Int J Public Health (2012) 57:7–14
DOI 10.1007/s00038-011-0268-2

ORIGINAL ARTICLE

Lessons from a Canadian province: examining collaborations between the mental health and justice sectors

Carolyn S. Dewa · Lucy Trojanowski · Chiachen Cheng · Frank Sirotich

Received: 8 October 2010 / Revised: 1 February 2011 / Accepted: 1 June 2011 / Published online: 17 June 2011
© Swiss School of Public Health 2011

Abstract

Objective The objective of this paper was to identify the factors that program developers perceived as important to the successful collaboration between the mental health and justice sectors in seven Ontario, Canada, post-booking programs.

Methods Semi-structured telephone interviews with developers of the programs in each region were conducted. Key informants were identified using a snowball technique. All transcripts were analyzed using a modified grounded theory approach.

Results The primary themes identified involved partnership development, adjustment to broader mandates and addressing ongoing challenges. Conclusions were validated through member checking.

Conclusions The findings highlight important considerations for cross-ministerial enterprises. If partnerships are constructed within the existing parameters of systems, the system with the most flexibility will be required to work around its partner's constraints. The role of the adapter could be acknowledged by having the funding flow through the adapter's system. Program development will involve a significant time investment including activities to become part of both systems' culture through education, establishing a presence and identifying boundary spanners. Long-run implications for both systems should also be considered.

Keywords Community mental health · Criminal justice · Court support programs

This paper belongs to the special issue "Intersectoral action to address the social determinants of health".

C. S. Dewa (✉) · L. Trojanowski
Health Systems Research and Consulting Unit,
Centre for Addiction and Mental Health, Toronto, ON, Canada
e-mail: carolyn_dewa@camh.net

C. Cheng
Canadian Mental Health Association, Thunder Bay,
Thunder Bay, ON, Canada

F. Sirotich
Canadian Mental Health Association, Toronto,
Toronto, ON, Canada

Introduction

Over the past two decades, there has been growing reliance on the criminal justice system to care for people with severe mental illness (Schneider 2010). This has been attributed in part to decreased psychiatric inpatient facilities (Schneider 2010; Morrissey et al. 2007). Morrissey et al. (2007) estimate that persons with severe mental illness in the USA are jailed 1.5 times more often than they are admitted to psychiatric hospitals. Additional US studies have found that between 28 and 52% of persons with serious mental illness have been arrested at least once (Fisher et al. 2006; Holcomb and Ahr 1988; McFarland et al. 1989). There is also evidence that a large proportion of people with serious mental illness have multiple bookings and charges (Rivas-Vazquez et al. 2009; Cusack et al. 2010, 2009). A Canadian study reported that compared to people without mental illnesses, those with mental illnesses have on average three times more police interactions (Hoch et al. 2009). Depending on the setting, methodology and specific definition of serious mental illness, estimates of the prevalence of serious mental illness among jail inmates and prisoners in the US vary between 6 and 31% (Broner et al. 2003; Ditton 1999; Lamb and Weinberger 1998; Steadman

et al. 2009) with prevalence rates among women more than double that of men (Steadman et al. 2009).

The USA is not alone in its experiences. Justice systems in a number of jurisdictions including Australia, Canada and the UK are facing similar challenges (Schneider 2010). As a result, the justice systems across jurisdictions are searching for interventions to provide mental health services for people when they come into contact with the criminal justice system (Schneider 2010). Diversion schemes have been identified as a strategy for reducing the presence of persons with serious mental illness in the criminal justice system (Schneider 2010).

Steadman et al. (1995) describe two broad categories of court diversion programs: (1) pre-booking and (2) post-booking with the former focusing on the intersection between the police and mental health services. Post-booking programs are targeted at people who have mental health needs and who either have been charged with or convicted of a criminal offense.

Lattimore et al. (2003) identified three models of post-booking programs: jail-based diversion programs, court-based diversion programs and mental health courts. Jail-based post-booking diversion programs are typically operated by pre-trial service personnel or specialized jail personnel who identify, assess and divert detainees with mental illnesses from custody to community-based mental health treatment with the consent of the prosecutor, judge and defense lawyer.

Court-based post-booking diversion programs (also referred to as court diversion programs) employ mental health clinicians who work within the courthouse. They receive referrals from court staff and conduct assessments and, in negotiation with the defense, prosecutor and judge, develop a treatment plan to facilitate a bail release of the accused person. Diversion can occur in the multiple courts before multiple judges.

