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What Factors Work in Mental Health Court?: A Consumer Perspective

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A substantial portion of individuals in custody are people with serious mental illnesses. Research shows approximately 16% of jail detainees and 16% of individuals in state prisons self-reported having an emotional illness or experiencing overnight stays in a psychiatric facility (Lurigio, 2000). Once incarcerated, people with serious mental illnesses are at a higher risk of victimization (Blitz, Wolff, & Shi, 2008) and spending more time in custody (Ditton, 1999) in comparison to people without mental illnesses. People with mental illnesses are also at risk of having an exacerbation of symptoms while in custody.

Mental health court (MHC) programs were created, in part, to divert people with mental illnesses from prison to community-based treatment in order to reduce some of the negative impacts associated with incarceration. Mental health courts are expanding across the nation but the evidence base is scant and involves substantial gaps in research. Although some research shows MHC participation can reduce future recidivism and increase mental health service use (Herinckx, Swart, Ama, Dolezal, & King, 2005; Steadman, Redlich, Callahan, Clark Robbins, & Vesselinov, 2011; Burns, Hiday, & Ray, 2013), it is unclear what mechanisms are impacting or influencing outcomes. Research involving populations similar to people served by MHCs has shown that the quality and strength of the relationship with an individual's probation officer is a central factor in both compliance and positive outcomes (Skeem, Loudon, Polaschek, & Camp, 2007). Although MHC researchers have speculated that participants benefit from MHCs when relationships among team members and social supports are strong (Herinckx et al., 2005), these associations have not yet been empirically tested.

The current study aims to address several unanswered questions by exploring MHC participant perspectives regarding the key factors in promoting change and by investigating the role, if any, that social support plays in recovery and recidivism. In order to both explore participant perspectives and estimate the association between social support and outcomes, a mixed-method design that draws from multiple data sources is utilized to address research questions and contextualize data. The qualitative portion explores participants' perspectives of the key factors involved in change within the context of MHC programs. The quantitative analysis complements the qualitative analysis by estimating the strength of associations between social support and service use, treatment adherence, and days spent in jail.

Social Support Network

House and colleagues (1988) define social support as “a positive, potentially health promoting or stress-buffering, aspect of relationships” (p. 302). Barrera and Ainlay (1983) conceptualize social support as verbal or nonverbal information or advisement and tangible resources or actions provided by the people in one’s social network, which can have emotional and behavioral impacts on the recipient. There are four domains of support in relationships including emotional (i.e., esteem, trust, concern, listening), instrumental (i.e., aid in the form of money, time, labor), informational (i.e., advice, suggestions), and appraisal (i.e., feedback, affirmation; House et al., 1988).

Some researchers conceptualize social support at a network level (Lincoln, 2008). This may be especially beneficial in order to examine the system of social support in an individual’s life, which may be particularly important among vulnerable populations. A social support network involves both informal and formal network members. An informal support network refers to family members, peers, friends, and/or acquaintances, whereas a formal support network refers to organizational entities, service providers, and other professionals involved in an individual’s life to promote sustainability and growth.

Social support is thought to impact outcomes through two functions: leverage and coping. Among people with mental illnesses, social support, especially from formal networks, may influence outcomes through leverage, which can increase individuals’ resources and facilitate upward social mobility (Briggs, 1998). Social support can also shape outcomes through a coping or buffering mechanism (Rogers, Anthony, & Lyass, 2004). Social support can reduce stress and hardships and buffer against chronic stress (House, 1981; Briggs, 1998). The coping function of social support is especially important for individuals who are chronically poor (Briggs, 1998); the resources gained through social support systems can alter one’s views of stressors. These resources can promote self-efficacy and enhance an individual’s ability to problem solve (Rogers et al., 2004), which increases one’s ability to cope.

Social support and outcomes

The perception of having social support and that people are willing to help in a time of need is thought to impact one’s self-esteem, stability, and feelings of control over the environment (Cohen & Syme, 1985); social support is also thought to impact health-promoting behaviors (House et al., 1988) and rule abidance for some individuals (Skeem et al., 2007). Although much of research links social support with physical health outcomes, mental health outcomes like distress, depression, and anxiety are also associated with the receipt of support (Turner & Brown, 2010). Turner and Brown (2010) argue that support may only be as helpful as the degree by which it is perceived. One’s perception of support is thought to be especially protective in buffering the impact of chronic stress and distress, which supports the use of measures to capture individual perceptions of social support and qualitative analyses to assess the individual variation inherent in support as utilized in the current study.

Social support plays an important role in treatment and recovery among individuals with mental illnesses. Research shows among people with chronic mental illnesses, network support improved overall measures of functioning. Specifically, social support improves the use of formal services (Lam & Rosenheck, 1999), increases treatment adherence (DiMatteo, 2004), reduces distress (Lincoln, 2008), influences recovery (Cohen & Syme, 1985), and impacts the course of schizophrenia (Buchanan, 1995), while an absence of support can increase psychiatric hospitalizations and substance use at least among populations with chronic illnesses (Swindle, Heller, & Frank, 2000). Peer support, in particular, is associated

with enhanced quality of life, self-esteem, psychological symptoms, and network satisfaction (Davidson et al., 2001). In fact peer provided support services were just as effective as non-peer services and significantly related to fewer hospitalizations and use of crisis-oriented services (Clarke et al., 2000).

Although much of the literature suggests supportive networks promote positive outcomes, some research calls into question social supports' utility throughout the continuum of treatment. Westreich and colleagues (1997) examined the role of social support among patients in a brief inpatient addiction rehabilitation program. Researchers report that in the early stages of treatment, perceptions of low social support from family members were related to greater completion of a voluntary inpatient program suggesting that social support from family members is not always beneficial to treatment completion and adherence. These findings also suggest the need for further research that examines the complexities of support giving and receipt for individuals recovering from illness and addiction, as this study aims to do.

