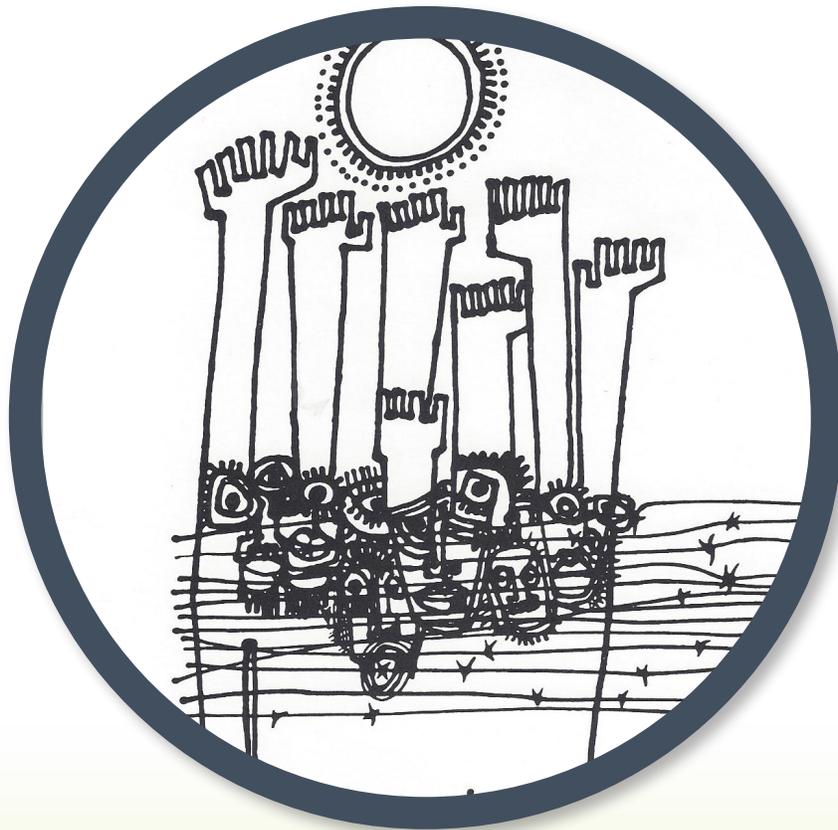


BEHAVIORAL HEALTH IN OHIO CURRENT RESEARCH TRENDS

Volume 2 No. 1 ● March 2014



Promoting Wellness and Recovery

Featured Research Topics:

Mental Health Courts
Veterans Treatment Court
TARGET and Juvenile Justice
State of Ohio Drug Trends

BEHAVIORAL HEALTH IN OHIO ~ CURRENT RESEARCH TRENDS

ISSN 2166-8590 Volume 2 No. 1 • March 2014

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Current Research Trends or *CRT* is a service of the Office of Planning, Quality and Research (OQPR). Its purpose is to disseminate behavioral health research findings related to Ohio’s public mental health system.

CRT e-Journals are organized thematically to highlight a single critical topic. Most *CRT* articles focus on research funded, in whole or in part, by the Office of Quality, Planning and Research at OhioMHAS. However, manuscripts about behavioral health studies conducted in Ohio but not funded by OhioMHAS are also welcome for possible inclusion.

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Sanford Starr, MSW, LISW-S

Deputy Director, Office of Quality, Planning & Research

Kraig Knudsen, PhD

Chief, Bureau of Research and Evaluation
Editor-in-Chief

Helen Anne Sweeney, MS

Manager, Bureau of Research and Evaluation Unit
Managing Editor

Shirley Bowen, PhD/ABD

Publications Coordinator



Ohio Department of Mental Health and Addiction Services
30 East Broad Street, 8th Floor
Columbus, Ohio 43215
(614) 466-8651 voice
(614) 752-9696 TTY
Fax (614) 466-9928

John R. Kasich, Governor
Tracy J. Plouck, Director

BEHAVIORAL HEALTH IN OHIO CURRENT RESEARCH TRENDS



Table of Contents

Moving Research into Practice4 <i>Tracy Plouck, Director, Ohio Department of Mental Health and Addiction Services</i>	4
Blending the Roles of Court and Treatment4 <i>Evelyn Lundberg Stratton, Esq., Retired as Justice from the Supreme Court of Ohio</i>	4
Behavioral Health Research in Ohio <i>Kraig Knudsen, Chief, OhioMHAS Bureau of Research and Evaluation</i>5	5
Recognition and Understanding of Goals and Roles: The Key Internal Features of Mental Health Court Teams7 <i>Mary Gallagher, PhD, David Skubby, PhD, Natalie Bonfine, PhD, Mark R. Munetz, PhD, Jennifer L. S. Teller, PhD</i>	7
Courting Compliance: Case Managers as “Double Agents” in the Mental Health Court19 <i>Ursula Castellano, PhD</i>	19
The Value of Implementing TARGET within a Trauma-Informed Juvenile Justice Setting40 <i>Monique T. Marrow, PhD, Kraig J. Knudsen, PhD, Erna Olafson, PhD, PsyD, Sarah E. Bucher, BS</i>	40
The Effectiveness of a Veterans Treatment Court: A Pilot Study50 <i>Kraig J. Knudsen, PhD, Scott J. Wingenfeld MPA</i>	50
Self-Injury Implicit Association Test: Comparison of Suicide Attempters and Non-Attempters59 <i>Prachi Kene, PhD, Joseph D. Hovey, PhD</i>	59
A Comparative Study Examining Parental Perception of Care and Treatment Outcomes for Justice Involved Youth with Mental Illness68 <i>Kraig J. Knudsen, PhD, LISW, Joseph Perzynski, MSW, Carol Carstens, PhD, LSW</i>	68
Characteristics of Adolescent Marijuana Admissions in Ohio FY 2008 and FY 201178 <i>Rick Massatti, PhD, MSW, LSW, Laura Potts, MA, Surendra Bir Adhikari, PhD, MedSoc</i>	78



Moving research into practice

I am proud to present this agency’s first issue of *Behavioral Health in Ohio – Current Research Trends* as a new, recently-consolidated entity. The Ohio Department of Mental Health (ODMH) and the Ohio Department of

Alcohol and Drug Addiction Services (ODADAS) joined forces this past July, creating the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

One of the many benefits of uniting the two departments is that individuals served in the mental health and addiction systems now have access to expanded and coordinated statewide treatment options that more efficiently connect them to a full continuum of care. Another important advantage is an enhanced Office of Quality, Planning and Research (OQPR) that is responsive to community requests for data related to behavioral health trends in Ohio. Through the *Current Research Trends* publication and other reports, staff members in OQPR will provide analysis that will help treatment providers, behavioral health authorities, community stakeholders and the state as a whole make the best management and care decisions. Whether related to investments or service delivery, these data-informed decisions can position Ohio as a national leader.

In this issue, the focus is on the state’s criminal justice and juvenile justice systems. This theme fits well with one of OhioMHAS’ top priorities, as \$1.5 million in administrative savings from the consolidation was re-invested in projects that support partnerships between behavioral health and local jails. A recurring theme that runs through the seven studies highlighted here is multi-agency collaboration. The Center for Effective Public Policy recognized the systemic nature of criminal justice problems, of which substance abuse and mental illness are often at the center, and suggested “collaborative justice partnerships” have a high potential to reduce crime and costs to the system while increasing public confidence. At OhioMHAS, collaboration is a key factor in our strategic plan goals, and has been a departmental core value of both ODMH and ODADAS for many years. Collaboration is simply the most realistic, responsible means to accomplish more with fewer resources. In December, Gov. John Kasich credited the state’s “strong, effective partnerships” in its progress toward making Ohio a better place to live, work and raise a family.

I hope you will find the research contained in this issue as enlightening as I do. Let’s keep working together and applying our growing base of knowledge to address the complex needs of Ohio’s behavioral health field.

Tracy J. Plouck
 Director, Ohio Department of Mental Health and Addiction Services



Blending the Roles of Court and Treatment

As a trial judge first elected in 1986, I was new to the criminal justice system. I had never handled a criminal case. That was my first exposure to the issues of mental illness in the justice system, and

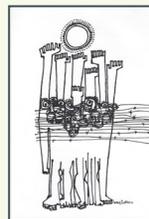
I was very frustrated and totally unaware and untrained in what to do with those defendants.

After I was on the Ohio Supreme Court, I first heard about a mental health court. I already knew about drug courts. They seemed to me such a better way to deal with the problem.

Fast forward 17 years: specialized dockets, such as mental health courts, are now well-established in Ohio. But the benefits ripple far beyond just the judge and the defendant. Each specialized docket court represents a center of cooperation and collaboration where silos used to exist. The judge may preside, but it is clearly a team effort. The judicial systems give the treatment team the clout to ensure compliance; the treatment team gives the court tools, resources, and options that improve public safety, reduce recidivism, but most importantly, change the lives of those whose mental illness often is the main reason they end up in court. In Ohio, we have drug courts, mental health courts, DUI courts, prostitution courts, and a growing number of veterans courts. In fact, Ohio leads the country in this team effort. Every one of these specialized docket courts represents a collaboration.

This journal looks at that important interplay between the court and the behavioral health and treatment community, between the punisher and the healer, and how both roles meld to improve and even save lives.

Evelyn Lundberg Stratton, Esq.
 Retired as Justice from the Supreme Court of Ohio



On the Cover: Featured on the cover of this first 2014 issue of *Behavioral Health in Ohio – Current Research Trends* is a detail of a drawing by Leroy Clarke. Clarke hails from Trinidad and Tobago where he is considered a national treasure. He worked for many years in New York City where he produced one of his most memorable series, *Fragments of a Spiritual*. This untitled drawing is from that series. The drawing brings

to mind a range of concerns and was first published in 1972 in the *Attica Book*, a social justice art project by Benny Andrews and Rudolf Baranik. The editors were pleased to gain permission to present a portion of the drawing, which also appears in full on the cover of Lee Bernstein’s 2010 study on the arts and politics in prisons .

Contact info: <http://www.leroyclarke.com/>
 Email: leroyclarke@hotmail.com





Dear Colleagues:

In this *Current Research Trends*, the first issue of Volume 2, we continue our focus on questions concerning the involvement of individuals with behavioral health issues in the criminal justice system. While the entire volume is not focused on the criminal justice system, there are a number of important articles concerning these matters. Three articles, in particular, address treatment courts. Courts have traditionally been responsible for determining guilt or innocence and delivering sentences based on illegal behavior. Treatment courts, on the other hand, are therapeutic in nature and not punitive. These courts require treatment for substance abuse and/or mental health conditions. This represents a significant paradigm shift in the criminal justice system, moving away from the traditional model and focusing more on community integration, therapeutic processes, and rehabilitation. Treatment courts take into consideration the context of the individual's life at the time they committed the illegal act; and have been shown to successfully reduce recidivism, improve treatment outcomes and overall quality of life. As such, many states are adopting this model for their court systems.

In this issue there are two studies about the goals and roles of mental health court teams. The study by Gallagher, Skubby, Bonfine, Munetz, and Teller uses key informant interviews of personnel working in 11 Ohio Mental Health Courts to examine the role and function of personnel participating on mental health court teams. The results suggest that mental health court personnel understand individual roles within the teams, recognize and appreciate differences on the team, and share common goals for the team. Further, the study explored recruiting individuals with experience in or a willingness to learn about both the criminal justice and mental health systems. The second study conducted by Ursula Castellano examines how case managers in mental health courts work within multiple systems to ensure clients receive the best treatment results possible, while simultaneously maintaining an expectation of personal accountability and upholding the rules of the court. Findings from this study suggest that case managers are vital to the success of the mental health courts and operate as “double agents” working on behalf of the court while advocating and caring for their clients.

Three articles examine the outcomes of behavioral health interventions used with juveniles and veterans involved in the criminal justice system. The first study, conducted by Marrow, Knudsen, Olafson, and Bucher examines the effectiveness of “Trauma Affect Regulation: Guide for Education and Therapy” (TARGET) on juveniles placed in detention centers throughout Ohio. TARGET is a therapeutic milieu designed to create juvenile justice settings that are trauma informed. Results from the study show that youth who received TARGET evidenced significant reductions in depression, threats toward staff, use of physical restraints, and seclusion when compared to those in “Treatment As Usual” (TAU). The second intervention study examined the efficacy of providing a “Veterans Treatment Court” specialized docket to trauma-affected veterans. This study found that veterans involved in the Veterans Treatment Court experienced significant improvements in post-traumatic stress disorder (PTSD), depression, substance abuse, self-harm, functioning, social connectedness, family functioning, and sleep.

The final article in this series examines the effectiveness of the “Behavioral Health/Juvenile Justice” (BH/JJ) project. The BH/JJ project was an initiative to provide a collaborative treatment model of care to youth with severe emotional disturbances in Ohio. BH/JJ youth received wrap-around services, evidence-based interventions, and family engagement services. The study found that parental perception of client-level outcomes was superior for the BH/JJ youth when compared to youth receiving TAU. Specifically, the BH/JJ group showed reductions in police contacts and arrests, increased social functioning and social connectedness, and school attendance when compared to TAU. Taken together, these articles offer further evidence that when provided evidence-based treatment and coordinated care, justice-involved individuals do recover from the deleterious effects of trauma exposure and behavioral health problems.

Finally, we conclude with research by Kene and Hovey that evaluates the self-injury implicit association test. In this study, the investigators examined the differences in implicit identification with self-injury and implicit attitude towards self-injury between suicide attempters and non-attempters.

