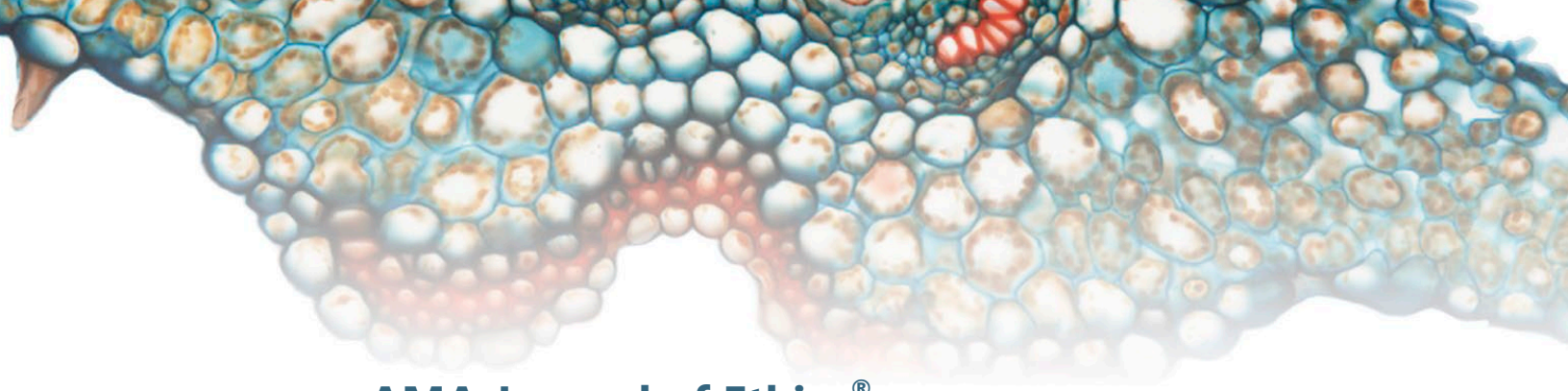

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ORIGINAL RESEARCH: PEER-REVIEWED ARTICLE

Interprofessional Learning and Psychiatric Expertise in Mental Health Courts

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Abstract

Background: Interprofessional collaboration is crucial to reduce overincarceration of people with severe mental illness. Learning how to collaborate occurs in 2 complementary ways. One model emphasizes cognitive tasks: becoming familiar with the values and knowledge of other disciplines. Another model emphasizes practical interactive skills: calibrating one's preexisting expertise to the demands of the local workplace. This qualitative study assesses the 2 models in the case of psychiatrists in a multidisciplinary mental health court who learned to divert people with psychiatric disease from jail and hence advance the court's mission.

Methods: Ethnographic research was conducted over 4 years with the staff of a US mental health court. Interviews with 3 psychiatrists and observations of 87 staff meetings and probation review hearings were recorded on handwritten notes. Notes were transcribed, entered into a qualitative database management program (NVivo 12), and coded using the grounded theory approach. A master codebook was developed to identify crosscutting themes.

Results: Psychiatrists did not need deep familiarity with the values or skills of legal professionals to divert people with psychiatric disease from incarceration. They successfully inserted their expertise through 3 strategies—teaching about pharmaceutics, suggesting concrete interventions based on details of diagnosis and behavior, and shifting the collective assessment of defendants from a punitive to a therapeutic framework—that depended on their acquiring new interactive skills. However, they failed in their efforts to refine the eligibility criteria for admitting new defendants to the court; their expertise was underutilized because of the makeup of this interprofessional team.

Conclusion: Reducing the overincarceration of people with severe mental illness depends on interprofessional collaboration. This study shows that discerning opportunities for (and blockages to) applying one's preexisting

expertise and learning the perspective of other disciplines are key complementary ingredients of interprofessional learning in this setting. Research in other treatment courts is needed to assess the generalizability of this single case study.