In contrast, mental health courts are diversion initiatives in which the diversion process occurs in one specialized court where the judge, prosecutor, defense lawyer and other court staff have specialized training in working with persons with serious mental illness. Court personnel work collaboratively in conjunction with mental health court liaison staff to link the accused to treatment and supports.

As diversion initiatives have proliferated, evaluations emerged in the literature examining the effectiveness of these programs. The findings indicate that diversion programs are associated with less days spent in jail (Steadman et al. 1999; Hoff et al. 1999; Christy et al. 2005; Broner et al. 2005; Lattimore et al. 2003), longer time to re-arrest (McNiel and Binder 2007) and either reduced recidivism (Moore and Hiday 2006; Teller et al. 2004; Trupin and Richards 2003) or produced no increase in recidivism rates when compared to people with serious mental illness processed in the traditional court system (Shafer et al. 2004; Steadman et al. 1999; Christy et al. 2005). With regard to clinical outcomes, there is evidence that diversion programs are associated with reduced homelessness and psychiatric hospitalizations, and improvements in psychosocial functioning (Cosden et al. 2005; O'Keefe 2006). More recently, systematic reviews of the outcome literature indicate that these initiatives reduce time spent in jail (Sirotich 2009) and recidivism, as well as improve clinical outcomes (Sarteschi 2009).

However, these is a dearth of research exploring the elements related to either the successful implementation of diversion programs or the challenges faced in implementing these programs, which operate at the nexus of the mental health and criminal justice sectors. A search of the published literature in *MEDLINE*, *PsychINFO*, *PubMED* and *Social Work Abstracts* using the keyword terms of *court diversion*, *jail diversion*, *mental health diversion*, *mental health court*, *pre-booking diversion*, and *post-booking diversion* yielded little research examining important factors in the implementation of mental health diversion initiatives. Rather, the extant research focuses on the outcomes of diversion initiatives or their day-to-day process and procedures (Boothroyd et al. 2005; Trupin and Richards 2003; Linhorst et al. 2010).

A noticeable exception is a study by Steadman et al. (1995) in which they conducted a US-wide survey of jails to identify jail diversion programs and conducted site visits at 18 jail diversion programs where they interviewed program administrators, staff and stakeholders to identify factors common to the most effective programs. Steadman et al. (1995) focused on jail-based services operated by jail personnel and administered by the corrections sector. Further research is needed to examine factors for a successful cross sector collaboration between mental health and justice sectors in other post-booking models of diversion (e.g., court diversion programs), especially among programs operated by health service organizations rather than justice service institutions.

The purpose of this paper was to contribute to the literature by identifying factors that program developers perceive as important to the successful collaboration between the mental health sector and criminal justice sector in seven post-booking programs (referred to as court support programs) distributed in seven regions throughout Canada's most populous province of Ontario. We explore the recommendations that program developers regard as critical implementation factors as well as ongoing challenges that arise as they provide services to this population.

Methods

This study is part of a larger project called the Matryoshka Project (Dewa et al. 2010) that used a mixed methods approach to examine the continuity of care experienced by clients of the community mental health system. The study of the multiple layers and complexity of systems was well suited for the use of triangulation that a mixed qualitative and quantitative design offers. The larger Matryoshka Project and its mixed methodology are described elsewhere (Dewa et al. 2010).

This paper is based on a subset of semi-structured interviews conducted using qualitative methods. The interviews were with court support program developers and were conducted to better understand the structure of their programs and their development. Because the purpose was to describe the process of program development rather than to test theories, a qualitative design using a modified grounded theory approach (Glaser and Strauss 1967; Lingard et al. 2008) was employed.

Ethics approval was obtained through the Centre for Addiction and Mental Health. The sample comprised key informants who were familiar with the development of the court support programs at each site. All potential interview participants received an e-mail invitation that described the study. All people who were invited agreed to be interviewed and signed an informed consent form prior to the interview. Snowball sampling (Kuper et al. 2008a) was then used to identify other potential interviewees. Despite snowball sampling from the seven sites, only nine people were identified for interviews. All nine interviews were conducted. All interviewees were either program directors or agency administrators. It was interesting that none of the service partners from the justice sector were identified as potential interviewees. This may reflect the fact that the funding flowed through the mental health agencies and these agencies were responsible for the development of the court support programs. As a result, many of the interview participants came from these programs.