The findings showed that suicide attempters and non-attempters did not significantly differ in regards to implicit identification with self-injury or attitudes toward self-injury. We have also started a new section of the journal, entitled *Trends from the Field*. In this section, we plan to provide the behavioral health community with up to date information on behavioral health trends affecting local Ohio communities. Information will include brief reports on service and epidemiological trends in counties across the state. We hope that Ohio localities use this information for planning and programming purposes. In this edition, Massatti, Potts, and Adhikari examine the characteristics of adolescent marijuana admissions in Ohio from 2008 to 2011. Their report suggests that marijuana is the most frequently abused drug among Ohio's adolescents. The average age of first use is 13, and the age of first admission for treatment is 16. More than half (58%) of the adolescents in treatment for marijuana use also reported some form of polysubstance abuse. In terms of criminal justice involvement, 81% of the adolescents reported no arrest record 30 days prior to admission for treatment. Finally, when considering outcomes, treatment retention was associated with more positive results. OhioMHAS is working to provide the information on results such as these on an ongoing basis -- here, in the e-journal and elsewhere on the Department's website: <http://.mha.ohio.gov>

At OhioMHAS, we believe that research and evaluation are essential to advancing the quality and effectiveness of the behavioral health system. Through the use of properly designed research and evaluation, the field can develop new programmatic approaches, advance best practices and better appreciate the needs of those we serve. I hope that you will find the topics addressed in this first 2014 issue of *CRT* interesting and informative. It is our goal that you will benefit from and possibly adapt some of the results of the research to strengthen the ongoing operation of behavioral health programs throughout Ohio. One of the functions of the OQPR is to identify and develop linkages around critical problems and questions within the behavioral health system. Once problems and questions are identified, we work closely with universities and other resources to develop research and evaluation projects to provide viable answers. To achieve this end, we actively encourage evaluators and researchers in settings throughout Ohio to apply their talents and expertise to the many priority questions which remain unsolved in

all areas of public behavioral health. As in the past, we invite continued dialogue with those in the research and evaluation community who wish to explore these challenges with us. For information about recent research and evaluation activities and possible grant opportunities, visit our website at <http://.mha.ohio.gov>.

On a final note, we are indebted to the authors and contributors who made this edition possible. We would also like to thank Director Tracy Plouck for her steadfast devotion to advancing the field of behavioral health through continued support of behavioral health services research and evaluation. Without their support, the research presented in this volume would not have been possible.

Kraig Krudsen, PhD

Chief, Bureau of Research and Evaluation
Office of Quality, Planning, and Research
Ohio Department of Mental Health and Addiction Services

RECOGNITION AND UNDERSTANDING OF GOALS AND ROLES: THE KEY INTERNAL FEATURES OF MENTAL HEALTH COURT TEAMS

Mary Gallagher, PhD¹ • David Skubby, PhD² • Natalie Bonfine, PhD¹ • Mark R. Munetz, PhD³ • Jennifer L.S. Teller, PhD³

¹Kent State University, ²The University of Akron, ³Northeast Ohio Medical University

To whom correspondence should be addressed: Mary Gallagher, Department of Sociology, PO Box 5190, Kent State University, Kent, OH. Tel.: (330) 672-8359. Email: mngallag@kent.edu

1. INTRODUCTION

As the number of individuals with mental illness who are involved in the criminal justice system increases, courts have developed specialty programs or dockets designed to strategically address the needs of this population (Munetz & Griffin, 2006; Steadman, 2005). Mental health courts (hereafter MHCs) are one such program. The broad goal of MHCs is to improve the lives of individuals with mental illness who become involved in the court system by linking them to community mental health treatment and helping them avoid further involvement in the criminal justice system (Munetz & Griffin, 2006). There has been a rapid diffusion of MHCs and similar diversion programs in countries throughout the world, including the United States, Canada (Slinger & Roesch, 2010), England and Wales (James, 2010), Australia (Richardson & McSherry, 2010), and Sweden (Svennerlind et al., 2010).

Although MHCs were embraced and widely implemented long before

Abstract: The increasing involvement of people with mental illness in the criminal justice system has led to the formation of specialty programs such as mental health courts (hereafter MHCs). We discuss MHCs and the teams serving these courts. Specifically, we examine team members' perceptions of MHC goals and their own and others' roles on the MHC team. Using a semi-structured interview instrument, we conducted 59 face-to-face interviews with criminal justice and mental health treatment personnel representing 11 Ohio MHCs. Findings from our qualitative data analyses reveal that MHC personnel understand individuals' roles within the teams, recognize and appreciate the importance of different roles, and share common goals. MHCs could foster this level of understanding and agreement by working to recruit and retain individuals with experience in or willingness to learn about both the criminal justice and mental health systems. Future research should explore the impact of MHC team functioning on client outcomes.

Keywords: Mental health court • Mental illness • Interdisciplinary team • Professional roles

any evidence of their effectiveness existed (Schneider, 2010), a growing body of research indicates that they are achieving their objectives of reducing the involvement of individuals with mental illness in the criminal justice system and linking them to needed mental health treatment in the community (e.g., Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Frailing, 2010; Hiday & Ray, 2010; McNiel & Binder, 2007; Moore & Hiday, 2006; Palermo, 2010; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005). However, the majority of MHC studies to-date have only examined single courts, though there are a few studies that have investigated two or more MHCs (e.g., Goldkamp & Irons-Guynn, 2000; Griffin, Steadman, & Petrila, 2002; Palermo, 2010; Redlich, Steadman, Monahan, Petrila, & Griffin,

2005; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006; Redlich et al., 2010; Trupin & Richards, 2003).

Since MHCs have proliferated without a clear implementation model and have been broadly defined (Steadman, Davidson, & Brown, 2001), MHC practices and structures are negotiated within each individual jurisdiction (Redlich et al., 2010). As a result, eligibility requirements, procedures, team structure, and other features tend to vary across MHCs (Council of State Governments, 2005; Thompson, Osher, & Tomasini-Joshi, 2008). Given this variation in court processes and characteristics, findings from single-MHC studies -- or even studies that include a few MHCs -- may not generalize across jurisdictions. To understand how

MHCs operate most efficiently and effectively and to investigate the ways in which contextual factors impact MHC implementation, researchers must be able to make cross-program comparisons (Trupin & Richards, 2003). A preliminary step in making such comparisons is to identify the key internal processes that operate within MHCs. The present study, like most others, focuses on MHCs in the United States (Slinger & Roesch, 2010). Specifically, we explore how MHC team members from 11 Ohio MHCs define and recognize the goals of MHC and their respective roles on the team to better understand how internal team features may impact MHC operations. The ways in which personnel interpret the goals of MHC and define their own and others' roles (and the relationships between them) on the team are important internal characteristics of MHCs that may impact team members' role performances, interactions, and the overall effectiveness of the MHC. For example, breakdowns in communication among MHC team members could affect their interactions with clients in ways that may impede the clients' progress and recovery. In other words, team members' perceptions of the goals of the MHC and their role orientations within it may directly affect team dynamics and indirectly affect client outcomes.

Some MHCs are entirely court-based with treatment provided by court personnel, but most MHC teams are comprised of a mixture of mental health treatment personnel (i.e., social workers, counselors, and psychiatrists) and criminal justice personnel (i.e., judges, magistrates, attorneys, and probation officers). Traditionally, mental health and criminal justice roles and associated orientations have been quite distinct (Coggins & Pyncheon, 1998). Customarily, mental health professionals are primarily con-

cerned with treatment of illness, with public safety as a secondary concern, and the use of police influence a last resort. Criminal justice professionals are primarily concerned with public safety, use police influence routinely, and consider treatment needs as a secondary concern. MHCs attempt to merge these concerns.

Nearly two decades ago Keilitz and Roesch (1992) suggested that a "paradigm shift" was needed to improve justice and mental health systems interactions. They called for a shift away from a strict emphasis on legal doctrine to a systems approach in which the complex "interrelated steps, tasks, and processes in the interactions of the justice and mental health systems" were emphasized (p.1). Steadman (1992) observed that a number of successful programs at the interface of mental health and criminal justice systems all had in common an individual with the skills necessary "to smoothly, albeit carefully, crosswalk the three, often competing, systems of corrections, mental health and the courts. These positions amounted to what the organizational literature had termed boundary-spanners" (Steadman, 1992, p. 76). The presence of a boundary-spanner on a MHC team may decrease the likelihood that conflict will occur between individuals with different professional backgrounds. Although recent interviews with stakeholders in a MHC indicated that they believed the nonadversarial team approach was one feature of MHC that made it effective (McNiel & Binder, 2010), empirical evidence of fluid working relationships, effective communication, and decision-making of MHC criminal justice and mental health treatment personnel have yet to be demonstrated (Waters, Strickland, & Gibson, 2009).

1.1 Current Study Overview

The questions guiding this research are: How do mental health treatment and criminal justice personnel describe the goals of MHC and understand their own and others' roles on the MHC team? And how might shared or divergent understandings of goals and roles impact team functioning? To answer these questions, we use qualitative research methods to assess how MHC team members with potentially different roles and orientations toward crime, punishment, mental illness and treatment work within the same organizational structure. Specifically, we conduct case studies of team dynamics in 11 Ohio MHCs using key informant interview methods. We chose this method because it is well-suited for our research goals of obtaining information about the perceptions of stakeholders and the interactions among them, beginning to specify important components of the internal dynamics of MHCs, and investigating the degree to which MHC implementation varied across sites (Sofaer, 1999). Given that roles related to the criminal justice and mental health systems are traditionally distinct, an examination of how they coalesce within MHC teams will provide insight into the processes by which these interprofessional teams work together to define and achieve common goals in the face of different, and sometimes competing, orientations. We believe that our analyses will also contribute to the development of conceptual models of MHCs by identifying ways in which the degree of shared goals and internal integration of roles may impact team functioning and, ultimately, client outcomes. We go beyond most previous research by examining 11 well-established MHCs in the context of a single study, and thus, have a greater ability than studies that have examined fewer MHCs to begin

to elucidate the general patterns of MHC team dynamics.

2. BACKGROUND

2.1 Mental health court team dynamics

Factors that influence MHCs include those external to the court as well as internal characteristics such as team members' personalities, interactions (Wolff & Pogorzelski, 2005), and views about MHC processes and outcomes (McNiel & Binder, 2010). It is important to examine and understand the internal dynamics of MHCs, because if there is something unique about the way a particular team interacts that influences client outcomes, studies not considering those processes may misattribute client outcomes to other aspects of the court intervention (Wolff, 2000).

All MHC teams are comprised of several individuals from different professional backgrounds, each with different knowledge bases, areas of expertise, goals, and interests. Patterns of interaction among MHC team members that are characterized by respect and cooperation may facilitate positive and productive working relationships. Conversely, patterns of interaction characterized by tension and conflict could potentially hinder a team's ability to effectively communicate and work together toward developing and meeting common goals. Attention to team members' perceptions of MHC's goals and the meanings and duties associated with the roles they hold within it will enable us to identify important components of the interactions between MHC team members and how they are shaped by the professional positions that they hold.

For most teams comprised of individuals from various professions, problems within the team will reflect the problems of the disciplines to which team members are connected (Lichtenstein, Alexander, McCarthy, & Wells, 2004). On the surface, mental health and criminal justice goals and professional roles may seem incompatible (Coggins & Pynchon, 1998; Lamb, Weinberger, & Gross, 1999; Munetz & Teller, 2004), but we know relatively little about how they may come together in practice. We would expect problems that arise as MHC team members interact to reflect many of the same challenges facing the criminal justice and mental health treatment systems at large. However, adherence to principles of therapeutic jurisprudence may help the MHC team coalesce around a shared vision. Therapeutic jurisprudence is a concept that was introduced by Wexler and Winick (1991), described as "the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences" (p. 981). A recent study conducted by Ray, Dollar, and Thames (2011) demonstrates that one aspect of therapeutic jurisprudence in MHC is judges' more frequent use of reintegrative shaming (i.e., condemning unacceptable behavior while showing respect and forgiveness to the offender) as opposed to stigmatizing shaming (i.e., condemning unacceptable behavior while showing disapproval of the offender and labeling him or her as a deviant person). Wolff (2002) has suggested that by using therapeutic jurisprudence as a framework, MHCs "become dual agents, representing both treatment and justice concerns" (p. 431). So if an entire MHC team embraces the concept of therapeutic jurisprudence and the associated practices, can the team be assumed to function conflict-free and know how

to modify each member's traditional professional role to maximum effect?

While accepting therapeutic jurisprudence as an organizing concept may be relatively easy for a MHC team, operationalizing this dual agency is likely to be more difficult. For instance, courts expect clinicians to provide information that will help meet the objectives of serving justice and resolving disputes, but offering that information may compromise therapeutic processes and goals (Candilis & Appelbaum, 1997; Strasburger, Gutheil, & Brodsky, 1997) by hindering clinicians' ability to maintain the usual neutral, non-judgmental stance toward clients, and potentially jeopardizing the effectiveness of treatment (Candilis & Appelbaum, 1997; Gutheil & Hilliard, 2001). Therefore, it is important to consider and address issues that arise when mental health professionals are involved in treatment and court-related aspects of their clients' lives (Strasburger et al., 1997), as well as boundary issues that arise when criminal justice professionals have to contend with both legal and mental health-related issues faced by the individuals they encounter in court.