There has been increased attention given to the importance of social support networks in the lives of people who are involved in the criminal justice system. Research on social support among people in custody demonstrates that receiving social support improves the successful completion of parole and improves post-release family unification (Schafer, 1994) and reduces recidivism (Bales & Mears, 2008). Similar to people in recovery from addictions and mental illness, peer support also plays an important role in promoting outcomes like reduced substance use and recidivism among people who are re-entering the community (Andreas, Ja, & Wilson, 2010).

Although there is a trend in research towards examining social support in treatment and social support among individuals who are in custody, little research has focused on the role of social support when serious mental illness intersects with the criminal justice system. One study investigated the social support systems of women re-entering their communities post incarceration with co-occurring disorders of mental illness and substance abuse. Findings of the study revealed that women who reported higher levels of social support reported less depression and felt more empowered (Salina, Lesondak, Razzano, & Parent, 2011).

The purpose of the current study is to address unanswered questions in MHC research regarding key factors involved in change and contribute to knowledge regarding the social support networks of individuals with an intersection of mental health challenges and criminal justice involvement. Based on social support theory and existing research, it is expected that the quantitative analysis will reveal that MHC participants' perceptions of their social support network will be associated with treatment adherence, use of social services, and the number of days spent in jail. As is customary in qualitative analysis, the qualitative portion of this study is not theory and hypothesis driven. Rather, semi-structured interviews included questions meant to inductively explore consumer experiences with the MHC in order to better understand what factors impact change from consumer perspectives.

Methods

The Setting

Mental health court participants from two Midwestern counties (referred to below as Court A and B) were recruited for this study between September 2010 and April 2011. Court A was established in 2004 and operates out of five different sites within the county while Court B was established in 2005 and includes a single site. Both MHCs in this study were located in an urban environment; however, Court B also covers a suburban and rural area. Courts A and B have a dedicated docket for people with mental illnesses and a single judge is

assigned to that docket. A team approach is utilized by both courts such that the judge, caseworkers, probation officers, court administrators, and attorneys meet frequently with one another to discuss participants' adherence to program requirements.

Participant eligibility is similar between the two courts (i.e., voluntary, most charges were non-violent/non-victim, exclusion of developmental disorders). However, Court A only accepts participants with felony charges; Court B accepts felony charges primarily but does allow for misdemeanor charges as well. Court A is largely post-conviction, meaning individuals must plead guilty in a traditional court prior to MHC participation. MHC participants from Court A serve approximately two years under MHC supervision. Court B has participants with both pre- (i.e., individual does not plead guilty prior to MHC participation) and post-conviction agreements. In comparison to Court A, Court B has a wider range of supervision times with as little as one year to as much as three years.

Both MHCs require participants to engage in mental health and substance use (when needed) treatment. The two courts offered similar services including outpatient mental health treatment (e.g., psychiatrist appointments, medication monitoring, psychiatric nurse home visiting, group therapy, individual therapy), inpatient and outpatient substance use treatment, vocational programs, support groups, and peer-recovery groups. Court A relies on a network of community treatment providers to supply the needed mental health and substance use treatment. The MHC staff work with community providers and MHC participants to monitor and supervise engagement in treatment. Court B also utilizes treatment providers, but those providers work within one agency and work as a team directly with court personnel.

In order to monitor participants, both courts require frequent contact with participants through formal court hearings and regular appointments with the MHC team. The MHC teams use rewards to encourage compliance and sanctions to deter problem behaviors. Both courts offered a similar range of incentives. Sanctions for non-compliance could include increased reporting to MHC staff, increased frequency of urine screening, community service, and in extreme cases overnight stays in jail. Rewards include verbal incentives such as adulation from the MHC team to more tangible incentive such as reduced court appearances, overnight passes to stay with family, and ultimately graduation from the program. Participants who entered the MHC under a pre-conviction agreement often had their charges dropped or reduced once they successfully completed the program.

Eligibility and Sampling

In the current study, eligible participants were adults enrolled in the MHC between two and eighteen months and who were not in custody. Ninety-one participants met eligibility criteria and were invited to participate through the distribution of flyers by the researcher or MHC staff. Eighty participants (88%) consented to study participation (40 from each court) for the structured interview. The 11 eligible participants who were not enrolled did not participate because they did not return the researcher's phone call, did not have a working number, or presented with paranoid delusions that interfered with the consent process.

During the consent process prior to the structured interview, participants were asked if they were interested in participating in a second interview. Seventy-nine participants consented to recruitment for the second interview. Thirty-five individuals were purposively sampled and invited via phone to participate. Purposive sampling occurs when the researcher selects cases strategically to provide depth into the phenomenon under study; the cases selected were meant to include study participants who were most able to engage in a dialogue regarding their experiences with the MHC in order to shed light on the concepts under study (Kemper, Stringfield, & Teddlie, 2003). The sub-sample was additionally selected based on

sex, criminal history, and substance use as these factors have impacted recidivism in past studies (Hartwell, 2004). Of the 35 individuals sampled, 26 consented to participate (13 from each court). The nine individuals who did not consent to participation, did not show up to the scheduled interview, did not return the initial phone call to schedule the follow-up interview, or did not provide a working phone number.

Procedures

All eligible people who consented to participating in the research project met with the researcher for an interview at a location convenient for the participant. The structured interview consisted of standardized measures and questions regarding demographics, attitudes toward medications, symptomatology, and perceptions of support. Participants also provided consent for the researcher to collect administrative data regarding treatment adherence, the number of days spent in custody, and the number of social services used each month for six months following their structured interview. Participants who consented to participation in the semi-structured interview, met with the researcher one to four months after their initial interview. The second interview consisted of open-ended questions regarding participants' experiences with the MHC and their perspectives regarding the factors that are important in promoting change. The appropriate Institutional Review Board reviewed and approved all forms and procedures in working with human subjects.

