substance use convictions _____
   Domestic or family violence offenders _____
   Sex offenders _____
   Regional offenders (i.e., they're from this area) _____
   First-time offenders _____
   Repeat offenders _____

7. Types of specialized populations you work with (sex offenders only, etc.)

   _____
   _____

   Number of years working with this population? _____ months/years
8. Do you belong to any professional associations? Yes   No   If yes, please list:

   _____

Appendix C

Parent Study Interview Questions for Mental Health Providers

I.   **Expectations**
        A. When you think about when you first started working with offenders in a rural
            area, what did you expect it to be like?
        B. Have your expectations changed? How so?

II.   **Role of the court**
        A. What are the most common sanctions or sentences given to offenders from the
            courts you work with?
        B. Are there other expectations they have to meet (like travel, registration, residency,
            or other things)?
        C. What diversionary options are there in your community?
        D. When the court makes a recommendation, how much do your clients have access
            to what they need to make that happen?
        E. Do some offenders have a harder time meeting their requirements? How so?
        F. In your opinion, how fair are the sentences or sanctions from the court? Are some
            of them less or more fair? What makes the difference?

III.   **Treatment programming**
        A. As far as treatment goes, what do people typically need when then come to you?
        B. Who decides how long the client will be in treatment? Is it you, or the court, or
            some other agency? Is it usually enough time to meet client goals? Why or why
            not?
        C. Do most of the offenders you work with have individual or group therapy? Which
            would you prefer that they have? Why?
        D. Are there services to help with clients with payment? In the end, who pays for
            treatment?
        E. How often is it the case that clients are in multiple forms of treatment at the same
            time?
        F. How is your clients' motivation? Does that make a difference in terms of their
            overall success in treatment? Do you do anything in particular to address
            motivational issues?
        G. Different types of clients – either different offenders, or people assigned to
            different kinds of treatment – what are things that you've noticed in terms of how
            they approach treatment, or how willing they are for treatment?

IV.   **Treatment success vs. failure**
        A. What seems to work best for the offenders on your caseload?
        B. What do you think is most effective about what you do?

C. Are there things you could do that would improve outcomes for the people you work with? Have you tried these? Why or why not?
D. Why do you think people fail in terms of being back in the community?
E. What issues do you see with availability of providers or services in your community?
F. How do you know if someone has failed? How quickly do you find out?
G. How many of your offenders end up back in jail or prison, or have new charges? Where do they end up?
H. How much of that do you feel could be prevented?

V. **Communication & service collaboration**
A. How important to you is communication with other providers or people who are supervising your clients?
B. How often do you discuss specific offenders with other people? How often do you have to report anything? Does this make your work easier, or is it more complicated?
C. What kinds of rules do you have to follow in contacting others about your clients?
D. What kinds of things help you communicate with others about your clients?
E. What kinds of things get in the way of communicating with others about your clients?
F. What is your responsibility in comparison with other people or agencies who work with your clients? How well are roles and responsibilities between agencies clarified?
G. Do you ever disagree with people in other agencies about the client? If so, how does that work out?

VI. **Role of community**
A. Are there any other services that you provide on a more informal basis?
B. How much do clients talk to you about the resources available to them, like housing, or employment?
C. Are there options for family reunification? Trauma services? Crisis services?
D. How well do you think services are coordinated in your area?
E. What services do you think are missing in your community?

VII. **Stigma**
A. How does your community feel about the people you work with, either in general, or compared to other types of offenders?
B. How do your clients react to this? Have they had any specific kinds of things happen to them?

C. What kinds of local initiatives or businesses affect your clients? For example, mugshots or arrest records, registration, or other public notifications? What are the pros & cons of these practices, in your view?
D. How do people in the community react to you when they hear you work with offenders?

Appendix D

Parent Study Interview Questions for Criminal Justice Professionals

I.   Expectations
   A. When you think about when you first started your job, what did you expect it to be like?
   B. Have your expectations changed? How so?

II.   Role of the court
   A. What are the most common sanctions or sentences given to offenders from the courts you work with?
   B. Are there other expectations they have to meet (like travel, registration, residency, or other things)?
   C. What kinds of diversion programs are available? How much of a role do you have in making recommendations to the court?
   D. When the court makes a recommendation, how much do your probationers/parolees have access to what they need to make that happen?
   E. Do some offenders have a harder time meeting their requirements? How so?
   F. What kinds of differences have you noticed, either across jurisdictions or types of offenses, for offenders on your caseload?