2.2 Professional roles and boundaries

Individuals possess job role identities that are comprised of perceptions and evaluations of themselves as occupants of particular professional roles. Professional roles are associated with certain sets of attitudes, behaviors, and tendencies that are shaped by the disciplines with which they are connected (Lichtenstein et al., 2004). Given that the nature of the roles of criminal justice personnel in MHC are different from the traditional criminal justice role requirements, it may be that criminal justice personnel experience incongruity between the way they see themselves in their

respective occupational roles and the new tasks they must perform in the context of MHC (Keys & Furher, 1987). The presence of inconsistencies between role definitions and role requirements can undermine job success and satisfaction and potentially compromise organizational efficiency and effectiveness (Keys & Furher, 1987). Role inconsistencies, then, could impede cooperation and collaboration on MHC teams and potentially lead to poor client outcomes.

While the majority of MHC personnel have either criminal justice or mental health treatment backgrounds, some may have experience working within both systems. Other individuals may be boundary-spanners who use their diverse knowledge and experience to facilitate cross-system communication and cooperation (Steadman, 1992). Steadman (1992) proposed that successful diversion programs invariably included a boundary-spanner. However, it is not clear that every MHC or other inter-professional team will have an identifiable boundary-spanner.

Some suggest that certain professional boundaries are becoming increasingly obsolete in the context of partnerships such as MHC. For example, Carnwell and Carson (2005) state that “it is reasonable to suggest that current models of partnership, which are organized around current professional identities, will give way in the long term to ‘problem specific’ professions” (p. 5). MHCs are problem-oriented partnerships because they developed in response to the complexities associated with criminal justice involved people with mental illness (Watson, Hanrahan, Luchins, & Lurigio, 2001), who tend to be processed with little regard for their mental health needs (Carnwell & Carson, 2005). A partnership between

the criminal justice and mental health systems seems to be a viable strategy to address this problem, but the success of such a partnership may require a shift from the traditional orientations of each system (Carnwell & Carson, 2005) toward orientations that are more consistent with therapeutic jurisprudence.

Interprofessional teams, by their very nature, may pose challenges to traditional, socially valued role definitions and boundaries between professions, and there is some debate about the relative benefits of clear, rigid boundaries between professional roles versus blurred, permeable boundaries (Brown, Crawford, & Darongkamas, 2000). Interprofessional working can be beneficial in that it may promote the exchange of ideas and erode differences in professional identities, but there is also evidence that it may solidify boundaries and impede cooperation (Brown et al., 2000; Walker, 2003). Within a MHC team, mental health treatment and criminal justice roles and their associated perspectives may conflict. Despite the existence of boundaries and the potential for discord, MHC teams are expected to develop and adhere to a common set of goals.

2.3 Goal consensus on interdisciplinary teams

Research on team knowledge spans several academic areas and has considered concepts such as team mental models, information sharing, and cognitive consensus (see Mohamed & Dumville, 2001 for a review). Common to all of these literatures is an interest in the ways in which teams, especially those comprised of members with clearly differentiated roles, work to develop shared perspectives and goals in the context of collaborative partnerships (Mohamed & Dum-

ville, 2001). A potentially challenging task for interdisciplinary teams is to develop an orientation or philosophy that incorporates the variety of professional viewpoints and approaches that are represented on the team (Lankshear, 2003).

Here, a distinction between the nature of interaction within multidisciplinary versus interdisciplinary teams is useful. In multidisciplinary practice, team members are merely aware of and tolerate one another, but interdisciplinary practice is characterized by active coordination across disciplines (Ray, 1998). For teams to move from multidisciplinary to interdisciplinary practice there must be common ground upon which they share knowledge, professional interests, and instincts (Ray, 1998). The basis for developing and maintaining those shared understandings may reside in an interdisciplinary team’s ability to come to a consensus about and mutual commitment to team goals.

MHC team members’ agreement on common goals is likely to produce what Walker (2003) referred to as “collective responsibility,” or a recognition that the viability of MHC depends on achieving core objectives and goals (p. 193). Researchers agree that “collective efficacy,” or team members’ beliefs that efforts of the group as a whole are essential to accomplishing shared goals, and that each member can and will do his or her part to contribute to that effort, is also essential for successful interdisciplinary collaboration (Johnson, Wistow, Schulz, & Hardy, 2003, p. 70). This sense of mutual responsibility develops over time through the standardization and routinization of team practices, through decision-making processes, and through the formation of shared team goals (Walker, 2003; Waters et al., 2009). Theoretically, each MHC team will fall somewhere

along the continuum from interdisciplinary to multidisciplinary practice. In other words, MHC teams will differ in the extent to which they share a common understanding of the goals of the team as a whole.

3. DATA AND METHODS

To address our questions about the ways in which mental health treatment and criminal justice personnel understand the goals of MHC and recognize their own and others' roles on the MHC team (and related questions that are beyond the scope of this paper), we first surveyed all MHCs and mental health boards in Ohio. Using these data, we developed a semi-structured interview instrument informed by a review of literature concerned with internal dynamics of multidisciplinary teams and group decision-making. The interview guide was structured to address theoretically important aspects of team dynamics, but questions were open-ended to give respondents the opportunity to expand on certain ideas, share personal accounts, and provide additional information that they felt was important.

3.1 Sample

Because we were interested in MHCs that had operated long enough to have obtained some degree of standardization of program procedures, we identified MHCs in Ohio which had program completers.¹ Fifteen of the 25 MHCs in Ohio at the time of

our study met that requirement: 12 municipal (misdemeanor) courts and three common pleas (felony) courts. We interviewed personnel from 13 of the 15 courts.² During the interview process, personnel from one of the municipal courts and one of the common pleas courts indicated that they did not consider themselves to be or operate as "true" MHCs. Those courts were excluded from the present analyses. Results presented here are based on data from the remaining 11 courts.

Face-to-face interviews with three to eight members of each MHC team were conducted between July 2007 and July 2008. To identify potential interviewees, we contacted the presiding judge of each court who then either suggested team members to be interviewed or designated an individual to coordinate interviews. We interviewed 59 court personnel; 29 criminal justice professionals and 30 mental health professionals. After complete description of the study to the participants, written informed consent was obtained.

All 59 individuals whom we interviewed were designated members of each MHC team, although some concurrently held other positions (e.g., a MHC case manager could have a caseload that included a mixture of individuals who were and were not participating in MHC). While the exact position titles and number of personnel who occupied each position varied across courts, our sample represents a diverse group of positions from each court. Specifically,

we interviewed 10 judges (17% of all interviews),³ two magistrates (3%), five probation officers (8%), two chief probation officers (3%), one bailiff (2%), one defense attorney (2%), one prosecutor (2%), one assistant prosecutor (2%), 18 case managers (31%) (at least one from each MHC), nine MHC supervisors/team leaders/coordinators (15%), two assistant MHC coordinators (3%), two case manager supervisors (3%), three forensic monitors (5%), one psychology graduate student (2%), and one National Alliance on Mental Illness (NAMI) representative (2%). Interviews lasted between 25 and 98 minutes, with an average interview time of 51 minutes.

3.2 Interview instrument

The interview consisted of three sections: (1) court operations, (2) internal dynamics, and (3) opinions and attitudes related to MHC (Shoaf, 2003). The first section included questions related to the respondents' perception of the primary goals of MHC, responsibilities, roles, duties, and opinions about the general processes and structure of the MHC. The second portion of the interview focused on respondents' perceptions of collaboration between individuals and agencies associated with the MHC and interpersonal relationships and communication between personnel. The final part of the interview concerned the respondents' opinions and attitudes related to MHCs in general.

¹Typically, the courts had been in existence at least 2 years. During the interview process, we discovered that one of the courts did not have any completers prior to the interviews. However, the court was well-established and anticipated successful completers within the next few months, so it was retained in our sample.

²We were able to establish initial contact with all 15 courts, but after numerous follow-up attempts via phone and email over the course of several weeks, we were unable to arrange interviews with two of the courts.

³We also interviewed the 11th judge, but the interview was conducted informally, and therefore, not recorded, transcribed, or counted as one of the 59 completed interviews.

3.3 Analyses

All interviews were tape recorded and transcribed. After transcriptions were reviewed for accuracy by members of the research team, data were organized and indexed into files by court. Responses to the questions regarding the goals of the mental health court, team members' responsibilities, communication, cohesiveness and shared norms, cooperation, and conflict among team members were then compiled into a single document for analysis. Three of the authors independently coded and sorted the data and identified themes (Weiss, 1994). Upon completion of the coding process, we discussed our independent analyses of the data and discovered much overlap in our interpretations and identification of emergent themes.

4. RESULTS

Our analyses revealed several themes of which we will concentrate on two: (1) Members of MHC teams recognized their own roles as well as the roles of their colleagues and (2) recognized and internalized the common goal of serving clients' needs. We present results associated with these themes, as we believe they constitute the foundation upon which subsequent themes concerning team members' role performances emerged.

4.1 Recognition of roles

One overarching theme that was apparent throughout our interviews with MHC personnel was that interviewees recognized and appreciated the diverse roles of MHC team members. This recognition materialized in three ways. First, team members understood and were clear about the nature of their own professional roles and duties. Second,

individuals attempted to understand the roles and responsibilities of other team members. Third, individuals respected the professional opinions of other team members.

4.1.1 Understanding one's own role

We found that mental health professionals saw their position within the team as having two primary functions; one, as an advocate for the client and two, as one who reminds other team members of the importance of treatment. When asked about their main responsibilities to the court, many case managers and therapists mentioned acting as an advocate for the client. One case manager stated, "I'm an advocate. I stand up with and for the client in front of the Judge. I ensure that weekly communication is made with the court about the client's status."

Mental health professionals also reported that they found themselves needing to remind other team members of the goals of the court and the duties of MHC personnel. One Forensic Supervisor said:

I really try to focus on the case management piece even though clients and staff are aware that there's the court issue and that they are under the court's jurisdiction. We still try to remind them that the main purpose of the program is treatment, because it's easy sometimes for the Case Manager to slip into the Probation role, and I discourage that.

Some criminal justice personnel also felt like they needed to remind others of their duties. Others saw themselves as coordinators of the program or "the glue that keeps everybody together," as one Bailiff stated. Often, individuals in these coordinating positions served as links, if not truly boundary-spanners,

between criminal justice and mental health personnel on the team. The following statement made by one MHC Team Coordinator clearly illustrates her boundary-spanning role on the team:

And so my job was really about selling this program. So it's like a program manager or a program coordinator, but really it's also a marketing person. My job is to market this program and make sure everyone is happy...It's my job to protect this program as well as the participants, and I think we do a pretty good job of it. But more often than not, it's a lot of making sure that people understand one another and spanning that boundary between team members and saying, "Come on you guys, this program's much bigger than us."

In addition to general coordination of the entire team and connecting disciplines, many criminal justice personnel saw their roles as being a link to the judge for other team members. Judges, in particular, were in a unique position, simultaneously acting as administrators and members of the MHC teams. Still, the judges we interviewed primarily saw their role as the final authority within the team, as the following judge's comments illustrate:

I guess my role is I'm the overseer. It's my ultimate responsibility that the right thing is done for this person and the right thing is done for the community and victims...

Or as another judge stated: "I'm the parent. I'm the rule maker."

While Judges saw themselves and were viewed by the other team members as having the final say in decisions made by the MHC team, they frequently solicited and considered the opinions and recommendations of mental health professionals before

making final decisions regarding current or potential participants. The Judges clearly recognized that they needed the best information possible about a client to make informed decisions. One Case Manager remarked about the Judge on her team, “She really relies on us as a treatment team to know the best course of action for this person...” Furthermore, Judges themselves were quick to acknowledge that they relied heavily on the treatment team for advice just as much as the treatment team relied on their legal expertise and authority. The following Judge’s comment is representative:

They feel they need the ‘stick’ that I provide, but they provide me with the knowledge of what’s going on with the person. To me, the key of specialty courts is I really get the information I need and determine how to deal with people that violate.

Although Judges viewed themselves as members of the team and took the opinions of other team members into consideration, they also recognized their role as the final decision maker for the team.

4.1.2 Understanding others roles

Respondents also reported awareness of and appreciation for the orientations of other personnel on the MHC team. One MHC Monitor clearly understood the Probation Officer’s role:

So the P.O. (Probation Officer) has responsibility to the courts, and I mean, she has a lot on her hands, you know? They do a violation and commit a new crime; she has to deal with that. And I may say, ‘why lock them up?’ ‘But I have to, I’m the P.O., I have to lock them up!’ [Laughs]. So there’s differences in that opinion.

One Magistrate acknowledged the differing opinions and roles within the court:

I think we work well as a team. We have different views on things. Obviously, you have a perspective from the Judge’s standpoint, from my standpoint as the Magistrate, from the Counselors, from the mental health board individuals that do the funding to the... like I said, the Counselors who are day-to-day with these people. We have different roles.

In fact, many respondents felt that the presence of and balance between the different perspectives were important and beneficial to the court, as illustrated by the following statement made by one Case Director:

From a behavioral health perspective we don’t work with punishment, but we do very focused behavioral modification efforts to help people change their behavior. That’s what the court actually does. There’s a punishment for unacceptable behavior. And so they reinforce that, the consequences of that. And we on the other hand help people to realize the rewards of corrected behaviors. So, in that sense there’s a partnership with the court.

Overall, respondents reported that they not only acknowledged the presence of two different perspectives on the MHC team, but also that they welcomed and valued both. MHC team members were aware of the differing orientations of criminal justice and mental health treatment personnel, but believed them to be beneficial. Specifically, they felt that the presence of team members with different points of view gave the team a more balanced perspective, benefited the client, fostered partnerships between the court

and treatment personnel, and led to a more democratic decision-making process for the team. From this, a third sub-theme emerged that illustrated team members’ understanding of their own and others’ roles: mutual respect for and recognition of each other’s professional expertise.

