International Journal of Law and Psychiatry 60 (2018) 64–72

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy

The effect of systems collaboration on the individual outcomes of mental health court participants: A multi-site study

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1. Introduction

The proportion of people with serious mental illness (SMI) in U.S. jails ranges from 6 to 36% (Abram, Teplin, & McClelland, 2003; Kubiak, Beeble, & Bybee, 2010; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1996; Teplin, Abram, & McClelland, 1996; Trestman, Ford, Zhang, & Wiesbrock, 2007), which is approximately three to six times greater than the proportion of persons with a mental illness in the general population (Kessler et al., 2005). This over-representation is often cited as a result of the deinstitutionalization movement in the 1970s, whereby psychiatric hospitals were closed and the behaviors of individuals with SMI became more visible to law enforcement (Lamb & Weinberger, 1998). Torrey et al. (1992) argue that the detainment of individuals with SMI who commit misdemeanant or 'nuisance' offenses should be diverted to, and served by, the mental health system (Torrey, et al., 1992). As one potential solution to this problem, local jurisdictions have implemented various diversion programs in which persons with a mental illness, who have committed a crime, are granted an opportunity to avoid prosecution or incarceration by engaging in treatment services. The mental health court (MHC hereafter) is an example of a post-booking diversion program for persons with mental illness that utilizes treatment and services available in a given community to prevent or minimize the frequency of their contact with the criminal justice system.

MHC are a type of problem-solving court (also called specialty courts or therapeutic courts), which serve as an alternative to traditional criminal court processing. Although MHCs vary across jurisdictions in terms of eligibility criteria and program length, they have a similar underlying goal: to divert individuals with mental illness from the criminal justice system by altering the potential causes of their criminal behavior. One of the key features of a MHC is the "team" approach to decision making. The Council of State Governments Essential Elements notes that this team generally consists of a judge, treatment providers or case managers, a prosecutor, a defense attorney, and, possibly, a probation officer and court coordinator (Berman & Feinblatt, 2003). It is this collaboration of legal personnel with mental health and social service providers that creates the foundation of the MHC; however, this often requires critically examining one's professional training to adapt to the nontraditional nature of the MHC. As such, there are tangible differences in the degree to which individuals from criminal justice and treatment systems collaborate in a mutually beneficial relationship to achieve the goals of the court.

Within the MHC literature there is no accepted measure of model fidelity. Although the Essential Elements have been central in the implementation of MHCs, they offer little in the way of measurements that researchers can use to assess adherence to, or strength of, the model. Moreover, there is no specific Essential Element among the ten that formulates a definition of collaboration; rather it is implicit across the activities described across several elements. To address this we use these Essential Elements and Konrad's 5-level continuum of integration as a theoretical framework to create a taxonomy of collaboration within MHC (Konrad, 1996). Konrad's continuum ranks the intensity of inter-organizational collaborative structures among human service organizations.

To date, no study has attempted to link differences in and across MHC processes or characteristics to either criminal justice or mental health service outcomes. In this study we focus on exploring how MHCs vary in terms of collaboration, which we use to reference the MHC structure and practices of team members unite to create a shared mission and goals (Daunno, Sutton, & Price, 1991; Farabee & Leukefeld, 1999; Kubiak, 2009). Building on this framework of collaboration, we also investigate the impact of MHC collaboration on participant outcomes.

1.1. Background

Since the first MHC was established in the late 1990s, a number of studies have examined criminal justice and mental health treatment outcomes. These studies generally find fewer arrests, less time in jail, and reduced utilization of high-end treatment among MHC participants, especially those who complete the process, than comparison groups of similar defendants (Comartin, Kubiak, Ray, Tillander, & Hanna, 2015; Lowder, Rade, & Desmaris, 2017; Ray, Kubiak, Comartin, & Tillander, 2015; Sarteschi, Vaughn, & Kim, 2011; Steadman, Redlich, Callahan,

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https://doi.org/10.1016/j.ijlp.2018.08.004
Received 2 July 2018; Received in revised form 13 August 2018; Accepted 14 August 2018
Available online 29 August 2018
0160-2527/

Robbins, & Vesselinov, 2011). There have also been several studies that examine various aspects associated with the MHC processes. For example, process studies include examinations of the ways in which MHC proceedings are perceived by the participants (Canada & Ray, 2016; Canada & Watson, 2013; Munetz, Ritter, Teller, & Bonfme, 2014; Poythress, Petrila, McGaha, & Boothroyd, 2002; Wales, Hiday, & Ray, 2010), how interactions with the judge and case manager in MHC differ from traditional court (Canada & Epperson, 2014; Castellano, 2016; Ray, Dollar & Thames, 2011), and the decision-making process of the MHC team (Castellano, 2011; Lim & Day, 2016; Ray & Dollar, 2013; Trawver & Rhoades, 2013). These studies confirm the non-adversarial and collaborative nature of the MHC team. That is, rather than disputing guilt or innocence, in MHC, the defense and prosecuting attorneys work as part of a team with judges, mental health providers, and criminal justice staff to develop an individualized plan of treatment and services for each participant (Kubiak, Tillander, & Ray, 2012).