Measurement

Independent and control variables—Participants self-reported background characteristics including demographics, mental illness diagnosis, legal history, and number of months in the MHC. Standardized measures were used to assess symptom severity, attitudes towards psychiatric medications, and perceptions of support among participants' core network members, MHC judge, MHC caseworker, and participants' primary community treatment provider.

Symptom severity, which was used as a control variable in analyses, was assessed using the *Anchored Brief Psychiatric Rating Scale* (BPRS; Overall & Gorham, 1962). The BPRS is an 18-item measure with symptom severity reported on a 7-point scale from 1 (*Not reported*) to 7 (*Very severe*). The scales are reliable based on inter-rater reliability testing with scales ranging from $r(144) = 0.52$ through 0.90 (Overall & Gorham, 1962). Each item includes a description of the symptom and a descriptive anchor.

Participants' attitudes regarding medication were measured using the *Attitudes Toward Psychiatric Medication Scale* (ATPMS; Streicker, Amdur, & Dincin, 1986), a five-item instrument measuring perceptions of the effectiveness of psychiatric medications. The ATPMS is grouped with questions assessing effectiveness and questions assessing side effects; both sets of questions have good internal consistency, 0.80 and 0.61, respectively, among people with serious mental illnesses (Streicker et al., 1986).

In order to estimate participants' perceived network support, participants were first asked to list up to five people in their lives excluding treatment and court staff. Participants were instructed to identify the core people in their life. The social support scale of the *Social Support and Undermining Scale* (SSUS; Vinokur, Caplan, & Schul, 1987) was used to estimate perceptions of social support. The social support portion of the scale includes eight questions measuring the perception of support (i.e., emotional, instrumental, appraisal, and informational support). Internal consistency estimates of the scales range from a Cronbach alpha of 0.81 to 0.87 (Vinokur et al., 1987). Questions are rated on a 5-point scale from 1 (*Not at all*) to 5 (*A great deal*). Participants answered questions on the SSUS for each of their identified network members (up to five) and their formal network (i.e., MHC

caseworker, the MHC judge, and the primary treatment provider). Estimates of perceived support from core network and formal network members were summed and averaged for analytic purposes.

Dependent variables—Measurement of three dependent variables occurred for each of six months following participant interviews. Members of the MHC team provided the researcher with the number of days the participant spent in jail and the number of services the participant utilized per month including individual/group therapy, non-clinical groups (e.g., skill building, GED preparation, 12-step, vocational training), psychiatric visits, and substance use treatment. In addition, MHC caseworkers assessed treatment adherence each month using a four point scale (1 = *Never follows treatment recommendations*; 4 = *Always or almost always follows treatment recommendations*). The monthly variables were summed over the six months to create three single continuous variables for days in jail, service utilization, and treatment adherence.

Data Analysis

A concurrent triangulation mixed-method design was utilized to address research questions. In a concurrent triangulation mixed-method design, the study is constructed in order to explore phenomena and test for relationships between factors (Creswell, Plano Clark, Gutmann, & Hanson, 2003). Results of the quantitative analysis are directly compared and contrasted with the emerging themes in the qualitative analysis.

Qualitative analysis—In order to analyze participants' experiences with the MHC, a thematic analysis was conducted. Thematic analysis is an approach used to identify, analyze, organize, interpret, and present patterns or themes within data (Braun & Clarke, 2006). Themes are intended to capture "something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). Themes and the interpretation of these themes are generated recursively. The researcher asked open-ended questions regarding participants' general experience with the MHC (e.g., *In your experience with the MHC, what works? What doesn't work?*) and provided opportunity for participants to discuss anything about their experience that they perceived as important (e.g., *Is there anything you would like to tell me about regarding your participation in the MHC?*). Follow-up questions based on responses varied from participant to participant. In order to conduct the thematic analysis, the transcribed interviews were analyzed line-by-line; references to factors thought to impact individual change were coded. References were then analyzed line-by-line until salient themes emerged. The qualitative analysis was organized using Nvivo software version nine.

Quantitative analysis—Correlations were calculated between continuous dependent and independent variables. Bivariate analyses and theory-driven variable selection strategies were employed to identify parsimonious linear regression models in order to examine the association between perceived social support and service use, treatment adherence, and days in jail. Attitudes towards psychiatric medications, number of months in the MHC, symptom severity reported during research interviews, and MHC were used as control variables in the final models. Control variables were selected based on their theoretical significance, statistical significance in bivariate analyses ($p < 0.05$), and variable stability (both skewness and kurtosis). Although sex, criminal history, and substance use were identified in previous research to impact recidivism (Hartwell, 2004), these factors were not significant in bivariate analyses in this study and thus not used as controls. Participants with missing data were not included in the analysis. All quantitative analyses were conducted using SPSS predictive software version 20.0.

Results

Sample Description

Table 1 presents the demographic characteristics of the study sample. Over half of the study participants were male (55%) and African American (56.3%). The average age of participants was 39.6 ($SD = 12.1$) years old. Nearly half of participants in the study reported to be in a relationship (48.8%). On average, study participants completed 11.3 ($SD = 2.5$) years of education. Very few participants worked at the time of the baseline interview (5%); just over half of the participants received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). At the time of the initial interview, participants were in the MHC program for an average of 7.6 months. After the six month follow-up period, 10% of the study sample was terminated unsuccessfully or went missing four or more months of the follow-up period. A participant is considered missing when the MHC staff is unable to locate the participant.

The majority of individuals in the current study reported a primary diagnosis of bipolar disorder (58.8%). Ninety percent of study participants reported a primary diagnosis that is considered to be a serious mental illness (i.e., bipolar disorder, major depression, schizophrenia or schizoaffective disorder). The majority of study participants also reported a co-occurring substance use disorder (83.8%). The majority of participants were not experiencing severe psychiatric symptoms during the seven days preceding the structured interview. The average rating of symptoms among participants was highest for anxiety, depression, and feelings of guilt. The majority of participants agreed or strongly agreed that medication is necessary, helps to manage stress, prevents psychiatric hospitalizations, controls symptoms, and improves self-esteem.