4.1.3 Mutual respect

Our findings indicated a mutual respect among team members regarding decisions that were made during MHC team meetings. Every team we interviewed met as a group at least once a week (usually the day before or morning of MHC) to discuss clients’ progress. Many of the MHC team members we interviewed described team meetings as a context in which they felt free to express their opinions and hear the professional opinions of other team members. For example, one Team Leader often solicited the recommendations of Probation Officers:

So I’ll ask people, ‘What’s your opinion? What do you think? What are your recommendations?’... ‘Are there any problems from probation’s standpoint that we can expect to come up in court tomorrow? What are they? What are your recommendations and thoughts?’

There was evidence that MHC team members deferred to one another, depending on the nature of the issues posed by a given situation and the type of professional expertise required to address them. As one Forensic Case Manager explained:

If it’s a criminal law type decision, if they say this is what they have to do, we pretty much say well, you know, that’s what you have to do. That’s what you’ve got to do. By the same token, if we say that this

person needs this kind of treatment or needs to be in this kind of class or whatever, they usually defer to us and say, 'Well, you guys know what's best for them.' So normally that's the way it works.

The data clearly showed that MHC team members deferred to one another when the situation called for expertise in a different area, and mutual respect was widespread among personnel.

4.2 Recognition of goals

The second overarching theme that emerged from the analysis was MHC team members' recognition of the goals of helping clients in their recovery from mental illness and reducing criminal justice recidivism. This recognition was due partly to subthemes related to the selection of similarly-minded individuals onto the MHC team, and team agreement on and commitment to goals.

4.2.1. Selection into (and out of) being a team member

Selection into and out of the team was an important contextual aspect of the professional relationships inside MHC teams. First, we found that individuals were sometimes self-selected onto MHC teams because of their prior experience as criminal justice and mental health professionals or a predisposition to work with people with mental illness or other special populations. For example, one Case Manager said,

"I'll preface that with the fact that what I do for a living, I have an absolute passion for. I'm made to do this job..."

Second, we found that interviewees believed that they and their colleagues needed to begin with and maintain

a certain mindset to be an effective MHC team member. They felt that they had to be willing to get personally involved with clients and, as one Case Manager suggested, "invest the time and energy to try to make a difference" in the clients' lives. Several interviewees acknowledged this predisposition to be involved with persons with mental illness as an essential feature of a solid MHC team. They suggested that there was no place for team members who did not "buy into" MHC's goals or possess the willingness to adapt. As one Judge stated,

There is this kind of natural type of natural selection process that goes on. It's that some people come and go very quickly. They just get in there saying, 'This isn't working for me.' And then for some people, it's obvious, just don't fit in and they leave very quickly.

In general, we found that individuals were self-directed onto the MHC team because of their working knowledge of criminal justice and therapeutic perspectives, their predisposition to accept the program's goals, and their readiness to act on those goals on behalf of the client. Further, individuals were sometimes selected out of the team based on their own assessment or the assessment of others that they were not an appropriate "fit" for the MHC team.

4.2.2 Everyone's on the same page

Given the processes by which similar-minded individuals are selected onto the MHC team and the extensive planning that often goes into the development of MHCs (Thompson et al., 2008), it is not surprising that we found that most participants believed that they and their colleagues agreed on the goals of the court. They understood that

the main goals were to keep persons with mental illness out of the criminal justice system and link them to needed mental health services in the community.

Team members' agreement on the court's goals was widespread. Some indicated, however, that although the goals were generally agreed upon, the manner in which they went about reaching those goals differed. As one Forensic Supervisor said, team members get the "big picture," but "the interpretation of how things are to be done is sometimes in question, and that's why and when I intervene as a Supervisor to keep us on track with what the agenda is." One Magistrate stated, "I think that everyone has the same goal in mind, just different ways of getting there." Generally, we found that while individuals' treatment and legal recommendations for specific clients may have differed, they shared the same goals.

5. DISCUSSION AND CONCLUSIONS

5.1 Current study contributions

This paper presents results associated with two themes that emerged from our analyses of interviews with MHC personnel. MHC team members (1) understood their own roles and the roles of others on the team and (2) recognized and internalized the common goal of serving the clients' needs. We found that both mental health treatment and criminal justice professionals understood the general goals of MHC and were committed to working together to meet those goals. Most respondents recognized their own and their colleagues' professional roles and appreciated the professional expertise of all team members which manifested

itself in the respect for and willingness to defer to the legal recommendations of criminal justice personnel and the treatment recommendations of mental health personnel.

Consistent with a study of health-care teams comprised of individuals from different professions (Scholes & Vaughan, 2002), we found that traditional boundaries between MHC team members could be overcome if each member sought to exercise professional expertise and shared the aspiration to do what is best for the client. Importantly, our findings demonstrate that even on MHC teams that include members with distinct and sometimes conflicting orientations, professionalism and fidelity to the goals can dissolve potential barriers and foster a willingness of team members to work around obstacles.

We also found that MHC team members are aware of the importance of setting clear program goals. Most of the courts we studied had reasonably clear goal statements that all or most team members understood and agreed upon; however, research suggests that the process of getting to that level of agreement can be contentious. Developing clear goals can be problematic because of challenges that arise during the course of attempting to understand and negotiate the different perspectives that each organization brings to collaboration (Huxham & Vangen, 2000).

Our respondents indicated some degree of tension associated with identifying goals and, more specifically, differences of opinion about the particular means through which to accomplish goals, but did not characterize negotiations or their general interactions as difficult or problem-

atic. The fact that all of the MHCs in our sample had been in operation long enough to have successful program completers might explain why developing and understanding goals seemed less problematic than prior research has suggested. Nevertheless, it is likely that "...the nurturing process must be expected to be required indefinitely" (Huxham & Vangen, 2000, p. 800), and indeed, the individuals we interviewed seem to be continuously engaged in that process on their respective MHC teams.

Our data show that the relatively smooth process by which most of the MHCs in our sample "nurture" collaboration between criminal justice and mental health treatment personnel was facilitated by boundary-spanners or individuals with extensive knowledge of and experience working in both systems. They interacted with staff in their own specialty area and were able to develop and maintain interactions with others through their sound understanding of and extensive experience working within all systems involved (Steadman, 1992). While boundary-spanners were not present on all of the MHC teams in our study, several teams had individuals who occupied that role. Those teams acknowledged that the boundary-spanner facilitated understanding and cooperation between criminal justice and mental health treatment personnel. On teams that did not have a boundary-spanner, misunderstandings seemed more common.

Interviewees also spoke about other factors they felt contributed to team consensus about the goals of MHC. Consistent with previous research (e.g., Scholes & Vaughan, 2002; Waters et al., 2009), they mentioned the importance of individual personality characteristics. Research suggests that for individuals to work

effectively within a multidisciplinary team setting, they must adhere to a nonadversarial team approach (McNiel & Binder, 2010), be able to adopt the shared team culture, have an openness of communication and mutual respect for team members, and contribute equally to team practices (Scholes & Vaughan, 2002). This is a process that occurs over time, and can only occur when each member of the group understands the others' contributions and motives (Scholes & Vaughan, 2002). It may be that there was a certain ideal mixture of personalities on some MHC teams that facilitated their understanding of one another's roles and the development of and commitment to a shared vision.

Many MHC team members reported that they were drawn to working with special populations such as those found in MHC, and tended to select themselves into their respective jobs based on their beliefs that they possessed the necessary talents and strengths. These factors likely contributed to the clear understanding of their own and others' roles and responsibilities as well as team consensus about MHC goals.

5.2 Implications for mental health courts

Consistent with the views of stakeholders in a San Francisco felony MHC (McNiel & Binder, 2010), participants in our study saw expanded and ongoing training of staff as essential for improving MHC functioning and effectiveness. Based on those findings, we suggest that those interested in starting a MHC should attempt to assemble a team of highly talented and motivated professionals who all ascribe to the mission of MHC. It seems imperative that MHCs recruit personnel with experi-

ence in or a willingness to learn about both the criminal justice and mental health systems. Additionally, willingness to assert one's own professional opinions and to listen to and respect the opinions of others are desirable characteristics that should be sought out in new MHC team members and fostered in existing team members. These strategies will build trust, communication, and mutual respect among team members, which will improve the operation of MHCs and may impact client outcomes.

5.3 Limitations and future research directions

Although our study provides several important insights into the internal features of Ohio MHCs and their potential implications, our findings may not apply to other states. We were not able to include in our sample all MHCs in Ohio nor were we able to interview all individuals associated with each MHC team included in this study. While we were able to interview personnel who occupied a diverse range of positions on each MHC team, we were not able to schedule interviews with personnel from two of the 15 MHCs that met our criteria for inclusion in this study. However, our sample is still far more comprehensive than most studies of MHCs to date. Additionally, we drew upon data from each of the 11 courts to identify emergent themes, which provided us with some degree of confidence that they are salient issues for MHCs in general, or at least for the majority of established MHCs in Ohio. We do not know the exact reason why we were not able to maintain follow-up contact with two of the courts, but one plausible explanation is that they were deterred by the time commitment associated with participating. To address that

issue, future research might utilize data collection procedures that are less time-intensive than face-to-face interviews as a strategy to potentially increase participation and overcome schedule limitations (for both the respondent and researcher).

A second limitation is that our data only include information from the perspective of MHC teams. As McNeil and Binder (2010) suggest, future research should also consider the perspective of MHC participants. Data on clients' perceptions of team members' interaction with them and with each other would allow researchers to assess the extent to which MHC personnel and clients have similar understandings of and opinions about interaction among team members and between team members and themselves. For instance, recent research suggests that judge's interactions with both MHC participants and team members shape MHC team functioning and participants' outcomes (Wales, Hiday, & Ray, 2010).

A final limitation is that the nature of our qualitative data restricts our ability to systematically link MHC features with client outcomes. Given that program characteristics vary across MHCs (Wolff & Pogorzelski, 2005), future research should consider ways to quantify key MHC components to enable empirical investigations of the degree to which particular aspects of MHCs and their internal team dynamics and processes are associated with client outcomes.

ACKNOWLEDGEMENTS

This paper is based on work supported by an Ohio Criminal Justice Services Justice Assistance Grant (2007-JG-E0R-6583) and Ohio Department of Mental Health Transformation State Incentive Grants (TA-09-10-03-01, TA-08-24-03-02, TA-08-22-03-02, TA-08-22-03-01) (co-Principal Investigators Christian Ritter and Mark R. Munetz). The authors would like to thank Virginia Aldigé Hiday for her helpful comments on an earlier draft of this paper. We would also like to thank the courts, their personnel, the interviewers (Kristen Marcussen, Brent Teasdale, Pam Tontodonoto, and Jeffrey D. Monroe), and The Ohio Supreme Court Advisory Committee on Mental Illness and the Courts for their assistance with the project. Lastly, we thank Staci Kennedy and Jamie Klintworth for their assistance in scheduling and transcribing the interviews.

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COURTING COMPLIANCE: CASE MANAGERS AS “DOUBLE AGENTS” IN THE MENTAL HEALTH COURT

Ursula Castellano, PhD

Department of Sociology and Anthropology
Ohio University

To whom correspondence should be addressed: Ursula Castellano, PhD, Associate Professor of Sociology, Department of Sociology and Anthropology, Ohio University Bentley Annex 119, Athens OH 45701 castella@ohio.edu

Editor's Note: The John Wiley & Sons Ltd. controls the copyright for this article entitled “Courting Compliance: Case Managers as ‘Double Agents’ in the Mental Health Court.” Authored by Ursula Castellano the article was first published by the Law & Social Inquiry Journal of the American Bar Foundation online: 19 MAY 2011 | DOI: 10.1111/j.1747-4469.2011.01239.x Wiley & Sons has granted the Ohio Department of Mental Health and Addiction Services permission to include this article in this issue of Behavioral Health in Ohio: Current Research Trends. We are indebted to Wiley & Sons for permitting OhioMHAS to reprint this article.

Abstract: An ethnographic study of four Midwestern mental health courts was focused on how case managers influence the judicial response to offender noncompliance. Mental health courts, which bear little resemblance to traditional work group models, are staffed by teams of legal and social service professionals working collaboratively toward reducing recidivism and community reintegration for high-risk offenders. Few studies, however, have explored how treatment providers practice their trade in this new court organization. I investigate how case management professionals, working at the intersections of the social welfare and criminal justice systems, leverage courtroom decision making that results in greater leniency or enhanced punishment. The findings suggest that mental-health-court case managers act as boundary spanners in terms of their strategic use of resources to facilitate treatment goals. I conclude that case managers act as “double agents” challenging the state to advocate for clemency while enforcing client rules to uphold the integrity of the court.