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Background

The percentage of people with severe mental illness in US jails and prisons is between 3 and 6 times higher than in the general population.[1,2,3] Mental health courts offer a solution to this problem; they aim to divert people with severe psychiatric illness away from unnecessary incarceration to mental health treatment.[4] Toward this end, the courts emphasize collaboration not only between the public defender and state prosecutor, but also between the legal staff as a whole and mental health professionals. Although the details differ in each jurisdiction, a common procedure involves participants voluntarily pleading guilty (typically for nonviolent misdemeanors) and agreeing to probation and community supervision. The probation agreement mandates comprehensive mental health treatment (medications, addiction counseling, individual therapy, case management, and the like). In the court examined in this study, defendants come back for probation review hearings every 2 weeks and are reassessed. If they repeatedly violate their probation, it could be revoked and they could be remanded to jail to serve out their original sentence. If they participate in treatment, they are released from supervision after 12 to 24 months[5] and thereby avoid the harmful sequelae of incarceration.[6]

The court staff is an interprofessional work group comprising professionals from different disciplines (law, psychiatry, clinical psychology, and social work) with the shared goal of substituting mental health care for jail time. Psychiatrists in the current study occupied a distinctive and anomalous role. They were not the providers of record for defendants, who instead received care from community-based clinics. They had no mandate to treat or even interview the defendants. They were consultants who worked in a setting that was collaborative by design. They gave advice but stood entirely outside the formal patient-physician relationship. They also had no legal decision-making power since the judge and probation officer always made the final determination about defendants' ultimate freedom or incarceration.

This article explores how psychiatrists applied their expertise to divert people with psychiatric disease from incarceration to mental health treatment, given that they had no formal authority over defendants' treatment or legal fates. Their situation provides an empirical case study of interprofessional learning, which by definition occurs "when two or more professions learn with, from and about one another to foster collaboration in practice."[7] Two distinct but complementary models account for this kind of learning.[8] The cognitivist model emphasizes an individual's understanding of how other professionals conceptualize the basic tasks of work.[9] In this model, one must first grasp the core values of other professionals and master their cognitive maps in order to collaborate successfully.[10] (This model influences, for example, interprofessional pedagogy for medical students that exposes them to busy outpatient primary care settings and then teaches them how the skills sets of physician assistants and physical therapists contribute to patient care.[11]) The social constructivist model focuses on the

collaborative aspects of learning; it emphasizes the interactive and organizational context instead of the precise knowledge held by other workers.[12] Both models help explain how psychiatrists learn to operate on the court. In other words, psychiatrists face 2 learning tasks at once. They must understand how the legal staff assesses defendants and defendants' troubles in meeting the court's requirements. They must also learn the unwritten rules about interacting with professional peers in this shared and interdisciplinary space. This article assesses which type of learning most helps psychiatrists to contribute to the interprofessional mental health court team.

This study found that, in order to advance the team's shared goals, psychiatrists did not need to learn criminal law in general (types of offenses, range of sanctions, rules of evidence, and so on). They instead needed to understand why defendants typically have difficulty in conforming to the policies of this particular court. At the same time, they had to discern openings for their distinctive skills in fast-paced deliberations that mixed legal, penal, and clinical perspectives. They needed to translate their expertise into terms that were comprehensible to the legal staff and to do so in a novel setting where they did not have much formal authority. This study of interprofessional learning documents how members of a single occupational group learned to comprehend both a narrow range of technical knowledge and the immediate social dynamics of the work team in order to insert their perspective into case deliberations and to convince others to take it seriously.

Methods

A 4-year qualitative study of a pilot mental health court in a mid-sized US city was conducted. Eighty-seven sessions were observed, each comprising (1) precourt staff meetings with the interprofessional team (judge, lawyers, probation officers, social workers, case managers, psychologists, and a psychiatrist), followed by (2) probation review hearings ("open court") for defendants currently under supervision (4 to 6 at any one time and 30 over the 4-year period). Semi-structured interviews (ie, open-ended questions and follow-up probes) were conducted with the 3 psychiatrists who served on the court. All identifying details have been changed.

Handwritten notes were used to document discussions during staff meetings and open court as well as during the interviews. Notes were transcribed to word-processing documents within 24 hours. Transcribed notes were then entered into NVivo 12 qualitative data analysis software. Data were analyzed through the inductive grounded theory approach.[13] Open coding was undertaken by examining data line by line and assigning thematic labels to data, such as the answer to a single interview question or a brief exchange during a staff meeting, constantly comparing the labels for accuracy as coding progressed. As coding continued, the initial categories were separated into more specific labels and older data were recoded. Using this iterative process, a master codebook was developed to analyze subsequent data. The current study is based on interviews with psychiatrists and thematically coded data from psychiatrists' speech in staff meetings.