Trained interviewers used an interview guide to conduct the semi-structured telephone interviews (Appendix). The interviews were conducted in January–May of 2007. The interviews lasted between 30 and 60 min. All were tape-recorded and transcribed verbatim. An iterative process (Glaser and Strauss 1967) was used in which the interviewer and one of the authors reviewed the interview results. The interview team met regularly to discuss the emerging themes. In turn, the emerging themes helped to inform interviews. All transcripts were independently coded manually by two of the authors.

Validation of the resulting themes and conclusions was completed through triangulation in which results and conclusions were presented to interview participants, interviewers and the study research team (Kuper et al. 2008b). The multiple perspectives from these member checks helped to insure that the results were sufficiently comprehensive and accurate representations of experiences.

Results

All of the interviewees were asked about factors that contributed to the successful implementation of their programs. Three primary themes arose in the interviews: developing partnerships, adjusting to a broader mandate and identifying ways to successfully address ongoing challenges.

Developing partnerships

When asked what was one of the most critical factors contributing to the success of a mental health and justice program, all of the interviewees pointed to the importance of establishing partnerships within the justice system. One of the challenges is that within the justice sector, there are a variety of players and each must be engaged in the cooperative.

One interviewee described,

> … the linkages and the partnerships are all very key so it starts from the core working in that environment and certainly having the Crown's office onboard, the judiciary involved, the Duty Council involved so Legal Aid has a part to play. All of those key parts with the court setting are huge in determining the course and looking forward to success. If you do not have that partnership working, then the program is not gonna do very well so that is very important. Then there are all the linkages and partnerships outside of the court setting. That is all the support services that you try to offer us so working well with all of those other important players again in the community is another key element of the work we do. Again, that does not happen overnight. It takes a lot of time, diligence and work to help those things come together. [QL07]

The importance of establishing these relationships is magnified because the court support programs bring together two sectors operating under disparate mandates: that of the justice sector and the Ministry of Health and Long-Term Care. As a result, there are numerous opportunities for conflict. When asked about the development of their court support program, one program lead described,

> If you go back to the beginning, I think it is starting off completely in a new system and having to deal

with an adversarial system versus the supportive one that we are usually accustomed to in social services. I guess the challenge was getting people to buy into it… I think in the past, or even today, there is a stigma to mental illness anyway, but there is a greater stigma to those that are involved in the criminal justice system. [QL04]

This highlights the inherent tension between the two sectors. The justice community is mandated to and therefore concerned about adhering to and observing legal protocol and procedures. In contrast, the mental health community focuses on providing services that adapt to the differences in people, their needs, their circumstances and their illness experience. Thus, there is less emphasis on protocol than on addressing needs. One of the consequences of the two perspectives is that mental health and hustice programs are health interventions that are constrained to respect judicial procedure or outcome. This means that these programs are where the two systems find acceptable common ground.

To build bridges between the two systems, court support programs have relied on three strategies: education, becoming part of the protocol and establishment of a presence in court. Education involved helping partners to see court support as an effective support for them and for their clients. Key audiences for education include the referral points where mental health-related crisis may be greatest such as the police and hospitals. In addition, becoming a part of a system reliant on protocols also means adapting to the culture and becoming a part of the protocol. One interviewee described,

I guess bringing the community members, the police on board so that they recognize the benefit because sometimes it is easier for them to take the guy right to the hospital or whatever or take them to jail as opposed to taking them to the hospital and they keep them in overnight or something like that. We have done a lot of work in terms of education with the police and with the hospital. There are different access points to access safe beds either a police response to a crisis, if somebody presents in Emerg, if they present at the Crisis Centre or if it's one of our own clients, there are protocols in place. [QL09]

Another interviewee explained,

I think the police as well, their default is to go to the hospital. Part of it is a need to take some time in terms of cultural shift. What goes through their mind is fairly dichotomous. They either arrest criminally and proceed through the Criminal Justice System, or apprehension under the Mental Health Act and take them to hospital. So, it is sort of like a third option. I do not think it is really part of the mind set, and I think that will probably take some work in terms of education, both from bottom up in terms of doing educational sessions with various platoons, but also it comes from the top down, essentially central command indicating that these are services that should be provided by police, and that is really starting to happen now. [QL05]

Finally, the interviewees indicated that it was important to establish a presence in court. They felt that they needed to be seen by the justice staff as a daily reminder that they are there to help. By giving the court support programs office space in the often overcrowded courts, the courts also acknowledge the legitimacy of their role in the justice system.