We ride the fence. We're in this social work field, but we understand how the criminal justice system works. To ride that fence [means] to have that respect in the clinical field but also have it in criminal justice. Holding people accountable is important; having them be responsible for themselves and to something is important. I am not trying to get anybody off. So being able to understand that and not be a threat to either side of those fields, that's riding the fence. I know enough about the system and how things work; I understand the process, and I know where I can interject in things. My team, in particular, we all have that experience. You'll talk to my team, and they'll come across as being more punitive, but you'll still see the social work part of it. Going to jail can be a therapeutic issue; it's a consequence.¹

INTRODUCTION

One of the most pressing issues in the criminal justice system is the increasing number of mentally ill persons in jails and prisons. These correctional facilities have become de facto psychiatric institutions at great human cost as well as public expense (Denckla and Berman 2001; James and Glaze 2006). Offenders with mental illnesses pass through the justice system's revolving door from street to cell to courtroom; this defendant population

is more likely to be arrested, spend more time in jail, and have higher recidivism rates. In response to this complex problem, many jurisdictions have institutionalized mental health courts as a mechanism for diverting persons with serious behavioral health disorders from adversarial jus-

tice in traditional courts. One of the most notable distinctions of these specialty courts is that they are functional collaborations between clinical and legal professionals who are committed to addressing the complex problems in offenders' lives that contribute to the cycle of arrests. In

¹In person interview with Jaime Evans, treatment supervisor, Boone Municipal Mental Health Court.

lieu of criminal prosecution, court personnel utilize mental health assessments, ongoing judicial monitoring, individualized treatment plans, and other wraparound services, such as housing and employment assistance, to help individuals transition back into their local communities (Denckla and Berman 2001; Steadman, Davidson, and Brown 2001; Bazelon 2003; Berman 2004; Berg 2005; Fisler 2005; Mirchandani 2008; Miller and Johnson 2009).

The research on mental health courts largely consists of descriptive articles and empirical studies that examine the courts' effectiveness at reducing rates of recidivism (McGaha et al. 2002; Boothroyd et al. 2003; Trupin and Richards 2003; Christy et al. 2005; Cosden et al. 2005; Fisler 2005; Hiday et al. 2005; Steadman et al. 2005; Wolff and Pogorzelski 2005; Moore and Hiday 2006; Redlich et al. 2006; McNiel and Binder 2007). Very little ethnographic data exist on how court personnel evaluate and respond to problem cases in the day-to-day operation of the specialty docket. This study contributes to this noteworthy gap in the literature by exploring the social worlds of case managers in mental health courts who are contracted to provide community-based services to offenders facing judge-mandated treatment. The court's rehabilitative goals necessarily require that law enforcement officials employ the skilled expertise of social service agency representatives to support and supervise offenders' participatory compliance with the court program. Deeply involved in all stages of the mental health court, treatment providers are contracted through social service agencies to function as agents of the judiciary. They are primarily responsible for evaluating new court referrals, developing and maintaining files on caseloads, overseeing the

dispensation of medication, linking offenders to affordable housing and prospective employment opportunities, and keeping the court apprised of each client's rehabilitative progress (Tyuse and Linhorst 2005; Voorhis, Braswell, and Lester 2000). In short, these treatment providers participate in a complex web of problem-solving activities with criminal justice actors, community personnel, and client populations.

The analytic focus of this article is how social work professionals in these alternative courts influence judicial decision making in response to incidents of client non-compliance (Emerson and Messinger 1977). As evident in Jaime Evan's interview epigraph, treatment providers working in criminal justice institutions grapple with conflicting approaches to offender rehabilitation. From both a theoretical and practical standpoint, social workers practice their trade in the courtroom with an orientation that is different from law-trained actors (Lidz and Walker 1977; Munetz and Teller 2003; Whiteacre 2007). Criminal justice officials rely on coercive measures to ensure the offender conforms to court mandates and levy sanctions in response to criminal acts for purposes of punishment as well as deterrence. Counseling professionals, by comparison, seek to treat individuals internally and take a therapeutic approach to social deviance by helping individuals to adopt productive and healthy behaviors (Lidz and Walker 1977; Margolin 1997). The advent of alternative courts, however, strategically positions treatment providers at the institutional crossroads of the criminal justice and clinical fields. I highlight two central features of the case manager's role that offer important insights into how these programs operate in practice. In particular, they are held dually accountable in response to client troubles: they are contractu-

ally obligated to inform the court and ethically bound to treat the client (Nolan 2001). The parameters of the case manager's customary role as client advocate then must be redrawn in the context of the mental health court. This article examines how social workers redefine and retool their conventional approaches to client case management to reconcile these competing occupational identities. In short, the metaphor of "riding the fence" captures how case management professionals finesse the constitutive boundaries between treatment and law.

The article reports on findings from an ethnographic study of four Midwestern mental health courts and focuses specifically on how case managers influence judicial decisions in ways that bring about greater leniency and enhanced punishment in response to offender noncompliance. This article builds on the sociology of law, social control, and organizational literatures by theoretically situating treatment providers in the context of the problem-solving courtroom. First, I compare traditional and alternative courtroom models for the purposes of highlighting how the differences in criminal case processing enhance the authority of the treatment provider. Second, I explore the institutional parameters of the treatment providers' role by drawing on the boundary spanning literature to document empirically how they influence judicial decisions in this new court organization. I suggest that case managers are comparable to Blumberg's (1967a) notion of a courtroom double agent because they can mobilize resources to advocate for judicial leniency and enhance punishing sanctions. I then move to an overview of the ethnographic setting for my fieldwork and the substantive focus of the research, and finally I present my empirical findings

on how treatment experts influence the judicial response to client troubles in therapeutic as well as punitive ways. I conclude that case managers' ability to carry out double agent activities hinges on the accessibility as well as the skillful execution of institutional resources.

TRADITIONAL AND ALTERNATIVE COURTROOM MODELS

Most of the research on traditional courts presupposes that judges and attorneys are the central actors involved in judicial proceedings and sentencing decisions. Developed in an earlier era, the concept of the courtroom workgroup theorizes that legal officials work collectively with the expressed goal of processing criminal cases quickly and judiciously. These court officials modify their separate powers in order to maintain group cohesion, and in doing so, they jointly dispose of cases by way of informal negotiations and plea bargaining, with the result that few cases are adjudicated by jury trial (Eisenstein and Jacob 1977; Feeley 1979; Lipetz 1984; Dixon 1995). Workgroup members establish going rates to swiftly adjudicate cases, which in turn, reflect the workgroup's consensus about what particular crimes are worth in terms of negotiating a settlement (Sudnow 1965; Feeley 1979; Walker 2001).²

In subsequent courtroom research, Eisenstein, Flemming, and Nardulli's (1988) nine-court study introduced the notion of courts as communities, thereby paying closer

attention to how work relationships, processes, and organizational cultures constitute the workgroup. In communal fashion, work orientations are influenced by shared beliefs among court officials about how to handle criminal cases and their commonly held values and traditions as well as the special use of language to express ideas (Flemming, Nardulli, and Eisenstein 1993). In total, the concepts of the courtroom workgroup and the courtroom community have become the standard for explaining how the organization of the traditional court is linked to aggregate sentencing outcomes. These archetypes of criminal-case processing are beneficial for understanding how organizational and political factors influence court officials' adjudicative strategies as well as the meanings they ascribe to legal procedures. Alternative courts and the centrality of case management professionals in their routine operations, however, constitute a marked distinction from courtroom workgroup models based on procedural justice.

Alternative courts (also referred to as problem-solving courts) are structured in fundamentally different ways and bear little resemblance to traditional legal proceedings (Nolan 2001; Miller and Johnson 2009). One of the most distinguishing features is that case managers occupy a position of authority as treatment experts, and their influential role is augmented by the organizational contexts of the new courtroom model in several ways (Nolan 2001). First, specialty courts are staffed by "treatment teams," whose members are composed of a wider and more diverse set of actors,

including a presiding judge, social workers, attorneys, and probation officers.³ The concept of a team reflects the unique organizational makeup of these court programs. For example, the team typically meets before the weekly review hearings to orchestrate a collective response to clients in terms of their treatment progress. The court team model is also based on shared authority and joint decision-making practices, requiring that all members adjust their traditional roles to foster trust, cooperation, and transparency (Petrila and Redlich 2008). For example, case managers in this study led the weekly team discussions that were typically held in chambers, and court professionals frequently deferred to their recommendations for how to proceed with clients (Nolan 2001).⁴ Case managers' voices and visibility are further enhanced by the deference from or, in some instances, absence of attorneys on the court team.⁵ Nolan (2001) found that drug court attorneys yield their lawyering tactics in support of the foundational aims of the team to help the client address his or her substance addiction problem. This example of role shifting in the alternative courtroom suggests that, as attorneys recede into the courtroom backdrop, caseworkers advance to the forefront, supplanting legal authority with treatment authority.

Second, problem-solving courts are premised on the notion that law can be used to help offenders resume productive lives, a precept commonly referred to as therapeutic jurisprudence (Wexler 1992; Corvette 2000; Nolan 2001; Winick and Wexler 2003). Following Miller and Johnson

²Eisenstein and Jacob (1977) characterize the operation of the courtroom work group as a balancing act between the goals of individual actors and the collective interests of their sponsoring organizations.

³The team members vary across jurisdictions, reflecting the local legal culture and the availability of resources.

⁴For example, case managers orally suggest the judge's questions, verbal reprimands, and laudatory praise for clients.

⁵In this study, the Wayne County Misdemeanor SAMI court was the only program staffed by a public defender and a prosecutor.

(2009), however, I posit that the cohort of mental health courts in this study subscribes to the basic tenets and practices of what they call “problem solving jurisprudence” (30). This idea is specific to courts that are designed to address both community and individual problems. Alternative courts are modeled on a collaborative systemic approach to reducing recidivism for high-risk offenders. As the agents of problem-solving jurisprudence, case managers are critically responsible for drawing together and implementing a range of services for clientele who have “clusters of personal problems” (30), such as substance addictions and family troubles that are addressed in tandem with community resource problems, including a lack of affordable housing, transportation, and jobs.

Third, criminal case processing in these alternative courts is commonly depicted as therapeutic theater (Nolan 2001; Miller and Johnson 2009). The idea of the therapeutic theater allows us to advance Maynard’s (1983) theory of the ecology of the courtroom because the weekly review hearings are structured by different types of “dominant and subordinate encounters” (243). Maynard theorized that the courtroom is physically divided into three distinct regions (judge, lawyer, and audience), which correlate with individuals’ access to information and influence over legal outcomes. According to Maynard, “Moving from the back of the courtroom to the front involves a transition from a free-access area (the audience section), to limited access (the lawyers’ region), to very restricted access (the judge’s region)” (243–44).

The ecology in the traditional court is turned on its head in the context of the alternative courtroom. For example, the “audience section” (244) is closed to the public, and access is restricted to persons scheduled for a review hearing. The treatment focus of the court recasts the offender as a client, who is invited into the “judge’s region” (244) to bear witness to his or her recovery. The judge dons the customary black robe and takes the bench, but he or she departs from the edicts of common law and speaks directly to each person in a conversational manner (Nolan 2001). Of significance, the performance of weekly status hearings augments case managers’ real and symbolic power in the courtroom. They are granted center stage in the “lawyers’ region” (244) and openly testify to the offender’s program compliance and, in some instances, reprove a recalcitrant client pursuant to a line of questioning about his or her treatment failures. In total, the front and back stages of the weekly court hearings are orchestrated by treatment professionals who, by nature of their role, effectively reconstitute the social boundaries in the therapeutic courtroom.

Given case managers’ enhanced and expanded authority in the problem-solving courtroom, I suggest that they are commensurate with persons who occupy boundary-spanning positions (Steadman 1992). As conceived by organizational scholars, boundary spanners are responsible for facilitating communication and exchanging resources across multiple systems (Aldrich 1971; Aldrich and Herker 1977; Bradshaw 1999) “whose goals and expectations are likely to be

at least partially conflicting” (Miles 1980, 62). Case managers on the court team are similarly situated in that they routinely interface with the mental health, public welfare, and criminal justice systems to negotiate offenders’ access to viable treatment options.⁶ Researchers have recognized that boundary spanners are an essential factor in the success of most jail alternative programs (Grudzinakas et al. 2005; Petrila and Redlich 2008; Steadman 1992), yet the literature has not empirically identified specific strategies that boundary spanners use to ensure programmatic successes.

This article contributes to this area of research by showing how case managers, at the interstices of the criminal justice and community mental health systems, employ material, rhetorical, and symbolic resources to facilitate client outcomes. In doing so, according to the data, case managers strategically advocate for judicial leniency and enhance punishing sanctions in ways that are unique to problem-solving courts. This observation is supported by Roy Smith, a Mooring County case manager, who explained, “I’m their best friend or worst enemy. I tell clients, ‘If you’re good, I’ll do whatever I can to help you. If you’re bad, I’ll be the first one to tell the judge because that’s my job.’” Roy Smith’s interview quote encapsulates “riding the fence” in a manner similar to the quote by Jaime Evans in this article’s epigraph. The construct of “best friend-worst enemy,” however, suggests that case managers employ an arsenal of institutional practices for managing client compliance.

⁶Case managers draw upon a range of viable and appropriate resources for purposes of linking the courtroom to the community and community to the courtroom. Once the offender pleads into the mental health court, case managers monitor their involvement in substance abuse recovery programs, housing alternatives, governmental benefits, health care, and employment training, what Steadman (1992) refers to as external case management. The case manager also plays an internal case management role by relaying client information to the judge and working in correctional institutions to evaluate referrals and educate law enforcement personnel, both police and sheriff departments, about the alternative methods for managing persons with mental illness (Steadman 1992).