Results

Before psychiatrists joined the court, the legal staff realized how much they needed psychiatrists' expertise. For example, upon learning that one defendant was becoming more agitated despite adhering to his medications, the judge commented: "We don't have a psychiatrist here to tell us, has this been his history? He was doing well for so

long.... Is he going to be this way for the foreseeable future? The psychiatrist could say if these drugs are working well together. I have no idea."

Psychiatrists easily took on the role envisioned by the judge. They taught the team about the doses, indications, and potential side effects of medications. They extrapolated from people's prescriptions to their likely response to interventions. When the public defender asked whether she should push someone to find employment, the psychiatrist pointed out that the person's continued impairment on high doses of antipsychotic medication meant that he shouldn't be expected to return to work. This sort of advice gave psychiatrists immediate legitimacy; their expertise helped the lawyers manage cases more successfully.

Serving as de facto pharmaceutics instructors was one way that psychiatrists contributed to the court's mission. They also pursued 3 other strategies to create more room for their expertise despite their limited decision-making authority. First, psychiatrists often drew a connection between diagnosis and behavior. One psychiatrist reinterpreted a defendant's apparent sullenness as a "dysthymic reaction to the world" common among people with severe substance use disorder. She suggested that the defendant take an active role in Alcoholics Anonymous meetings, and, in the subsequent open court session, the judge made precisely this recommendation. In the case of a defendant with posttraumatic stress disorder, the psychiatrist pointed out that complaints of sleep problems may signal renewed instability and that the probation officer should increase home visits and therapy sessions. Such insights come easily to psychiatrists, so their interprofessional learning turned on applying these insights to the immediate practical needs of this interprofessional group.

Psychiatrists' second strategy went one step further by shifting the entire conversation about defendants from a punitive to a therapeutic register. Psychiatrists' ability to reframe other staff members' attributions of defendants' behavior was the most powerful application of their expertise. An exemplary case involved a defendant charged with strong-arm robbery and diagnosed with undifferentiated schizophrenia. (The diagnoses cited in court came from the paperwork provided by case management agencies and/or the Department of Corrections.) After the defendant missed several court sessions and was the subject of police reports of public drunkenness, the legal staff was ready to give up.

State prosecutor: He's not really engaging in the program. The police texted me: "He was drunk and he lied about his name. We arrested him on a Violation of Probation."

Judge: He wasn't home for his probation agent.... I'm not happy about him. He's not in the right frame of mind to do this court. There's no real willingness to change.

Probation officer: He doesn't have any intention to cooperate with anything.

The cascade of negative attributions pointed in one direction: revoking the defendant's probation and returning him to jail. At this juncture, the psychiatrist spoke up.

Psychiatrist: He has active substance use. He's not going to be available to participate in the court. He hears voices in his head, and the drinking turns down the volume, so he's going to keep drinking. Did he have assessment for Drug Court?

Probation officer: Yes, and they rejected him because of mental illness. Even though his mental health was stable for a long time, until he got into his alcohol.

Psychiatrist: There you go. He has the ability to be compliant for a long time, if he keeps away from drinking. Can you guys mandate him into a residential drug and alcohol treatment program?

The legal staff had built up a portrait of the defendant as uncooperative, unwilling to change, and a liar. The psychiatrist did not frontally oppose this characterization (as uncooperative and deceitful), but he attributed the defendant's behavior to an underlying substance use disorder, which he framed as a treatable disease. That is, the defendant was not cooperating because he lacked the capacity to do so. He'd broken the requirement of sobriety, but only because he was self-medicating, and hence he deserved to remain in the program. The psychiatrist had convincingly reframed the problem, and the judge eventually decided not to revoke the defendant's probation. It was an adroit and tangible contribution to the court's ultimate mission of diverting people from jail.

As their third strategy, psychiatrists argued for tighter and more consistent eligibility criteria (for admission to the mental health court and all of its programs, including treatment and probation), but their efforts usually failed. They were often asked to comment on particular candidates for admission, but, due to their limited role on the court staff, they could not conduct personal assessments. The psychiatrists instead offered only generic advice. They said that people who have psychotic symptoms and adhere to their medications are good candidates for mental health treatment but those with illnesses unrelated to the criminal complaint are not suitable. As one psychiatrist observed: "The resources of this court are scarce. So we should make sure they're used on people who really need them, who are fitted to them."