I know that in terms of diversion in general that a key piece has been that we are visible, and by visible I mean like for example in the court. We have got an office now. [QL08]

Learning to work under a broad mandate

Interviewees also pointed to learning to work under a broad mandate as an important factor for success. The mental health providers were expected to provide services to the broader population served by justice. One of the frequently used examples of the broader mandate related to the diagnoses and intake criteria. The justice community uses a more inclusive definition of mental health than is generally used in community mental health services. For example, the justice sector definition includes people with acquired brain injuries and mental health problems such as anger management issues in addition to those with diagnoses for mental disorders as defined by the DSM-IV. For mental health providers who are accustomed to serving clients with diagnosis-oriented severe and persistent mental disorders (i.e., schizophrenia, bipolar disorder), adjustment to this more inclusive target population can be problematic. As one mental health service provider described,

… you can stick a label on any behaviour and medicalize criminal behaviour. That is not to say that there are not individuals who are mentally ill and as a result of the illness come into conflict with the law, but there is also individuals where for example, an adjustment disorder…personality disorders, the involvement with the criminal justice system is actually a symptom of that disorder. So, they provide assistance for those individuals as well. [QL05]

Thus, court support programs enroll clients who in the past would not have been enrolled in a community mental health program. Other interviewees pointed out that these

less restrictive inclusion criteria require court support programs to provide services to more types of populations and collaborate with a new set of service providers. For example,

> Now, we try to work things out for folks… If we have a situation, which has happened a few times, where the individual clearly is not necessarily dual diagnosis but they are developmentally challenged or have an acquired brain injury and they are in the courts and clearly there is a problem. As long as they have their support, we will work out a diversion plan for them and we will work with those partners. We do not do the follow-up other than to report to say are they following the plan but they do get our help anyway. [QL01]

The mental health community faced an additional learning curve. The population that it was called upon to serve was not the one it had anticipated; the majority of clients they see cannot be diverted because of the nature of their charges. Although the court support programs were intended to target people who are considered “low risk” (MOHLTC 2006), often the court does not interpret the charges as being “low risk”. Yet, these people can benefit from mental health services. Consequently, rather than diverting people out of the court system, people who are in the justice system have been diverted into mental health services. It has been described with,

> … I was already doing diversion down there so it was clear to me that the amount of court support without the actual diversion is much higher than the actual number of diversions. I think that is a challenge in terms of your community understanding that right from the get-go that some of the groups thought that was outside your mandate; that if you were not diverting somebody that you should not actually be there. [QL01]

Continuing challenges

Court support programs continue to face a number of challenges. One of these involves accessing psychiatrists and other specialty mental heath services. One respondent explained that “getting them into the health system has been really hard. We are good on conviction services but having to access psychiatrists [is] a really big jump for us” [QL06]. Another interviewee perceived the lack of psychiatrists as part of “developing that network of services outside of court support” [QL05]. In part, the difficulty lies in identifying a psychiatrist. Another problem is related to having access to funding. As one interviewee asserted, it helps “if you can get your hands on the dollars for psychiatrists” [QL05]. A third barrier to accessing psychiatrists is the stigma that arises as a result of justice sector involvement.

Almost all the programs indicated that concurrent disorders were also a challenge. Thus, the programs have been making efforts to insure that these services are available to clients. Interviewees suggested that instead of providing linkages, these services should be offered within each program.

> As far as the referrals to addiction services, often the folks that we meet, actually a high percentage, do have concurrent disorders and we’re trying to deal with them within the agency, but also making referrals outside. We find it is usually a long wait to access addiction services. [QL04]

> Like the literature suggests, substance abuse is a significant factor for individuals being in conflict with the law. So, as a result, rather than outsourcing, which there could be delays in terms of outsourcing, and I think there is something to be said for integrated mode of case management and substance abuse counseling by the same service rather than siloed. [QL05]

The role of hospitals also significantly impacts on the service delivery in courts and in the community. Service coordination between hospitals and courts is a continuing challenge. The insufficiency of linkages with this service provider causes difficulties for clients who could receive services from both of them.