I argue that case managers act as “double agents” (Blumberg 1967a) by utilizing resources to challenge the state while enforcing rules to uphold the integrity of the court program. In his classic piece, Blumberg (1967a) asserts that defense attorneys, co-opted by the nonadversarial, plea bargaining court system, act as double agents marketing their legal expertise to the accused while working behind the scenes to negotiate a guilty plea.⁷ Comparatively, case managers deftly orchestrate the judicial response to noncompliance by tactically positioning themselves in opposition to both the court and the client. They capitalize on their reporting options to influence favorably how court officials respond to offenders’ recalcitrant behavior and deftly procure evidence of offenders’ probation violations in an effort to warrant taking disciplinary actions against them. In short, treatment professionals play both sides of the proverbial fence in a manner that is suggestive of double-agent activity. I conclude that case managers’ compliance strategies function to actively define the institutional parameters that govern clinical and criminal justice decision making in the alternative courtroom.

MENTAL HEALTH COURTS IN THE UNITED STATES AND THE MIDWEST

Problem-solving courts (drug and mental health, specifically) are part of a larger cultural movement to respond therapeutically to crimes involving persons with substance addiction or psychological disorders (Nolan 2001; Fidler 2005; Mirchandani 2008). Mental health courts, in particular, emerged as an institutional response to the growing population of mentally ill offenders in the criminal justice system (see Steadman, Morris, and Dennis 1995; Lamb and Weinberger 1998).⁸ Early or “first-generation” mental health courts generally accepted offenders charged only with misdemeanor and nonviolent offenses (Redlich et al. 2005). As mental health courts grew in number and evolved in scope, a “second generation” of felony level courts has been established for persons with mental illness charged with serious crimes (Redlich et al. 2005).⁹

Some of the earliest mental health courts arose from drug courts that needed a more specialized approach for working with offenders with dual diagnoses (substance use and mental health disorders). Eligible persons must typically plead guilty

to the pending criminal charges as a condition of program acceptance and agree to participate in mental health treatment in lieu of jail time.¹⁰ The team then agrees to suspend the jail or prison sentence pending the offender’s successful completion of court-monitored treatment (Nolan 2001; Petrila and Redlich 2008; Miller and Johnson 2009). The offender may be on the mental health court docket for up to two years, and persons graduate from the court program once they have recovered from their drug addiction or regained mental stability.¹¹

Public defenders and judges are the principal referral agents; they identify potential participants at various stages of criminal case processing and pass on their files to specialized mental health court personnel (see Steadman et al. 2005). Eligibility is typically determined by the criminal charge and a psychiatric diagnosis of an Axis One mental health disorder (schizophrenia, major depression, or bipolar disorder).¹² The case manager then conducts a clinical assessment with the referred person to gauge his or her level of motivation to participate in intensive treatment and to take inventory of his or her support systems in the community.¹³ Newly accepted clients are required to

⁷Blumberg (1967a) notes that defense attorneys as “double agents” are self-serving because they are looking to secure their fee, reduce their caseload, and foster productive informal networks with other court officials.

⁸In 1997, Broward County in Florida began the nation’s first mental health court as a specialized docket in the criminal courts. Subsequently, the passage of the Law Enforcement and Mental Health Project of 2000 approved the development of one hundred pilot mental health courts based on the Florida model. In the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, jail diversion and community- reentry programs were cited as best practices for offenders with mental illnesses. Eligible offenders agreed to participate in voluntary mental health treatment in lieu of jail time.

⁹Redlich et al. (2005) distinguish between first and second generations of mental health courts based on distinct characteristics between early and newer court models. These differences include the types of charges accepted, the diversity of plea structures, and different supervision models.

¹⁰The notion of voluntary treatment is a source of debate in mental health treatment literature (Redlich 2005). Clients participation in mental health court is not coercive to the extent that the defendant is made aware that he or she has the choice to have the case processed through adjudicative processes in traditional court (Bonnie and Monahan 2005; Poythress et al. 2002).

¹¹In some courts, the guilty plea is held in abeyance. If the defendant successfully graduates from the mental health court, the charges are dismissed.

¹²Typically, jail psychiatric services conduct the mental health diagnosis, or the offender may enter the criminal justice system with a previous diagnosis from his or her physician.

¹³The other team members typically follow the treatment provider’s recommendation to accept or reject the offender into the program. It should also be noted that referrals are often evaluated on an individual basis. Clients who do not meet basic criteria are not automatically exempted from program participation.

attend ongoing status review hearings for the purpose of reporting on their individual treatment progress to the judge.¹⁴ Persons graduate from the court program once the team members determine that they have regained mental stability, desisted from criminal activity, and demonstrated an ability to live independently. It should be noted that, although most mental health courts follow this basic model of operation, great variation exists in terms of their treatment modalities and judicial processes (Erickson, Campbell, and Lamberti 2006).¹⁵

According to a recent survey by the Council of State Governments

(CSG) Justice Center, approximately two hundred mental health courts operate in the United States (Psychiatric Services 2009). Thirty-three mental health courts operate in the midwestern state where I conducted this research. The programs in this study emerged between 1999 and 2006 in response to overcrowded jails and a high number of criminal cases involving persons with mental illness. Wayne, Mooring, Circuit, and Boone Counties contract for mental health and case management services with at least one nonprofit, community-based organization. The number of employed case managers and the ratio of clients to case managers varied in each court (see Table 1).¹⁶

Many case managers held social services positions prior to working in the mental health court, but few had previous experience working in the criminal justice system. Interestingly, when I asked the staff whether criminal offenders posed any special challenges to their job, the majority of them explained that they were not any different from the clients they served in nonlegal settings such as drug treatment programs, social welfare agencies, medical clinics, and homeless shelters. Case managers asserted that they “knew” the court-referred clients, meaning that they presented similar problems and issues related to the confluence of

Table 1
Summary of Mental Health Courts by County

	Mooring County 2006	Boone County 2006	Wayne County 2005	Circuit County 1999
Court type	Felony	Misdemeanor	Misdemeanor SAMI	Felony SAMI
Managers to clients ratio	2:15	2:25	5:20	6:45
Other core team members	Probation officer, judge, magistrate, and bailiff	Judge, clerk, housing and employment specialists	Probation officer, judge, public defender, and prosecutor	Probation officers, judge, magistrate, psychologist, and psychiatrist
Eligibility criteria	Axis 1 and 2 mental disorders and development disabilities	Axis 1 mental disorders	Axis 1 mental disorders and substance addictions	Axis 1 mental disorders and substance addictions
Plea structure	Deferred entry of judgment	Misdemeanor conviction	Misdemeanor conviction	Felony conviction
Treatment ideology	Self sufficiency	Maintain stability	Stress Management	Honesty and ownership
Client populations	50% African American, urban, and working poor	Caucasian, suburban, and poor	Caucasian, rural, and poor	Largely Caucasian, urban, poor, and having extensive prison records

¹⁴The court’s routine operations are structured by a system of rewards and sanctions to encourage treatment compliance as well as to hold offenders legally accountable for their actions. Incentives include judicial praise, candy, applause, a certificate, token gifts, advancement to the next treatment phase, and dismissal of criminal charges. Sanctions vary depending on the violation and the underlying conditions. Typically, they include judicial admonishment, increased court hearings, random drug tests, short-term jail stays, probation revocations, and program terminations.

¹⁵Unlike drug courts, there are no standard guidelines for defining mental health courts. Scholars have identified several key organizational features of mental health courts including (1) collaborations between court officials and mental health specialists to facilitate linking defendants to treatment resources in the community, (2) a specialized court monitoring system with a structure of sanctions and rewards for ensuring defendant compliance, (3) community-based treatment providers and/or probation officers to supervise clientele, (4) a cohesive mental health court team whose members meet weekly to discuss clients on the caseload, and (5) an explicit and well-developed treatment ideology (Slate 2003; Steadman et al. 2001).

¹⁶This study of four courts produced a sample of seventeen case managers; many held bachelors’ and masters’ degrees in social work (MSW) or licensed clinical social work (LCSW) degrees. I found some variation, however, across the courts with regard to case managers’ educational and professional background. For example, in the Circuit County Court, the supervisor was a trained clinical nurse, and two case managers were certified in drug and alcohol counseling. Two of the thirteen case managers were college students in the process of earning their social work degrees, and their client caseloads were closely monitored by the program supervisor. The demographics of the sample also reflected gender and racial diversity among the staff. Most of the case managers in the sample (eleven of seventeen) were Caucasian women aged thirty to fifty. The sample also included two Caucasian men, three African American women, and one Hispanic woman.

poverty, inequality, and deviance in society. Rather, the staff claimed that the major challenge in their job was negotiating appropriate responses to client noncompliance with law enforcement officials.

The four mental health courts all function on the same core operating principles, which are to evaluate offenders' program eligibility for court-supervised treatment and ensure they abide by the conditions of their release. However, some important variations can be found among the courts (see Table 1). First, the programs specialize in different defendant groups. The Circuit and Mooring courts work with felony defendants; the Wayne and Boone courts supervise misdemeanor defendants. Furthermore, the Wayne and Circuit courts specialize in defendants with dual diagnoses; these are typically referred to as SAMI (substance abuse and mental illness) courts. The Boone and Mooring courts, by comparison, accept only defendants with mental illnesses. Second, the programs vary with regard to the legal plea structures. In all four courts, the defendants must plead guilty to their charges; they are placed on probation and sentenced to comply with court-mandated treatment. In the Circuit, Boone, and Wayne courts, the defendant is formally convicted of the criminal charges; in the Mooring court, the charges are dismissed upon successful completion of the program.¹⁷ Third, the courts represent different treatment ideologies. In the Mooring court, case managers define a client as successful if he or she achieves some degree of self-sufficiency, such as getting a job or moving into his or her own apartment. In the Wayne court, case managers' approach to treatment is more socio-

psychological in nature. Their goal is to teach clients "therapeutic tools" to help them deal with the stress in their lives. In the Circuit court, officials measure success in terms of whether clients "own" their recovery and show initiative to work through four recovery phrases. The Boone court staff strives to maintain the person's housing and mental health stability. Fourth, these courts provide services to client populations from different racial and socioeconomic statuses as well as with varied criminal histories. In short, the case selection represents four types of mental health courts, thus allowing identification of the general structures and features of these specialty dockets.

DATA AND METHODS

The study entailed approximately sixteen months of ethnographic research in four mental health courts.¹⁸ I spent three to four months in each mental health court between 2007 and 2009. During my field studies, I conducted research in multiple settings and collected multiple forms of data, including direct observation of court proceedings and agency meetings, interviews with study participants, and compilations of archival materials. The ethnographic method of data collection is best suited to provide a deep understanding of the daily work lives of case managers and yields a rich description of the organizational settings. The premise of this research was guided by the following set of questions: (1) What are the formal rules and informal norms that structure interactions between case managers and court officials in the mental health court? (2) What is the role of case managers in routine

decisions to refer, accept, and manage cases in the mental health court? (3) What strategies do case managers use to facilitate a defendant's compliance with court-ordered treatment?

First, to capture and record the observational data, I wrote extensive field notes in three key venues where the activities of case managers took place: the courtroom, the mental health agency, and the judge's chambers. These settings are connected to one another in ways that constitute how case-processing decisions are negotiated between mental health providers, clients, and court officials. Each week, I observed the staff meetings when treatment professionals met to review the status of active clients and then attended the pre-court sessions in judicial chambers when case managers reported participants' problems, as well as successes, to legal officials. I also observed the court proceedings (also called status hearings or review hearings) when clients stood before the judge to report on their progress. At each site, a subsample of six participants was chosen for close observation as they moved through the mental health courts.¹⁹ This observation included being present during individual counseling sessions, accompanying case managers when they conducted home visits, and riding along when treatment professionals escorted clients to social service appointments.

The second component of this methodology was conducting in-depth, semi-structured interviews with all court professionals (including case managers, judges, and probation officers). The interview questions revolved around the formal and infor-

^{18.} The names of people, organizations, and locations have been changed to protect the identity of the field sites.

mal roles of team members, how and why a defendant is referred and accepted to the court, and how the court personnel respond to various forms of compliance and noncompliance. The third component of this methodology was collecting written records, including official court transcripts, the case files for the six clients in the subsample, and other internal memoranda.²⁰ In short, these various forms of data best identified the features and contingencies of the case managers' role in the mental health court. The research design was rigorously reviewed and approved by institutional review boards at the university level as well as the external granting agency.²¹ All study participants, including clients, signed informed consent forms.²²

I used the grounded theory approach to analyze the data (Strauss & Corbin 1998; Charmaz 2001) and began with the process of open coding to identify general patterns of social behavior. Then, as I became more familiar with the data, I began focused coding (Lofland et al. 2006). As coding and analysis proceeded, I refined initial concepts, ultimately producing a set of coded-data categories to explain social behavior more generally (Strauss & Corbin 1998). My field notes documented that case managers were deeply involved in the daily supervision and oversight of clients assigned to the court. The qualitative inquiry revealed that treatment providers employed strategies that are unique to these courts for reporting noncompliance to the judge. Of particular interest,

the data revealed that treatment professionals and law officials have different expectations concerning offender behavior. My emerging analysis focused specifically on how case managers were empowered to influence judicial discretion in ways that brought about a treatable or punishable response to client troubles.

In the following empirical sections of the article, I explore how case managers evaluate, define, and react to client-centered problems in the mental health court. Treatment professionals' strategies promote or dispute an offender's compliant status as well as attribute meaning to his or her criminal wrongdoing. The data illustrate that case managers negotiate competing professional obligations (client advocates and court informants) to unravel the complex relationship between clients' psychological problems and their intentional criminal actions. The first section highlights how mental health providers use evidentiary tactics in an effort to import treatment concerns into courtroom deliberations. The second section explores case managers' strategies for leveraging their discretionary powers to enhance penal sanctions against recalcitrant clients.