Participants were asked to list up to five people who they consider to be their core group of family and friends. On average, study participants reported 2.7 people in their informal networks. This is comparable to a study using the same method of data collection and involving a very similar population who reported an average of 2.9 core network members (Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2008). Participants perceived moderate social support from informal network members, $M = 32.85$, $SD = 6.45$, on a scale with a maximum rating of 40. Participants perceived slightly less support among formal network members, $M = 29.56$, $SD = 7.58$; these differences were statistically-significantly, $t(77) = 4.82$, $p < 0.01$. When looking at participants' entire social network (formal and informal combined), participants perceived moderate support, $M = 30.75$, $SD = 6.61$.

In the two years prior to MHC participation, participants were arrested, on average, 2.9 times. Participants reported the charge that led to their participation in the MHC. Most participants were arrested for retail theft or burglary charges (43.8%), drug related charges (21.3%), or battery and assault (17.4%). A small percentage of participants were charged with prostitution, criminal damage to property, trespassing, driving on a revoked license, forgery, probation violation, and resisting arrest (17.4%). The majority of charges were considered felonies (86.3%). Some participants reported that their charge was considered violent (13.8%).

Court differences—All factors listed in Table 1 were examined for between court differences. Independent t-tests indicate that participants from Court A are, on average, older, $t(78) = 2.49$, $p = 0.02$, $d = 0.55$, and reported being arrested more often, $t(78) = 2.38$, $p = 0.02$, $d = 0.55$, in comparison to participants from Court B. Participants also differed in race, $\chi^2(4, N=80) = 12.59$, $p = 0.01$, $V = 0.40$, and substance use diagnosis, $\chi^2(1, N=80) = 11.11$, $p < 0.01$, $V = 0.37$, as demonstrated in Pearson Chi-square tests. Court A had more African American participants and more participants with substance use diagnoses in

comparison to Court B. There were no statistically significant differences between courts in perceptions of network support.

Factors Involved in Change

Through thematic analysis, transcribed data were explored to better understand the various processes and factors that facilitate change as identified by participants. Data were coded as themes (referred to as factors involved in change) if participants discussed the component as being a driving force behind personal change. Participants identified salient factors involved in recovery, some of which are related to social support and some unique contributions, including structure and accountability, access to treatment, and instilling motivation. Each factor is discussed below and is illustrated with quotes directly from participants' experiences. Although discussed individually, the factors highlighted in this section often interact with other factors in various systems surrounding the MHC participant (i.e., the availability to quality treatment, housing options, employment or stable income). The findings of the thematic analysis suggest that it is likely that change results from the complex interplay of multiple factors and/or processes.

Structure and accountability—According to participants, the structure provided by the MHC program, including the role of accountability, is important in promoting change and positive outcomes. Participants acknowledge the role of structure in the MHC program in promoting and supporting change. References coded as structure and accountability included data describing structural features of the MHC (e.g., scheduling, requirements, policies) and accountability (e.g., having to be some place at a certain time, fulfilling court expectations, providing random drug screens) as features of the MHC that assist participants in promoting change in their life. Participants described the structure as, "It's like keeping me on my toes, making sure I'm doing what I'm supposed to be doing and making sure I'm taking my meds, going to meetings." Another participant discussed the MHC structure as having to be "... somewhere every day of the week and they keep me busy, which is not a bad thing, but sometimes it's overwhelming." Specifically, structure and accountability mean being required to adhere to a schedule of activities or services, report on one's progress to authority figures, and knowing that there is an expectation of responsibility, which if not upheld will involve consequences. The act of being held accountable, over time, facilitates participants' recovery by having a life with structured and meaningful activity.

When discussing the role of structure and intensity of the MHC program in participant experiences, participants used words like "need" and "good for me" in relation to goals of recovery. For example, one participant said, "It might be harsh, but in life I need that kind of structure to get back in focus." Another participant echoed with,

I need structure right now. Now, I was good at having structure before I got sick, and before I started using drugs, but I need the structure, and I know a lot of other people who have never had structure. So, if it's helping me, it's gotta help them.

Another participant further described the structure as necessary in recovery despite some initial frustrations with it:

Mm hmm, the constant on-my-back to do the right thing, despite me being a little upset with it, but I love that constant pushing that they're doing for me, and having me to do for myself. They're pushing me in the right direction. This might sound weird, but the more I get upset with them pushing me, the better my personality and everything gets stronger, and I can think clearly now. I can focus.

Participants also discussed the structure of MHC programs as being more intense than traditional probation. One participant had multiple previous experiences with traditional courts and probation. When asked to recall differences, the participant stated,

Oh, [MHC] is definitely more intense. They're right there. You don't get away with much. They want to know everything. They want honesty. Definitely, when I was on probation for the DUIs, I saw them once a month, and then maybe sometimes I didn't, and I'd just have to fill out a paper, and I might have still been drinking. I don't remember. But here, they hold you accountable. They drop me from time to time. Definitely more intense. I could get away with a lot when I was on probation before. Here, they're – and it helps me, though. I need that structure right now.

Structure and accountability, as discussed in participant interviews, appears to influence change through two different means: judicial leverage and instilling self-regulatory behavior. Frequent monitoring of drug and alcohol use through urine screens and breathalyzers by both probation and treatment providers is one feature of the MHC structure. One participant said the structure of the MHC worked well for him because of the intensity of his schedule and the random urine screens. He stated,

Because, you know, they sanction you if you get in trouble, you know, you could get your probation violated. You know, you're always—you're constantly always doing something. If you're not going to a group, you're going to be reporting to probation or going to court. They lessen up on you as time lapses and you do good. You know, you're always peeing in a cup; you don't even know when it's going to happen. You know, you can think, 'Well, she dropped me yesterday' and think, 'Well I can use now.' Shit, they dropped me two days in a row before.

In this case, the judicial leverage is using a legal sanction like jail to deter individuals from using drugs.