Discussion

In his description of court support services, the Honorable Richard Schneider (2010) writes,

> While the ‘nuts and bolts’ of mental health courts will vary, integral to the functioning of a mental health court is a multidisciplinary team approach. Judges and lawyers are supplemented by any number of psychiatrists, psychologists, case workers, and social workers who collaborate on how the particular needs of the accused can effectively be met. (p 202)

With this, the judge describes a program that supports the court through a team approach. This means that mental health services must follow the court’s lead. This description corroborates Steadman et al.’s (1995) assertion that integrated services and regular meetings among key agency representatives are ingredients critical to an effective jail diversion program. Indeed, the experiences described by the mental health providers reflect these basic premises. A great deal of time must be invested to develop

an effective team and partnership. There is also the suggestion of the potential contribution of specialized training that helps teams understand their counterpart's perspective.

Steadman et al. (1995) also indicate that successful programs rely on boundary spanners. This helps to explain the tension that mental health providers encounter. Schneider (2010) indicates that the priority of the court support programs is to serve the legal system. As such, these types of programs represent an intersection between the systems in which the mental health system must recalibrate its approach. Within these programs, mental health providers must not only consider the needs of clients, but also the legal sector. Thus, the partnerships and teams are constructed within constraints. The system with the least constraints will be required to work around the requirements laid out by the other system. This acknowledgment was made with the decision to have the new funding flow through the mental health system, the least constrained of the two systems. This point was further confirmed with the fact that none of the program developers perceived partners from the justice sector as being able to offer additional information about the program development.

For the mental health sector, the court support programs introduce an additional challenge by opening the mental health system to a broader group of clients. This may mean working with clients who do not necessarily have a psychiatric disorder or who have been convicted of more serious charges (McNiel and Binder 2010). This again highlights the need for additional training for community mental health staff. This is another characteristic of an effective program first referred to by Steadman et al. (1995).

There is also evidence that the more inclusive criteria opened the mental health system's door to more clients. This had a domino effect. The purpose of the court support programs is to provide mental health services to people who could benefit from them while they have contact with the justice system. Assuming that their need for mental health services does not end with their legal involvement, this also means that much of the work of the court support program will involve linking clients to services in the community once their involvement with the legal system ends. This leaves court support programs to rely on services and supports outside of the court support program. The success of linkages depends on the extent to which the local mental health systems can absorb the additional demand placed on them as a result of the increased referrals. As court support programs enrolled more clients and referred them to other programs, the other programs became overwhelmed by the demand for services. As a result, access to other community mental health services significantly decreased (Dewa et al. 2010). This brings the attention back to the domino effect and the need to identify where potential bottlenecks might occur prior to introduction of new programs. For example, the bottlenecks being reported in the mental health services areas might have been prevented, or minimized, if a system's perspective within each region had been taken into account when new entry ways into the mental health system were being implemented.

Interestingly, the work with the court clients also means that the mental health staff will encounter resistance from the mental health service community as they face the stigma associated with clients who have involvement with the justice system (McNiel and Binder 2010). For support programs to be successful in decreasing recidivism, discrimination that court support clients often face in accessing services in the broader system must be directly addressed through education, incentives or penalties, or a combination of all three.

Strengths and limitations

The results of this paper describe the process of court support program development. In this way, it contributes to the development of a theory to describe critical implementation factors that should be considered when providing services to this population when the health sector is the lead. Interestingly, we report similar results to those of Steadman et al. (1995) in their study of factors that contribute to successful jail-based diversion services administered by the corrections sector. Thus, these studies begin to indicate that there may be fundamental principles that contribute to successful post-booking cross-sector collaborations.

As such, they can serve as research guideposts in the next steps to understanding the generalizability of these critical components. That is, it will be important to examine the contexts in which they hold and those in which they do not, as well as the outcomes associated with these two conditions.

With regard to the application in the field, this is one of the first papers describing the elements that contribute to implementing post-booking diversion models that operate by health service organizations rather than justice service institutions. As such, the information gathered from this study will contribute to a better understanding of the combined factors and processes that both facilitate and inhibit developing inter-ministerial programs. The results provide a starting point from which the field can build and factors to consider as programs are implemented.

Conclusions

The experiences of the court support system highlight important considerations of cross-sector enterprises. If

partnerships are constructed within the existing parameters of systems, the system with the most flexibility will be required to work around the constraints of the other system. The role of the adapter could be acknowledged by having the funding flow through the system in which the most change will need to occur.