Conversely, there are a host of challenges that arise when such drastically different systems collaborate (e.g., criminal justice and treatment) to form a third system (e.g., MHC). This is further complicated by the fact that MHC teams do not always have the same constellations of professionals. For example, some courts may recognize other treatment and social needs of the participants and bring additional professionals into the milieu. This may include the addition of a substance abuse treatment professional, as substance abuse commonly co-occurs with severe mental illness and is a key predictor of offending (Swartz & Lurigio, 2007; Wilson, Draine, Barrenger, Hadley, & Evans, 2014; Wilson, Draine, Hadley, Metraux, & Evans, 2011). Successful collaboration of team members from multiple disciplines within MHC rests on the team approach, which includes a respectful and mutually beneficially relationship across legal, criminal justice, mental health, and substance abuse personnel. In addition, the Council of State Governments suggests that courts maintain an active advisory group of administrators from these same professions, who can facilitate collaborative efforts by problem-solving across systems.

Although research has examined levels of collaboration between criminal justice and substance abuse treatment agencies (Fletcher et al., 2009; Lehman et al., 2009), as well as collaboration among agencies and within drug courts (Wenzel et al., 2001; Wenzel et al., 2004), there has been very little discussion about the role of interagency collaboration in MHC (see Castellano, 2011 for exception). Konrad's continuum of integration was developed to assess collaboration within the social service system; however, it is applicable to cross-systems collaboration as well. The continuum of integration ranges from Level 1 to Level 5. Level 1 is the first step toward collaboration and is highly informal and often characterized by information sharing via intermittent communication between agencies. At Level 3, collaboration becomes formalized through written agreements, though the agencies are still autonomous. Level 5 is a fully integrated system that operates collectively under a single authority. Although the exact application of the levels to MHC is unlikely due to an inability for court and treatment systems to become fully integrated, the conceptual framework allows us to assess the strengths of the collaboration of the MHC.

Using Konrad's continuum, this study categorized courts into high and low-collaboration, and operationally assumes that courts with higher levels of collaboration will experience better outcomes as measured by higher completion, less recidivism, and lower levels of high intensity and costly treatment among participants. Therefore, we investigate this assumption by analyzing participants discharged from eight MHCs, five high collaboration courts and three low collaboration courts, one year after discharge.

2. Methods

A cross-site evaluation of eight MHC within one state was conducted by an independent team of university researchers. Each court was selected for participation in this study due to their successful application for funds to develop or sustain an existing MHC. Funding was jointly provided by the state court administrative office and the department of mental health. The lead investigator has several years of experience as an applied researcher at these intersections and has worked on county-, state-, and federal-level projects. This same author's institutional review board reviewed and monitored the study.

During the three-year study period (2009–2011), the eight courts collectively admitted 659 participants, with the MHC varying in capacity; sample sizes ranged from 22 to 169 participants. Of those admitted, 438 participants were discharged during the study period and 234 had been discharged for at least one year. In order to have consistent follow-up periods across participants and courts, the sample of 234 was used in this analysis. Although all courts had similar eligibility criteria for mental illness (i.e., serious mental illness and community mental health eligibility), courts differed on criminal eligibility. Some courts only allowed individuals with misdemeanor charges, while others allowed those with felony charges. Our continued engagement with jail diversion programs in some of these communities shows that eligibility criteria remains consistent over time.

2.1. Independent variable: collaboration

Qualitative data were collected through interviews with team members and observations of team meetings and court hearings. Interviewees were purposefully selected to represent both the mental health and criminal justice systems and focused on daily operations and administration of the MHC, the flow of participants through the court, team activities from referral to admission to completion, and shared understandings among team members. Researchers observed both MHC team meetings and status hearings at each court at least once, and routinely conversed with the individual stakeholders on the teams. Using these data we applied an inductive analytic technique which allows researchers to approach qualitative data with preconceived hypotheses, termed assertions, which can be developed and tested from existing literature and experiential knowledge. Therefore, our assertions for collaboration are: (1) MHC vary on their level of collaboration and (2) the higher the level of collaboration within a MHC, the better the outcomes.

Using language originating from the Essential Elements we created themes for coding within the data (see Table 1), to assess seven factors of collaboration. The first two factors capture the mental health expertise of the case manager, and the involvement of the mental health provider on the treatment team. Depending on the MHC structure, the case manager might be a court employee or probation officer; however, in some courts, the case manager had a background or training in mental health. The second factor captures the active involvement of the

Table 1
Court Level Descriptors and Integration Themes/Score by Mental Health Court (N = 234).

Court	A	B	C	D	E	F	G	H
Number of participants w/1 year post	10	84	27	26	3	12	35	37
Geographic region U = urban, R = rural, M = Metro	R	U	R	M	R	M	R	U
Court type F = Felony; M = Misd; B = Both	B	B	M	B	B	F	M	F
Integration Factors (n = 7)								
1. Case manager expertise	1	1	0	1	0	0	1	0
2. Mental health provider on team	1	1	0	1	0	0	1	1
3. Mental health provider at status hearings	1	1	0	1	0	0	1	1
4. Additional services	1	0	1	1	1	1	0	1
5. Substance abuse provider on team	0	1	1	1	0	1	0	1
6. Collaborative information gathering	1	0	0	0	1	1	1	1
7. Active advisory council	1	1	0	0	0	0	0	1
Total integration score	6	5	2	5	2	3	4	6