Structure and accountability also appear to be influencing change through the facilitation of self-regulation. Participants discussed how participating in the MHC instilled their own sense of structure and accountability. For some participants, the MHC structure may be promoting self-regulation. For example, one participant described the impact of structure and accountability by saying, "I think it's good for me to – I think if I have this guidance in my life for two years that I could continue on myself after that," while another participant said,

You know, that's one thing that's exciting, you know, it's something good that really came out of it. The routine, in itself, is something that they can't – you can't really put a price on that. You know, I've got it instilled in me. I do it every day.

The structure of the MHC and accountability required from it created a "foundation" for one participant's recovery: "I know my recovery's never gonna end, I'll be recovering the rest of my life, but I think after the two years here that I'll have a strong foundation and I'll have – recovery just will be a part of my life."

While structure and accountability were reported as positive factors that promoted individual change, there were overt references regarding the negative impact of structure and accountability. Some participants expressed the structure as being too stressful and too much for some people to manage while others referenced the angst that accompanies court hearings at times, the consequences of being taken into custody when probation is violated, and the uncertainty when seeing other MHC participants being taken into custody during court hearings. One participant became frustrated when talking about the role of accountability in his experience with the MHC and his ability to change. He reported,

And then they said another dirty drop I'll go to jail. That's – that's threatenin' me, you know, stipulations on me and all this is mine – I hadda 30-some years gettin' high, usin' narcotics, you know, you just can't stop instantly at once.

In summary, structure and accountability work for some individuals through the use of judicial leverage and the promotion of self-regulation. As participants shared, the use of judicial leverage may not be effective in promoting sustained change among participants; however, as discussed in the literature, using strategies to promote self-regulation (i.e., instilling social norms, rule abidance, the use of coping skills during stressful times) may be more helpful for longer-term change (see Tyler, 2009).

Supportive services—Participation in the MHC facilitates the perception that extensive support is available for participants when needed. Participants reported, "...they can hear me out, and I feel that, like, if I need anything, or need somebody to talk to, they're there for me" and "It [MHC] lets me feel that I have another support, another supporter that I mean it cares what happens to me, it cares what I do in life. It's there to help me." Another participant shared,

It just feels like you have so many outlets when you are having problems. If I can't get a hold of my therapist, I can call the counselor. [Treatment providers] has a 24-hour hotline, and they have a house for people who are having problems, you know, if it's a crisis. So, I feel like I have no excuse. I have someone to call if I'm having some problems mentally or wanting to use drugs. That's how it feels, that I have a whole bunch of people who want to help me.

As indicated in the above example, participants found that perceiving support helps them in their journey through recovery. References coded as support included data indicating participants felt the receipt of support or the perception that support was available by individuals involved in their care helped to promote personal change. The perception of social support and that people are willing to help in a time of need is thought to impact one's self-esteem, stability, and feelings of control over the environment (Cohen & Syme, 1985). Not surprisingly, MHC participants talked about their perceptions of lost control over their life; perceptions of support may be particularly important in buffering the loss of control inherent in the justice system.

Perceptions of social support within the context of treatment appear to play a role in managing symptoms for participants. For example, one participant discussed the role of support in her interactions with her individual therapist.

It's just being able to talk. If I have issues, if I notice I'm, you know, having - you know, if I'm acting impulsively, or thinking kind of shady, then I can go in there and discuss that with her, and leave out of there in an hour, you know, with a much more clear idea of what's going on, what's behind, you know, why I'm doing what I'm doing. And I'm able to correct some of the things that I'm noticing myself. You know, she's able to help me recognize that, and I think that's - you can't put a price on that.

Actual receipt of support within the formal treatment context is also mentioned as critical for individual change. Participants consistently use language that attributes support in therapy to positive outcomes in participants' lives. This finding is consistent with previous research. Social support, in previous literature, is thought to impact health-promoting behaviors (House et al., 1988) and mental health outcomes like distress, depression, and anxiety (Turner & Brown, 2010). Social support, as discussed by participants, is similar to the bond that Bordin (1994) describes as being essential in developing an alliance between therapist and participant.

One participant reported that support from the MHC staff was particularly important because he has no family; sizeable portions of participants are estranged from their family or have poor familial relationships. Some participants, however, do have family members who provide support in various ways that participants felt contributed to their recovery. For example, one participant shared, “Well, with my mental illness, you know, my girlfriend helps me. She reminds me to take my medication and stuff like that, you know. ‘Hey, honey, you take your pills’ and whatever, you know. Sometimes I forget. That’s part of the illness.”

Informal peer support within the treatment context is also important for client change. MHC participants consistently referenced the importance of supportive groups in their recovery. Group interactions (i.e., group therapy, MISA, AA/NA) involving peers are particularly important in recovery, according to participants. One participant shared,

All of it kind of ties in together because all of these [people] relate to your addiction and I think it just gives me a chance to vent. It gives me a chance to hear my solution through what other people say. Sometimes what they say is a solution for me. It gave me a chance to communicate and it gave me a chance to - I got connected with people. People would look forward to seeing me. It was, ‘Hey, [Name] how you doing?’ and give you a hug, ‘I’m glad to see you,’ so just through that it was helpful, all of it.

Another participant echoed the above by talking about the support she received from self-help groups and what role this kind of support played in her recovery.

Well they understand, for one. Everybody that’s there has been through what I’ve been through and got through it and can show me how they did it. They understand. I can’t say I would really be too receptive to somebody who read this in a book. You really don’t understand. There’s no possible way you could fully grasp the whole thing. You just couldn’t. So having somebody who knows...They’re just really supportive and unconditionally. There’s nothing you can go in there and you can go in there and just get shit off your chest without any – I don’t know. Everything about it. Nobody’s going to look at you crazy because they all probably did the same crazy ass thing that any other normal person would look at you like for – seriously. Yeah, I like it and it’s a spiritual program and just helps you deal.