The system leading the development of the collaboration will be required to invest a great deal of time to develop an effective partnership. This can take the form of activities to become part of the other system's culture through education, establishing a presence and identifying boundary spanners. It also requires consideration about long-run implications for both systems.

Acknowledgments The authors are also grateful for the excellent research assistance provided by the Matryoshka Coordinating team: Angela Yip, Michele Caveen and Desmond Loong. We would also like to acknowledge the participation of the programs and interview participants who supported this project and who so generously shared their experiences with us. We are also grateful for the helpful suggestions and feedback offered by the anonymous reviewers. This project was funded by the Ontario Mental Health Foundation. Dr. Dewa also gratefully acknowledges the support provided by her CIHR/PHAC Applied Public Health Chair. The Centre for Addiction and Mental Health receives funding from the Ontario Ministry of Health and Long-Term Care to support research infrastructure. Any errors are the sole responsibility of the authors and do not reflect the views of any of the funders.

Appendix: Interviewer Guide

Preamble: As you know, we are interested in learning more about and gaining insight into the development of your court support program. We would like to hear about the types of influences, challenges, and successes you encountered, as well as what you learned by participating in this process and how these lessons could be useful to someone developing a similar program.

1. Who or what were the important influences that directed how you went about developing your court support program?
2. Who were the key influences in the development of your programs?
3. What kind of direction and support did the Ministry of Health and/or Ministry of Justice and Ministry of Community Safety and Correctional Services provide with regard to the implementation and design of the program?
4. To what extent has your intake criteria changed since the new funding?
5. What have been the particular challenges in implementing your program?
6. What do you think are the important successes of your program?
7. Are there any ministry or international frameworks/guidelines for enhancing services to keep persons with serious mental illness out of the criminal justice and correctional services?
8. Did the frameworks (by Ontario, or internationally) have any influence on how you designed or implemented your program?
   a. Did they have to be modified to fit your geography and region?
9. What advice would you pass on to someone else starting a similar program?
10. Is there anyone else in your program that I should, or need to, talk with?

References

Boothroyd RA, Mercado CC, Poythress NG, Christy A, Petrila J (2005) Clinical outcomes of defendants in mental health court. Psychiatr Serv 56:829–834

Broner N, Lamon SS, Mayrl DW, Karopkin MG (2003) Arrested adults awaiting arraignment: mental health, substance use, and criminal justice characteristics and needs. Fordham Urb L J 30:663–721

Broner N, Mayrl DW, Landsberg G (2005) Outcomes of mandated and nonmandated New York City jail diversion for offenders with alcohol, drug and mental disorders. Prison J 85:18–49

Christy A, Poythress NG, Boothroyd RA, Petrila J, Mehra S (2005) Evaluating the efficiency and community safety goals of the Broward County Mental Health Court. Behav Sci Law 23:227–243

Cosden M, Ellens J, Schnell J, Yamini-Diouf Y (2005) Efficacy of a mental health treatment court with assertive community treatment. Behav Sci Law 23:199–214

Cusack KJ, Morrissey JP, Cuddeback GS, Prins A, Williams DM (2010) Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: a randomized trial. Community Ment Health J 46:356–363

Dewa CS, Jacobson N, Durbin J, Lin E, Zipursky RB, Goering P (2010) Examining the effects of enhanced funding for specialized community mental health programs on continuity of care. Can J Commun Ment Health 29:23–40

Ditton PM (1999) Mental health and treatment of inmates and probationers, Bureau of Justice Statistics Special Report. Publications of the US Department of Justice, Washington. http://bjs.ojp.usdoj.gov/content/pub/pdf/mhtip.pdf. Accessed 28 January 2011

Fisher WH, Roy-Bunjnowski KM, Grudzinskas AJ, Clayfield JC, Banks SM, Wolff N (2006) Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. Psychiatr Serv 57:1623–1628

Glaser B, Strauss A (1967) The discovery of grounded theory: strategies for qualitative research Publications of Aldine, Chicago

Hoch JS, Hartford K, Heslop L, Stitt L (2009) Mental illness and police interactions in a mid-sized Canadian city: what the data do and do not say. Can J Community Ment Health 28(1):49–66