This psychiatrist was taking a stand on a thorny topic that preoccupied this court from the start. The demand for psychiatric treatment in the criminal legal system far outstrips the supply,[14] so who deserves a place in this small mental health court? The question recalls debates in bioethics about rationing and triage in situations of scarce treatment resources. Psychiatrists, however, were not invited onto the court team to address ethical questions. Moreover, they had no real influence on intake procedures in general or on the decisions to admit particular defendants to the court. Only when speaking privately to me during interviews held off-site did they discuss the issue in depth. One psychiatrist complained that there was no rational paradigm in place to select the target population. From his perspective, the public defender's office uses the court simply as a way to connect its clients to needed services. But, he continued, the court occupies a specialized niche in the judicial and mental health systems. It works well for one kind of defendant but not for other kinds. He believes that because lawyers do not properly risk-stratify the candidates, the court as a whole is much less effective than it could be. (He did not cite any evidence for this belief but based it instead on his decades-long experience as a clinician at the county psychiatric hospital.)

This psychiatrist never had the opportunity to present his views to the team. The work was too fast-paced, and the rules about eligibility (to the court as a whole, including community supervision and treatment) were established long before psychiatrists joined the group. Moreover, psychiatrists were slotted into the role of advice giver in particular cases and not treated as a source of critical insight into the court's overall operation. Therefore, no one thought to ask for their ideas.

Discussion

Psychiatrists' interprofessional learning entailed mastering the basic procedures of this treatment court and understanding why defendants might fail its requirements. They also had to discern precisely what the legal staff needed to know about people's clinical condition and then translate their expertise into understandable terms and immediate interventions.

The tasks were not conceptually challenging. They did, however, require a savvy awareness of the way that legal staff—on the basis of their own professional vision—built up negative attributions about defendants' behavior. Psychiatrists learned how to speak up at just the right moment and in ways that others found credible and helpful, and in so doing reframed these attributions. The integration of psychiatrists into this interprofessional group fits the classic notion of legitimate peripheral participation. That is, they engaged with central work processes "but only to a limited degree and with limited responsibility for the ultimate product."[15] The psychiatrists resembled apprentices; they were newcomers to an established occupational group and thus inserted into the low end of the workplace hierarchy. Without any formal instructions, they had to absorb the goals and routines of the group and learn to make contributions from the sidelines.

The analogy to apprenticeship, however, is not perfect. The psychiatrists drew on skills entirely outside the domain of legal professionals. For this reason, they could redirect the trajectory of a defendant's case in ways that would never have occurred to the judge or lawyers and that advanced the collective mission of diverting people from jail. In general, however, the psychiatrists never made the transition from peripheral to central actors in this reform project. Unlike apprentices, their competence was established at the start and it never developed, at least in the eyes of the legal team. Hence the judge and lawyers never sought out psychiatrists' advice on any issues other than the symptoms and capacities of individual defendants, even when systems-level advice might have improved the court's operation.

Conclusion

Mental health courts are just one attempt to end the disproportionate incarceration of people with severe psychiatric illness. Many related diversion programs share the same challenge: to integrate the expertise of legal, penal, law enforcement, psychiatric, and social work professionals.[16,17] Their success depends on interprofessional learning, as illustrated in this study.

The limitations of this study are inherent to ethnographic research, which is inductive, not hypothesis driven, and based on small samples that do not provide statistically significant results. A single case study is rarely generalizable, especially when the context differs across cases. For example, the psychiatrists in this mental health court were only consultants, and there was little communication between the legal staff and the actual treating clinicians who were scattered across several health care and case management agencies. Larger courts often work more closely with outside clinicians.[18,19] Case studies do help identify current gaps, unmet needs, and opportunities to improve established practices, however. This research shows not only how psychiatrists successfully contributed to the team but also how their expertise was underutilized. A potential improvement would be for the work team to schedule dedicated times, outside of the regular court sessions, for its members to reflect on themselves and their progress in aligning diverse perspectives. After all,

interprofessional learning works best through a combination of daily engagement and more distanced reflection.[20] Periodic staff meetings are needed to assess the challenges of interdisciplinary work and to search for new linkages between expertise and outcomes that would advance the group's long-term reformist goals. At the same time, communication is needed between ground-level court staff, on the one hand, and senior administrators at the county level, on the other, as administrators have the most leverage to make system-level changes in the function and mission of treatment courts.[21]

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