TREATING NONCOMPLIANCE

Scholars have reported that, under the rubric of treatment, social service workers use a variety of tools to garner client compliance with therapeutic goals (Peyrot 1985; Skoll 1992;

Margolin 1997). In his study on the micropolitics of drug treatment, Peyrot (1985) found that counselors "treat legal problems" (357) by expressing sympathy toward and encouraging court-ordered clientele to express their frustrations against the justice system as a way to build a trusting relationship. As noted previously, one of the distinctive features of mental health courts is that legal and treatment professionals function as a team to fashion a collective response to incidents of client noncompliance. Little research exists, however, on members' competing expectations of what the offender can and should achieve in the context of court-mandated treatment to successfully transition back into the community. Case managers' normative obligations to treat individual troubles must be reconciled with law-trained actors' inclination to penalize deviant activity. These empirical illustrations highlight mental health professionals' evidentiary tactics for classifying client noncompliance as worthy of a therapeutic intervention for the purpose of garnering clemency from the court. This section illustrates that case managers' internal decision-making practices for constructing "treatable problems" are particularly reliant upon the skillful use of resources emblematic of fair due process.

Raising Reasonable Doubt

Raising reasonable doubt exemplifies how case managers use evidentiary tactics to challenge the viability of the evidence that the client violated program rules.

¹⁹ I was able to achieve a diversity sample in terms of gender, race, length of time in the court program, and compliance status.

²⁰ I did not collect records on the client's psychiatric or medical history.

²¹ The study was also reviewed and approved by the quality review team at one of participating mental health agencies.

²² I sought informed consent only from clients who could fully and voluntarily give me permission to sit in on meetings with their case managers. I deferred to the expertise of the case managers to make this determination, and they played the primary role in selecting appropriate clients to include in the subsample. I adopted an additional protocol to protect clients' rights by requiring that the mental health case manager be present during the informed consent process and also sign the consent form to ensure the client was voluntarily participating in the study.

As Karen Vaughn, a Wayne Court case manager, said to me during a case review meeting, “We wear a number of hats, and cheerleader is one of them.” Specifically, treatment providers draw on formal legal ideals to bring about a judicial reprieve when a participant is accused of unlawful activity. In traditional court proceedings, reasonable doubt is a level of certainty that a jurist must have to find a defendant guilty of a crime. A finding of guilt or innocence is based on common sense after careful and impartial consideration of all the evidence. Treatment courts generally eschew official procedures for evaluating evidence of wrongdoing; however, the constellation of the treatment team represents different institutional perspectives on how to respond to clients’ delinquent behavior. The strategy of raising reasonable doubt demonstrates case managers’ ability to dispute the judge’s call to arrest clients by claiming they should be given the “benefit of the doubt” that they did not purposefully or defiantly violate program rules.

The following account provides an example of how treatment providers use their influential power to raise reasonable doubt and thwart the court’s ability to take punitive action. Brian, an eighteen-year-old Caucasian man, was diagnosed with bipolar disorder and convicted of inciting panic: he called in a bomb threat at a public high school. He had been in the court program for six months at the time of this incident. On Thursday afternoon, the team gathered in the empty courtroom for the weekly case review meeting. Brian was scheduled on the docket for a progress report, and Magistrate Wilensky was presiding.²³

Case Manager Roy Smith commenced the meeting by reporting that Brian’s grandmother had called to say that he was in a car accident and would not be able to make it to court. As I recorded in my written field notes, a flash of anger and incredulity crossed Magistrate Wilensky’s face; he used finger quotes to refer to Brian’s “alleged car accident” and said pointedly, “I think I should issue a warrant right away.” The probation officer nodded in agreement and noted, “This is like the twentieth time Brian’s had an excuse for not coming to court.” The magistrate asked the team, “Can I issue a warrant?” Laura Barnes, the senior case manager, asked somewhat in jest, “Aren’t you presumed innocent until proven guilty?” The magistrate swiftly replied, “Not in mental health court.” Case Manager Roy temporarily settled the dispute by saying, “Let’s wait and see if Brian can produce either a police report or a tow bill” as evidence of his car troubles.

The next morning, Roy and Laura gleefully faxed Magistrate Wilensky a copy of a police accident report formally documenting a weather-related traffic incident in which Brian’s car slid off the rainy highway. I secured the copy of the fax page and it read as follows:

To: Steve [Magistrate Wilensky]

From: The Bleeding Hearts [Case Managers Roy and Laura]

Re: B for Branded [Brian]

Message: [Should we] assume guilt without any evidence?

Brian’s example demonstrates how case managers call into question the magistrate’s assumption that the

client purposefully defied program rules to prevent the court from issuing an arrest warrant. In doing so, staffers advocated for judicial clemency by holding court officials accountable to one of the basic legal tenets of jurisprudence in an alternative court: the presumption of innocence. This empirical example also demonstrates how the meaning and possible outcome of a client problem was fundamentally altered because case manager had access to discovery files (the police report and the defendant’s criminal history), which they used as material grounds for granting judicial clemency.

The team approach to participant troubles is evident in that the magistrate asked the treatment providers if he could arrest Brian rather than invoking his rightful legal authority to issue a warrant. The magistrate’s request to arrest Brian was countered by the case managers’ tactic of “raising reasonable doubt” that the client purposefully failed to appear in court. This example also reveals that the cultural norms of conflict resolution among the Mooring court team members included teasing, joking, and playing up their ideological differences, which, in turn, reveal the symbolic power afforded to staffers’ righteous observance of the law. In the fax memo, case managers self-labeled their position as “the bleeding hearts” and referred to the client as “B for Branded” to highlight the magistrate’s preconceived finding of the participant’s guilt. Here, treatment professionals challenged tongue-in-cheek the court’s power to punish by questioning the assumption that Brian committed wrong-doing. In the end, case managers helped to vindicate the client after a factual finding

²³The Mooring court team is staffed by a superior court judge, a magistrate, two case managers, a probation officer, and the judge’s bailiff. During Judge Stein’s frequent absences to preside over other criminal trials, Magistrate Wilensky takes the bench and supervises the mental health court docket. The magistrate presided over approximately one-half of the weekly court dockets during my fieldwork.

of innocence.

Filing Rebuttals

Filing rebuttals refers to Mooring County case managers' strategy for raising objections to the court's ruling that the client failed to abide by the terms of his or her treatment contract. One of the most important decisions among team members was whether to advance clients to the next phase of the court program. The Mooring mental health court is structured by four treatment levels. Once the defendant pleads into the court, he or she enters the program at level one. At this initial stage, the client must attend court weekly and work closely with the case manager to devise an individualized recovery plan. As the participant gains mental stability, seeks employment, and generally shows evidence of taking responsibility for his or her life, the client advances through the second and third program levels and appears in court bimonthly and monthly, respectively. Upon completion of level four, the offender "graduates" from the mental health court, and the felony charge is dismissed. The team evaluates status promotions on the client's compliance history and individual achievements, such as getting a job, having his or her driver's license reinstated, or earning a GED. The following excerpt from my field notes highlights that case managers and court officials measure program compliance differently. For example, staffer Roy explained, "Judges tend to see clients in black and white; either [the client] did it, or they did not do it" referring to particular objectives set out in the treatment plan. As a tactical response to the judge's "white and black" approach, case managers "file a rebuttal" to object to the court's attempt to hold the participant liable for failing to meet the agreed-upon

life goals.

For example, in one account from my field notes, Nadine, a thirty-four-year-old African American woman who suffers from paranoid schizophrenia, was convicted of attempted arson when she lit her mother's bed afire. Nadine lived in the same house with her mother, three teenage children, and other members of her extended family. Part of Nadine's recovery plan was moving into her own apartment as a step toward showing initiative and gaining independence. While many property owners will not rent to persons with criminal records, Roy successfully advocated on Nadine's behalf, and the landlord agreed to lease a small one-bedroom unit to her, provided that Roy closely supervised her tenancy. The day before she was scheduled to move into the new apartment, Nadine changed her mind and opted to stay at her mother's house. In spite of this disappointing development, Roy thought Nadine was doing well, well enough to be promoted to level two. She was taking her medication, coming to court regularly, and working periodically with her aunt selling t-shirts at local flea markets. However, Roy explained that Judge Stein was not happy that Nadine elected to forgo an opportunity to live independently. He noted, "The judge wanted to hold this against the client" by objecting to his request that the court move Nadine to level two. In essence, the judge held Nadine legally liable for failing to move out of her family home. To oppose the judge's ruling, the case managers "filed a rebuttal." Roy gave the details: "[Nadine] did move to level two against the judge's wishes. We [Roy and Laura] talked the judge into moving her up by arguing that the apartment move was not part

of the original treatment plan."

This excerpt illustrates that case managers used their explanatory powers to contest the court's inclination to punish Nadine for failing to take an independent step toward self-reliance by not promoting her to the next program level. To rebut the court's ruling, the treatment professional presented the client's situation in a more nuanced way in order to nullify the argument put forth by the judge. Roy successfully argued that the apartment move was not part of the formal treatment contract and, thus, could not be considered as evidence that she had committed a violation. Here, the case manager finessed the symbolic notion of fairness in the eyes of the law as the justification for Nadine's promotion.

Thus far, these empirical examples highlight that case managers hold significant influential power to question and challenge the court's proclivity to sanction offenders' failures to meet program expectations. The strategies of "raising reasonable doubt" and "filing rebuttals" demonstrate that mental health providers draw upon formal legal ideals to advocate for a therapeutic response to client noncompliance. These tactics, in effect, span the court team's parameters for what constitutes treatable noncompliance.

Suspending Judgment

The disclosure of confidential information is fundamental to the operational dynamics of the treatment team for the betterment of the offender's recovery as well as being in the interest of public safety.²⁴ Confidential disclosure represents a role conflict for case managers as treatment court team members. As counselors, they are ethically obligated to act on behalf of the client's

psychological well-being; as agents of judiciary, they are expected to report on all aspects of the offender's life, including evidence of illegal behavior (see Lidz and Walker 1977; Fox 1999; Nolan 2001). Treatment staffers are granted a great deal of organizational autonomy over the distribution of participant data, allowing them to manage selectively what and how client information is passed along to court officials (Nolan 2001). The following empirical examples of suspending judgment highlight the conditions under which treatment providers opt to treat problem cases by suspending their obligation to report information to the court. I show that the use of rhetorical scripting is an important source of capital for case managers seeking to control the team's remedy to client problems in a particular fashion.

The following account from my field notes illustrates how case managers suspend judgment when there is insufficient evidence that the client has committed an offense worthy of court intervention. The Wayne court case managers frequently disagreed with Judge Michaels in terms of appropriate responses to problem participants. Part of staffers' frustration stemmed from their belief that the judge's rulings overstepped the boundaries of his legal training. Karen explained, "You can't make clinical decisions from the bench. The judge expects us to know when our expertise

begins and where it ends. The judge should know when his expertise begins and where it ends too."

This strategy of suspending judgment was commonly deployed when client troubles fell squarely into the clinical arena such as medication noncompliance. SAMI court clients' dual illness diagnoses posed specific organizational problems, which informed case managers' approach to treatment. A routine trouble among the SAMI clientele was that they were prone to abuse their psychiatric drug prescriptions. This phenomenon was so common that treatment providers used the phrase "monkeying with their meds" when they suspected this type of participant trouble.²⁵

On Tuesday mornings, the treatment providers meet at the mental health agency to prepare the Wednesday court docket list, discuss difficult participants, and review new referrals. Staffers also use this opportunity to "compare notes" on clients and "get on the same page" about how they will present problems to the court. On this particular day, I was in attendance and recorded the staff discussion of Tina's drug test result, which was labeled "a top priority" by Karen. Tina, a forty-one-year-old Caucasian woman, had a positive drug test for marijuana and barbiturates. It was not unusual for clients recovering from a substance addiction to periodically test positive, usually for

marijuana or alcohol. Case managers measured participant compliance by reductions in drug levels rather than by the presence or absence of drugs in their systems. Barbiturates, however, are doctor-prescribed medication to treat insomnia and reduce anxiety.

A discussion ensued among staffers about where Tina got the pills, particularly because the barbiturate levels were high enough "to suggest foul play," meaning she probably took them to get high. To weigh the evidence, Karen pointed out two possible options: "Either [Tina] had a legitimate prescription or she took someone else's medication," both of which were legally sanctionable. Karen made the call to "float on it for now," meaning not report the drug test results to Judge Michaels until she spoke to Tina's psychiatrist. Karen expressed her doubts about Tina's innocence by labeling her as "slick" and said "her intelligence is our nemesis." Later, Karen told me that, "I want to be on the same page as doctors because clients like to divide and conquer." Karen, however, justified her decision to suspend judgment by claiming that they did not want to "hang her [Tina] for something [meaning the pills]" that was legitimately prescribed. Tina's case highlights that treatment providers will reserve judgment on delinquent behavior, particularly if they need to investigate further the root cause of the problem. However, it is important to note that case managers also opt

²⁴Critics of therapeutic jurisprudence express concern that court-mandated treatment may be counterproductive and harmful to the traditional relationship between the client and the caretaker (Anderson et al. 1996). For example, Emerson (1969) found that juvenile court therapists had a hard time building rapport with offenders because they feared the information would be reported to the judge.