Both quotes illustrate the central role of support-based services involving peers in recovery; the following quote builds on the previous quotes as the participant who shared her experience connects the support she received from group to maintaining her sobriety.

A couple weeks ago, when my mom was in the hospital, I was having a hard time. And I was sitting waiting for group to start, and my mind was like I wanted to use. I really did, and I had a really hard time, like, ‘Maybe I should bring it up in group. No, I’ll just call my sponsor when I get home. No, I’ll do this.’ Well, I had total tunnel vision. I just wanted to use. So, when I got in group, I blurted it out, and my group reminded me of all the consequences I will have, forget the court and all that, but my sister-in-law and my brother - they’ve just had it, and we’re right now doing really well - jail, starting backwards, I’m gonna be depressed, I’ve gone this far. They just all reminded me of all the good things that’ll happen if I don’t pick up, and that I just need to get my mind off, get it off, and I was glad I did that. It was hard for me because part of me didn’t want them to talk to me about it. I wanted to use, and that was the bottom line. But because I told them, they saved me.

Participants with a history of substance use reported that the people in their networks and activities they participate in have an influence on their recovery. Similarly, in previous research, twelve-step groups were especially helpful in rebuilding networks for individuals who had networks that were supportive of drinking (Longabaugh, Wirtz, Zweben, & Stout,

2002). Engagement in treatment and support groups not only helps clients to build a healthy recovery network of peers, but it also assists clients in detaching from their external negative peer groups. Fundamentally, group-based treatment can expand individuals' networks of people in support of recovery efforts.

Participants found that keeping involved in activities related to recovery like working at a halfway house or taking a leadership role in Alcoholics Anonymous, help to ensure that their network includes many supportive people with similar goals. Participants suggest that family is important in recovery but that their peers are critical, especially when peers have had similar experiences with substance use and mental health concerns. Previous research has discussed the unique role of peer supports as being critical to individuals in recovery. In fact, researchers have postulated that connections formed between "similar others," may be more supportive than familial networks (Thoits, 1995). These similar others share the experiences of the individual; however, they are not embedded in the possibly stressful context of their family system. In sum, participants perceive that supportive services offer significant opportunities to strengthen support within their networks, which they found to enable and promote individual change.

Providing access through treatment—Participants identified aspects of treatment including services coordinated by, provided by, or accessed through the MHC as being of central importance in promoting positive outcomes. The MHC program offered access to treatment and services that participants were unable to utilize prior to MHC participation because individuals were uninsured or underinsured, treatment providers had limited beds for treatment, or the individual was unaware of service options. Participants also discussed how treatment facilitated recovery and what role it played in personal change.

The availability of mental health and substance use treatment in both counties in this study is challenging in the current economic climate. Participants interviewed had been in treatment at least once before the MHC program. Experiences varied but many participants referenced challenges they faced in trying to obtain treatment. The MHC program, in participants' experiences, increased access to treatment through the MHC staff's connections to community treatment providers, sources of funding, and advocacy. Every interview conducted with participants included references made regarding treatment; although some participants reported the MHC staff needed more connections to community-based services, especially surrounding employment, the vast majority reported the MHC program offered access that he/she had not had in the past. The following quote illustrates the concept of increased access and is one of many quotes in the data that support this theme. The participant quoted below is recalling a conversation she had with her MHC caseworker.

I know for a fact because yeah, because all these people are looking for beds in different places. I'm the only one here who's court mandated and they're having a hard time getting into anywhere... Yeah, [MHC Caseworker] like, "Yeah, babe, you're going to go to [Treatment]." This other girl called [Treatment] and they told her, "We won't be able to get you into March. We'll give you an appointment in March. We're getting like a thousand phone calls a day." [Other treatment] was saying the same thing to somebody else. So [MHC] was able to get me in no problem.

In addition to accessing services, participants also discussed assistance in paying for medications, transportation to appointments, and assisting in applying for entitlements. Having benefits and a source of income is an important first step to positive outcomes. However, participants also referenced the benefit of having a team of individuals who assist in treatment and towards recovery-oriented outcomes. The following quote is one of many that reflect this theme.

You know, you've got more people to talk to when you're just a participant - or when you're a participant in [MHC], you know, you've got one-on-ones where you've got to talk to your therapist and your case manager and stuff, you know, as being just a regular, you know. You don't go through as much intense therapy and stuff. They give you therapy and stuff with the [MHC] program, which is better.

Participants also consistently referenced the MHC program as being responsible for assisting in obtaining the right diagnosis, medication, and/or treatment regimen. Participants discussed the importance of having the right diagnosis, being connected to the right treatment, and taking the right medications. One participant had a new diagnosis and said she was "coached" on how to take care of herself and her illness. Participants frequently reported difficulty with treatment in the past due to medication mismanagement and ill-fitting treatment programs. One participant shared the importance of his connecting with the psychiatrist affiliated with his MHC program.

The medication I'm on now is - I'll put it this way, in my own words, I stopped taking medicine that I've been prescribed to in the past but I won't even think about stopping this medication because I believe it's the right medication that I'm on.

References regarding treatment and stability arose consistently throughout the interviews.

Once engaged in treatment, participants discussed the utility of their treatment in recovery and producing change. Every participant engaged in treatment was able to identify and discuss one aspect of treatment and service provision that he/she found helpful in recovery. One participant found that individual and group therapy assisted in managing his illness and substance use. "It gave me coping skills to know that if it can be done I can do it. Fight the trigger." Participants discussed participation in parenting classes, coping skill groups, understanding mental illness and substance use, MISA groups, individual therapy, and community support and how these services have prompted individual level change and recovery. For example, a participant said, "I won't never forget in my whole life some of the things that I learned in that. And I use them every time I see [my son]. You know, and that's stuff that I'll have with me for a lifetime that came out of that." Another client echoed the same thought regarding the sustainable changes inherent in the services received within the context of their MHC program.