Hoff RA, Baranosky MV, Buchanan J, Zonana H, Rosenheck RA (1999) The effects of a jail diversion program on incarceration: a

retrospective cohort study. J Am Acad Psychiatry Law 27:377–386

Holcomb W, Ahr P (1988) Arrest rates among young psychiatric patients treated in inpatient and outpatient settings. Hosp Community Psychiatry 39:52–57

Kuper A, Lingard L, Levinson W (2008a) Critically appraising qualitative research. BMJ 337:a1035

Kuper A, Reeves S, Levinson W (2008b) An introduction to reading and appraising qualitative research. BMJ 337:a288

Lamb HR, Weinberger LE (1998) Persons with severe mental illness in jails and prisons: a review. Psychiatr Serv 49:483–492

Lattimore PK, Broner N, Sherman R, Frisman L, Shafer MS (2003) A comparison of prebooking and postbooking diversion programs for mentally ill substance-using individuals with justice involvement. J Contemp Crim Just 19:30–64

Lingard L, Albert M, Levinson W (2008) Grounded theory, mixed methods, and action research. BMJ 337:a567

Linhorst DM, Parks-Linhorst PA, Stiffleman S, Gianino J, Bersen HL, Kelley BJ (2010) Implementing the essential elements of a mental health court: the experiences of a large multijurisdictional suburban county. J Behav Health Serv Res 37:427–442

McFarland BH, Faulkner LR, Bloom JD, Hallaux RJ (1989) Chronic mental illness and the criminal justice system. Hosp Community Psychiatry 40:718–723

McNiel DE, Binder RL (2007) Effectiveness of a mental health court in reducing criminal recidivism and violence. Am J Psychiatry 169:1395–1403

McNiel DE, Binder RL (2010) Stakeholder views of a mental health court. Int J Law Psychiatry 33:227–235

Moore ME, Hiday VA (2006) Mental health court outcomes: a comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. Law Hum Behav 30:659–674

Morrissey J, Meyer P, Cuddeback G (2007) Extending assertive community treatment to criminal justice settings: origins, current evidence, and future directions. Community Ment Health J 43:527–544

O'Keefe K (2006) The Brooklyn mental health court evaluation: planning, implementation, courtroom dynamics, and participant outcomes. Publications of the Center for Court Innovation, New York. http://www.courtinnovation.org/_uploads/documents/BMHCevaluation.pdf. Accessed 28 January 2011

Ontario Ministry of Health, Long-Term Care (2006) A Program framework for: mental health diversion/court support services. Publications of the Ontario Ministry of Health and Long-Term Care, Toronto

Rivas-Vazquez RA, Sarria M, Rey G, Rivas-Vazquez AA, Rodriguez J, Jardon ME (2009) A relationship-based care model for jail diversion. Psychiatr Serv 60:766–771

Sarteschi CM (2009) Assessing the effectiveness of mental health courts: a meta-analysis of clinical and recidivism outcomes. Dissertation, University of Pittsburgh, United States. ProQuest Digital Dissertations database (Publication No. UMI 3384946). Accessed 28 January 2011

Schneider RD (2010) Mental health courts and diversion programs: a global survey. Int J Law Psychiatry 33:201–206

Shafer MS, Arthur B, Franczak MJ (2004) An analysis of post-booking jail diversion programming for persons with co-occurring disorders. Behav Sci Law 22:771–785

Sirotich F (2009) The criminal justice outcomes of jail diversion programs for persons with mental illness: a review of the evidence. J Am Acad Psychiatry Law 37:461–472

Steadman HJ, Morris SM, Dennis DL (1995) The diversion of mentally ill persons from jails to community-based services: a profile of programs. Am J Public Health 85:1630–1635

Steadman HJ, Cocozza JJ, Veysey BM (1999) Comparing outcomes for diverted and nondiverted jail detainees with mental illness. Law Hum Behav 23:615–627

Steadman HJ, Osher FC, Clark Robbins P, Case B, Samuels S (2009) Prevalence of serious mental illness among jail inmates. Psychiatr Serv 60:761–765

Teller JLS, Ritter C, Rodriguez MS, Munetz MR, Gil KR (2004) Akron Mental Health Court: comparison of incarceration and hospitalizations for successful and unsuccessful participants in the first cohort, Stormer Report. http://cjccoe.neoucom.edu/uploads/MHC%20Results/stormerreport.pdf. Accessed 28 January 2011

Trupin E, Richards H (2003) Seattle's mental health courts: early indicators of effectiveness. Int J Law Psychiatry 26:33–53