III.   Treatment programming
   A. What percentage your probationers/parolees are required to go to some kind of mental health or substance abuse treatment?
   B. Who decides how long the client will be in treatment? Is it the court, treatment providers, or someone else?
   C. Who pays for it?
   D. How often is it the case that an offender is in multiple forms of treatment at the same time?
   E. How is their motivation to complete treatment or court orders? Do you see that making a difference in their overall success in treatment? Do you do anything in particular to address motivational issues?

IV.   Treatment success vs. failure
   A. What seems to work best for the offenders on your caseload?
   B. What do you think is most effective about what you do?
   C. What things do you wish you could do but either cannot or that haven't worked before?
   D. Why do you think people fail in terms of being on supervision in the community?

E. What issues do you see with availability of providers or services in your community?

F. How many of your offenders end up back in jail or prison, or have new charges? Where do they end up?

V. **Communication & service collaboration**

A. How important to you is communication with treatment providers or social services agencies who are working with offenders on your caseload?

B. How often do you discuss specific offenders with other people? How often do you have to report anything? Does this make your work easier, or is it more complicated?

C. What kinds of rules do you have to follow in contacting others about any given offender?

D. What kinds of things help you communicate with others about an offender?

E. What kinds of things get in the way of that communication?

F. What are your responsibilities in comparison with other people or agencies who work with an offender? How well are roles and responsibilities between agencies clarified?

G. Do you ever disagree with people in other agencies about the client? If so, how does that work out?

VI. **Role of community**

A. How much do hear from offenders or their families about the resources available to them, like housing, or employment?

B. Are there options in your community for family reunification? Trauma services? Crisis services?

C. How well do you think services are coordinated in your area?

D. What services do you think are missing in your community?

VII. **Stigma**

A. How does your community feel about offenders and seeing them stay in the community? What kind of differences have you noticed between offenders and community response – maybe in terms of reactions to a certain type of offender, or after media coverage of a trial or crime?

B. How do you think offenders react to this? Have they had any specific things happen to them as a result?

C. What kinds of local initiatives or businesses affect offenders in your area? For example, mugshots or arrest records, registration, or other public notifications? What are the pros & cons of these practices, in your view?

D. How do people in the community react to you when they hear you work with offenders?

Appendix E

Theme and Subtheme Titles

Mental Health Provider (MHP) Themes and Subthemes

1.0   Appreciation for and process of collaboration
1.1   Interprofessional collaboration is important when providing offender treatment
1.2   Appreciating interprofessional service motivates MHPs to have better relationships with CSPs
1.3   Appreciating interprofessional service is associated with efficiency
1.4   Challenges emerge from different systems
1.5   Motivation to collaborate is heterogeneous among CSPs
1.6   Not all systems are sufficiently connected

2.0   Individual characteristics and roles
2.1   Clinical service role
2.2   Providing a service to community supervision programs
2.3   Advocacy
2.4   Assuring clients of professional boundaries
2.5   Maintaining the professional relationship

3.0   Characteristics of communication
3.1   Who wants information drives communication
3.2   Formal standards regarding interprofessional communication
3.3   Impact of communication technology on collaborative relationships

4.0   Elements of effective collaboration
4.1   Nurturing positive and active relationships
4.2   Professionalism
4.3   Mutually defined roles
4.4   Perspective taking
4.5   Having multiple modes of communication is good, though direct communication is better

5.0   Involvement of the courts
5.1   Courts retain a superior role
5.2   Courts provide specific mandates for MHPs to follow
5.3   Expectations vary by court
5.4   Courts may have a limited understanding of mental health services
5.5   CSPs can mediate the division between the courts and MHPs

Community Supervision Professional (CSP) Themes and Subthemes

1.0   Collaboration and service coordination
1.1   Communication is valued
1.2   CSPs are the gateway to mental health services

1.3   Confidentiality standards as a barrier to collaboration
1.4   Apathy as a barrier to collaboration

2.0   Professional roles
2.1   Enforcing conditions
2.2   Making appropriate referrals
2.3   Informing courts of offenders' progress
2.4   Maintain professional role boundaries

3.0   When conflict occurs
3.1   Overemphasizing role boundaries and identity contributes to conflict
3.2   Different priorities contribute to conflict
3.3   Working collaboratively can resolve conflict

4.0   Lack of knowledge about other professionals

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