I want to be in a zone so I don't have to accept what I hear in my head and what I see and everything else; I don't want to have to accept it. And the [MHC] program has taught me to deal with it, you know, on a daily basis, instead of trying to use and self-medicate myself as to try to escape from reality.

In the current study, participants reported that treatment provided in the context of MHCs addressed their mental illnesses, substance use disorders, past trauma, "crime addictions," and criminal thinking. In reference to individual therapy, one participant described how his treatment combined symptom reduction and addressed antisocial behaviors: "I think it's an important part of my, should I say recovery?...if symptoms come back, I won't have that criminal-minded attitude and end up doin' something I regret. I think it helps." One criticism of MHCs is that they only provide services to address mental health problems; however, the current study provides preliminary evidence that participants also receive services and treatment that begins to address some of the issues related to their criminal justice involvement.

Facilitating motivation—According to participants, one important process in promoting recovery is facilitating motivation "to do better" and to "work" the program. Participants found the use of reinforcement was helpful in facilitating motivation and program success. An example is illustrated in the quote below.

The reward, I hate to say that I should be rewarded to stay clean, because it's my choice, but it makes it worth it, you know? I'm doing this every day, and then to actually go first today and not to have to see the judge for a month - it was just every week, and then every other week, and now it's every month. That is a good reward. I'm doing well and they're letting me know that they know I'm doing well, and that makes me feel good. It's like trying to please your mother, your family, you know, as a kid.

As is evident from the above quote, reinforcement facilitates motivation but there is also motivation to make staff proud or to please staff. External sources of motivation, like reinforcers, help to instill or facilitate internal motivation for participants. The reinforcement acts as motivational tools to encourage participants to continue working towards recovery. Rewarding behavior to promote change has a long history in theories of operant conditioning (see Bandura, 1969). These findings are also supported by the research surrounding the effectiveness of contingency management in outpatient treatment settings for individuals who have problems with substance dependence (Petry, Martin, Cooney, & Kranzler, 2000). Contingency management uses reinforcers like money or vouchers for retail goods when participants submit negative urine screens for alcohol and/or drugs. Studies suggest that the use of reinforcers increases program retention and extends periods of sobriety.

According to participants in the current study, tangible goods in addition to staff approval can act as reinforcers. Staff responsiveness, in particular, may be a powerful source of reinforcement. Although participants discussed the receipt of reinforcers in semi-structured interviews, many participants were not able to identify reinforcers given by the MHC staff when asked during the structured interviews. Participants were prompted to recall the number and types of reinforcers received in the MHC, and less than one quarter was able to identify reinforcers. Some participants were not aware that the MHC used reinforcers. It may be especially important to make the use of reinforcers in MHC more apparent in order for participants to benefit from the use of approaches related to operant conditioning.

Social Support and Outcomes

In the MHC and related literature, social support was speculated to be a factor involved in reducing recidivism and increasing service use. Through thematic analysis, participants identified salient factors involved in recovery, some of which are related to social support and some unique contributions. One of the goals of this research project was to explore the factors or processes that consumers perceived to be important in promoting change; a second goal was to estimate the associations between factors identified in the literature as promoting change in MHCs (i.e., social support) and outcomes. In order to estimate the association between participants' perceptions of their social support network and outcomes, linear regression analysis was conducted. As outlined in Table 2, perceptions of social support in participants' networks were not significantly associated with any measured outcome. Counter to what was hypothesized, participants' social support network did not significantly influence positive clinical or legal outcomes among MHC participants including service use, treatment adherence, or the number of days spent in jail.

Although results were not statistically significant, it is worth noting the direction of the associations between support and outcomes. For example, social support increased as service use increased, which is not surprising based on previous literature. It is surprising, however, that as perceived social support increased, the number of days spent in jail increased but treatment adherence decreased. Support was conceptualized at a network level to include friends, family, and providers. These surprising results may speak to the differential influence of support between formal and informal network members. These

results are unexpected and discordant with previous research. Possible explanations for these inconsistencies are explicated below.

Discussion

Mental health court participants identified a number of important factors that they perceived to be involved in change including the structure of the MHC program and personal accountability, supportive services, access to treatment provided through the MHC, and increased motivation. Counter to what was hypothesized, in the quantitative analysis MHC participants' social support networks were not significantly associated with social service use, treatment adherence, or the number of days spent in jail. As postulated by Corrigan and Phelan (2004), subjective factors represent an individual's perception of the quality of their network, level of satisfaction and mutuality gained between individual and network members. This study's qualitative findings provide evidence of the importance of not just examining quantifiable factors related to support but the subjective nature of social networks to uncover the various aspects of the support systems that promote change in the lives of MHC participants. Moreover, an examination of the subjective nature of social networks provide insights into the factors that shape change in the lives of the larger population of individuals receiving services due to their mental illness and criminal justice involvement.

There were significant differences in perceived support between formal and informal network members such that, on average, participants perceived greater support from friends, family, and non-treatment involved acquaintances in comparison to providers and MHC staff. Considering that research has shown that the informal systems of family members and peers outside of treatment can serve as a detriment to treatment progress and support (see Westreich et al., 1997), this may, in part, explain the unexpected findings in the quantitative analysis, but would greatly benefit from further analysis. While this study sought to focus on the consumer's perceptions of support within their informal and formal networks, further study into network members' perspectives could help tease apart results and provide a more comprehensive understanding of the social support exchange process. Nevertheless, supportive services, from participant perspectives, were a major factor in promoting change. It is possible that different kinds of support offered by formal network members (i.e., emotional, instrumental, appraisal, and informational) and informal network members may influence outcomes in different ways. Thus, disentangling how various forms of support shape outcomes is useful.

When interpreting the findings of this study, a few key limitations are important to consider. One limitation is the relatively small sample, which was unavoidable due to the size of the MHCs. The follow-up period of six months was also relatively short. Future research should include a longer follow-up period of post-MHC participation in order to assess the longer-term associations between support and outcomes. Perceptions of participants' social support networks were only captured at one point in time; it is likely that these perspectives may change throughout the course of involvement in MHCs, considering previous research has shown that the utility of social support can vary at different points in treatment (Westreich et al., 1997). Finally, MHC participants did identify a number of factors within the MHC that they believe cause change; however, this study did not employ a research design that allows for causal relationships to be determined. Future research would strengthen the body of MHC literature by investigating the causal associations between identified factors and clinical and legal outcomes.

The current study findings present significant insights that have a number of implications for service providers and researchers. Based on MHC participant perceptions, program structure, holding individuals accountable and utilizing approaches to instill motivation

while also providing support were especially helpful in promoting their recovery. Service providers working with people who have mental illnesses who are also involved in the criminal justice system can incorporate these factors into their daily work. These factors can be incorporated not only within the MHC context, but more broadly within micro relationships and macro organizations that service the general population with an intersection of mental illness and criminal justice involvement. For example, it is often necessary to hold people accountable for their actions especially for people in the criminal justice system. When taking these measures (i.e., requiring urine screens, giving sanctions, implementing fines), it may be especially helpful if providers do so while providing support and implementing strategies to address possible issues surrounding motivation (e.g., goal setting, motivational interviewing). Although quantitative results did not support the importance of social support, MHC participants did identify supportive services as a salient factor in recovery. Providers, including mental health workers and probation officers, should provide support, when possible, in their interactions with clients. They can also refer clients to services that involve information sharing (e.g., educational groups) or peer support groups in order for their clients to have a number of sources of support.

This study examines the experiences of a population which lies at the intersection of many marginalized groups; the clients in the MHC system not only have mental disorders and criminal justice involvement, but they also have addiction and substance use problems, as evidenced by the study group's 83% rate of self-reported drug/alcohol use. It is essential to utilize measures developed to consider this population's uniqueness. The measure used to estimate support in the current study was developed for the general population. This measure may not effectively capture support for this population and may be one of the reasons why hypotheses were not supported. Further development of population specific measures of support is needed for future research.

Additionally, considering that research suggests a relationship between perceptions of stigma, perceptions of social support and client access and engagement in informal and formal social networks (Beals et al, 2009; Hartwell, 2004), future research is needed to explore how stigma shapes perceptions of social support and individual change and motivation. Considering this populations' potential to encounter stigmatization due to criminal justice involvement, mental illness and addiction (Hartwell, 2004), research that explores the role of stigma in perceiving support is a critical next step.

Conclusions

With the large numbers of people with mental illnesses in the criminal justice system and the heightened risk this population faces when in custody, the development of alternative programs is essential. Mental health courts are one of many programs being used to address the complex needs of people with mental illnesses and criminal justice involvement. Although there is mounting empirical support for MHC program effectiveness, it is unclear what factors are important in promoting change. In the current study, MHC participants identified the structure and accountability inherent in MHC programming, supportive services, access to treatment, and approaches used to instill motivation as salient factors in their recovery. Although the importance of social support was not supported quantitatively, further research is needed to fully understand the role of social support networks for this population.

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Table 1

Sample Description (N = 80)

		%*	n
Sex	Female	45	36
Race	African American	56	45
	Bi-racial	5	4
	Caucasian	34	27
	Latino	4	3
	Native American	1	1
Relationship Status	Single	46	37
	In a relationship, not married	40	32
	Married	9	7
	Div/Widowed	5	4
Employment	Part-time	4	3
	Full-time	1	1
Program Retention	Graduated/Remained active	90	72
	Terminated/Missing	10	8
Receiving SSI or SSDI		51	41
Substance Use Diagnosis		84	67
Mental Illness Diagnosis	Bipolar	59	47
	Schizophrenia spectrum	30	23
	Depression	5	4
	Major Depression	3	2
	Other (ADHD; GAD, Phobia)	5	4
Primary Charge	Retail theft/burglary	44	35
	Drug related	21	17
	Battery/assault	18	14
Felony		87	69
Violent Crime		14	11
		M	SD
Age in years (range 19 – 65)		39.6	12.1
Education in years (range 3 – 16)		11.3	2.5
Months in MHC (range 2 – 18)		7.6	5.2
Core Network Members (range 0 – 5)		2.7	1.2
Arrests in 2 yrs. Prior to MHC (range 1 – 14)		2.9	2.4

* Categories may not equal 100% due to rounding

Table 2
Perceptions of Social Support and the Association with Service Use, Treatment Adherence, & Jail Days

	Service Use (n = 70)		Treatment Adherence (n = 75)		Jail Days (n = 77)	
	<i>B</i> ±	<i>SE</i>	<i>B</i> ±	<i>SE</i>	<i>B</i> ±	<i>SE</i>
Perceived Support	0.12 (−0.08, 0.32)	0.10	−0.05 (−0.19, 0.08)	0.07	0.80 (−0.08, 1.68)	0.44
Symptom Severity	0.08 (−0.07, 0.22)	0.07	−0.16 (−0.24, −0.07)**	0.04	1.09 (0.50, 1.69)**	0.30
Attitudes Towards Psych. Medication	0.12 (−0.43, 0.66)	0.27	0.20 (−0.14, 0.55)	0.17	−1.75 (−4.09, 0.60)	1.18
Months in MHC	−0.38 (−0.64, −0.12)**	0.13	0.08 (−0.08, 0.25)	0.08	−0.59 (−1.71, 0.52)	0.56
MHC	0.60 (−2.22, 3.42)	1.41	−2.25 (−4.00, −0.50)*	0.88	0.88 (−11.02, 12.78)	5.97
Constant	12.70 (0.47, 24.93)	6.12	24.99 (17.17, 32.80)	3.92	−11.56 (−64.24, 41.15)	26.43
	F = 2.42 (p = 0.05) R ² = 0.157		F = 3.68 (p = 0.005) R ² = 0.208		F = 3.41 (p = 0.01) R ² = 0.191	

* p < 0.05

** p < 0.01