²⁵My field notes during the case review meetings documented several possible reasons for why clients "monkey" with their medication. According to case managers, clients may stop taking their psychiatric medication or take it differently than prescribed because they do not like the side effects, such as weight gain or drowsiness. Second, clients may take too much of the medication if their symptoms of mental illness do not subside with the authorized dosage. A third possibility that has prompted case managers to use the phrase "monkeying with meds" occurs when they suspect that clients are selling and trading their prescription drugs or taking someone else's medication for the purpose of getting high. This last issue was particular to clients assigned to the Wayne County mental health court. The surrounding rural communities were characterized by entrenched subcultures of substance abuse and mental illness, and clients were prone to draw upon these informal networks to engage in illegal behavior.

to suspend judgment as a furtive attempt to control the client's possible manipulations. Staffers were suspicious of Tina's drug test results and devised a plan to covertly investigate where she got the pills.

In a second example, during a case review meeting, I recorded how case managers coscripted a request to the judge to suspend judgment for a recalcitrant client by classifying his ongoing police contact as an illness-driven behavior. Kevin, a twenty-two-year-old Caucasian man, was a client in the Boone Municipal Mental Health Court. After a few months in the program, he was re-arrested and charged with criminal stalking and felony breaking and entering. Jaime Evans recapped the alleged offense: he was accused of breaking into his ex-girlfriend's house and physically restraining her from calling the police. Kevin explained to Jaime when she visited him in jail that he "just wanted to say hi." Jaime instructed Felicia Anderson, one of the two lead case managers, on how to handle the case during the scheduled court review hearing that afternoon. She said,

If the judge tries to terminate him, tell the judge that they want to wait and see what happens. Tell the judge to encourage him to stay in treatment and stay connected to his treatment providers. Since Kyle was sick at the time of the incident and it's his first time getting treatment, [the traditional court judge] may be more lenient on him, and if they see that he is trying to get more help, it will also help his case.

Jaime turned to me and explained, "You have to tell the judge exactly

what you want them to say." Here the case manager crafts language to script for the judge both what the problem is (not serious enough to warrant termination) and a viable solution (continued involvement with community-based treatment). The above example further supports the point that case managers have direct access to the most valuable resource available to court team members: new client information. They are in frequent contact with offenders, their families, and other law enforcement entities and are thereby empowered with a capacity to obtain and distribute information in discretionary ways. I also suggest that case managers' rhetorical strategies can be successful because they own the necessary phrasing and clinical terms to leverage therapeutic claims. They also appear to justify their actions of withholding information from the court by asserting their superior knowledge of mental-health-related issues. Interestingly, these examples suggest that treatment personnel employ the tactic of "suspending judgment" because they see it as beneficial to the client to preserve the discrete areas of expertise in law and treatment.

To summarize, in the context of the mental health court, treatment and legal professionals represent different institutional perspectives on deviant behavior. These empirical examples demonstrate that case managers' strategies for challenging, redefining, and concealing incidents of program noncompliance are purposeful for achieving successful outcomes. Mooring court treatment providers "raise objections" to the court's attempt to punish wayward clients by drawing on legal ideals to

advocate for judicial leniency. Wayne and Boone court case managers' strategies for "suspending judgment" attempt to usurp power from the court by withholding and selectively framing participant information.²⁶ In all, the employable strategies for treating compliance account for how case management professionals reconstitute the institutional parameters that govern judicial decision making. I now turn to case managers' strategies for orchestrating a punitive response to program violations.

SANCTIONING VIOLATIONS

A central component of the therapeutic jurisprudence paradigm is that recovery stems from treating the offender's individual pathology and encouraging empowerment through self-actualization practices (Fox 1999; Nolan 2001; Paik 2006b). If the client is being truthful, forthcoming, and admitting mistakes, he or she is considered to be genuinely "doing the program" (Paik 2006b, 216). For case managers, the failure of the offender to properly disclose—either by lying, lying by omission, or not admitting wrongdoing—was classified as a serious violation of the terms of program participation. This section examines mental health professionals' tactical methods for orchestrating a punitive response to clients' program violations. Although Peyrot (1985) found that counselors claim allegiance to the client by highlighting their independence from the social control agents, this study reveals that case managers realize their new legal authority in the context of the mental health court as beneficial for controlling cli-

²⁶The data also suggest that different client populations necessarily inform mental health professionals' approach to treatment. The Wayne County Court, for example, reveals that dual diagnosis clients are prone to engage in particular illness-driven behaviors that require specialized care.

entele (Nolan 2001). Driving to conduct a home visit, staffer Roy Smith explained to me that the court is very useful because “I can always threaten the client that I will tell the judge.” Similarly, during an interview with staffer Brenda Maas, of the Wayne court, she said, “I think it is really good to have ‘legal teeth’ in the program. People really won’t comply if it wasn’t for sanctions and the law and the threat of jail behind it.” These statements highlight how case managers reconcile their therapeutic principles in the context of the mental health court. That is, the use of legal social control is an effective means for coercing treatment compliance.

The empirical examples that follow demonstrate that mental health professionals directly and subversively align themselves with punitive instruments of social control to augment their sanctioning powers. I recorded numerous occasions when Circuit county court staffers intoned, “If you fail a discipline, you are subject to the discipline of others” when reaching a consensus of how to deal with a troublesome client. To discipline in this context, however, requires case managers to access resources for policing compliance commonly associated with law enforcement. Staffers’ symbolic alliance with probation officers, in particular, is often necessary to realize material consequences for client noncompliance. Specifically, these data reveal that case managers strategically position themselves in a network of probation officers, psychiatric experts, and courtroom judges to expand their arsenal of punitive options

and increase their power to punish.

Recruiting Operatives

Recruiting operatives refers to case managers’ strategy for increasing surveillance of clients’ suspect behavior by commissioning probation officers to collect evidence of wrongdoing. While mental health professionals have discretionary powers as treatment experts, they have limited resources to document and act upon illegal activity. Case managers and probation officers work in partnership to supervise jointly clients in the community. Beyond this general casework description, however, there is a distinct division of labor between the probation officer as a law enforcement agent and the case manager as a treatment provider. The job of the probation officer is to monitor and, if necessary, enforce the conditions of the offender’s release from jail. If the client breaks the terms of his or her probation, the officer is responsible for conducting an investigation, returning the offender to custody, and filing the necessary documents to revoke probation if the client is terminated from the program. In comparison, case managers develop, monitor, and adjust participants’ individualized treatment plans. They rely on probation officers’ law enforcement powers and articles of coercion to investigate noncompliant behavior.

The following excerpt from the Circuit County court demonstrates how case managers “recruit operatives” when they suspect clients of purposefully tampering with their drug

test results. The Circuit court provides mental health services to felony defendants with serious mental disorders and substance addictions (called a SAMI court). The SAMI court is characterized by a formal division of labor among treatment professionals and court officials, making it distinct from other programs in this study.²⁷

It was a routine practice among all the courts in this study to drug test clients as a standard measure of compliance. Commonly referred to as UAs (urinary analyses), drug tests were proffered and, in some cases, administered by the probation department. Similar to Paik’s (2006a) ethnographic study of a juvenile drug court, case managers claimed that some clients were aware of the flaws in the drug-testing procedures and knew how to “beat it,” meaning manipulate or “rig” the results. In particular, offenders who produced false-positive drug tests raised the concerns and suspicions of the program staff (Paik 2006a).²⁸ False positives occur when a client initially produces a positive urine drug test, but when the test is taken to the laboratory for verification, often at the request of the client, the result is negative. False positives are rare occurrences; however, during the case review meetings, I recorded several possible explanations for these types of drug test results. For example, if an individual ingests some over-the-counter medications, such as cold tablets, it may produce a false positive. In some cases, false positives may occur if a person cleanses his or her system with detoxification products prior to submitting the drug sample.

I observed and took notes

²⁷. There are four full-time licensed and credentialed case managers, a nurse, a psychologist, a psychiatrist, a program director, a community-services liaison, a judge, a magistrate, and two probation officers. In addition, two program coordinators play a role in facilitating communications between the various facets of the criminal justice system and the mental health court team. The defendant is commonly identified as a possible referral by pretrial services in the county jail. A case manager then conducts an interview with the arrestee and, if deemed program amendable, forwards the referral to the team psychologist. The psychologist then interviews the defendant to determine whether he or she meets the dual diagnostic criteria (substance addiction and serious mental illness). At the Thursday case review meeting, the psychologist then presents his diagnosis for the new referrals, and the team makes a decision to accept or deny the defendant.

during the Circuit court staff weekly case review meeting on Thursday mornings at 9 a.m. to discuss the clients scheduled on the court docket that afternoon. In attendance at the meeting were the case managers, the supervising nurse, two probation officers, and the psychiatrist. The meeting commenced with an open discussion of Angela's and Lisa's false-positive drug test results. Angela and Lisa, two Caucasian women in their late twenties, had been in the Circuit mental health court for nearly a year. Like most clients referred to the court, they had extensive criminal justice histories, including prison records and a serious drug addiction, coupled with a diagnosed mental disorder. They resided in single rooms at the local YMCA, and both had sketchy compliance histories, including outbursts and disruptive behaviors during group therapy sessions. The week prior, both Angela and Lisa had produced a positive *UA*; they protested the results, and the probation officers sent the samples to the laboratory for additional testing: the tests were found to be negative. Marlene, Angela's case manager, noted that her client had "a medical background and may know what to take to get a false positive." Staffer Susan, reported that her client Lisa "bragged that she knew [the test] would be a false positive." The probation officer tapped her fingers on the desk and tilted her head askance. "[It's] looking funny," she said. Case managers draw on clients' behaviors and actions beyond the drug test to assess their compliance

(Paik 2006a).

To begin the investigative work, Marlene first contacted Magistrate Kline to notify her of the circumstances surrounding the false-positive drug tests. The following day, Magistrate Kline sent an e-mail to the staff indicating that, according to the Federal Drug Administration, cough syrup could trigger a false positive. Participants are not permitted to take over-the-counter drugs that contain addictive substances, including cough syrup, without staff approval. The team discussed what they determined to be two likely possibilities: either the women were taking cough syrup to mask another illegal substance, or they were taking large amounts of the codeine-laced medicine to get high. Marlene petitioned the probation officers to search the women's rooms at the YMCA to look for any evidence of cough syrup such as empty bottles or purchase receipts. At the next weekly case review meeting, the probation officer reported that she did not find anything in Lisa's or Angela's rooms. However, the probation officer picked up new evidence that the women may be engaged in illegal activities. She first reported the following account from her search of Lisa's room: "[I] did not find anything in Lisa's room but found something else—a receipt for a prescription at Rite Aid. There was another paper by the bed, a list of three pharmacies with phone numbers for thirty tablets of Oxy-Contin. It looked like she was calling to get prices." The staff concluded that Lisa was probably selling the Oxy-Contin, but they did not yet have sufficient

proof to arrest her.

Next, the probation officer reported that the YMCA's records documented Angela's seemingly erratic behavior over a period of several days. She had signed in and out of the facility every five to ten minutes. To further implicate Angela, Marlene began her own surveillance project and went to the YMCA to investigate Angela's comings and goings by questioning the front desk staff. The following excerpt from the next case review meeting demonstrates how Marlene, prompted by the probation officer's preliminary investigations, secured incriminating evidence against the client.

- Psychiatrist (to Marlene):** What's the curfew [at the YMCA]?
- Marlene (to Psychiatrist):** 9 p.m. [Angela says she] signed in at 9 p.m. [The YMCA staff] reviewed the security tape, and [she] came in at 1:48 a.m. She falsified records [on the sign in sheet]. [Angela] is still trying to convince me she was there at 9 p.m. [I'm] not buying it.
- Program Director (to Marlene):** [She's] on tape, right?

²⁸ The drug testing procedures were prearranged to minimize clients' opportunities to manipulate the urine sample. Case managers organized clients into color-coded groups for drug testing purposes. On any given week, the case managers randomly selected a group (i.e., the blue group) to submit a drug test, which case managers called "doing a drop." After group therapy at the mental health agency, clients were instructed to go next door to the probation department. There, the probation officer collected the urine samples in sealed cups and used a chemical white strip to obtain an instant read of the results. Case managers, however, drawing on their vast knowledge about clients' behavior, occasionally suspected the drug test results as spurious (Paik 2006a). Under these conditions, the sample was sent to a testing laboratory for a complete and more rigorous analysis.

Marlene (to Program Director): Yeah, [but] she doesn't know about the tape.

[The staff o-o-ohs and a-a-ahs at this latest revelation, and then laughter ensues.]

Probation Officer (to the staff): We like a little drama.

The staff discussed that the “word on the street” was that Angela had been smoking crack and had been tricking the previous couple of months. The court review hearings were scheduled later that afternoon. Prior to the hearings, the case management staff, including the probation officers, met with Magistrate Kline in the small jury deliberation room to discuss the status of the clients on the docket. Marlene showed copies of the YMCA records to Magistrate Kline and informed her of the surveillance tape documenting Angela’s repeated curfew violations. She then made her recommendation to the court: “Do a urine [test] and take her into custody today. She’s out of control.” Angela appeared in the courtroom and stood in front of Magistrate Kline. Marlene then reported that she had had a positive drug test; she was subsequently arrested, and her probation was scheduled for revocation. In short, the strategy of recruiting operatives illustrates that case managers solicit law enforcement agents to help collect incriminating evidence against clients who defiantly violate the program rules.

Securing a Jail Sanction

The research on drug treatment courts has found that judges routinely use jail sanctions, also called *motivational jail* or *flash incarceration*, to punish clients for failing to conform

to the behavioral expectations of the program (see Hora, Schma, and Rosenthal 1999; Nolan 2001; Griffin, Steadman, and Petrila 2002; Burns and Peyrot 2008). The study reveals that contract case managers attempt to guide the judge’s sanction against noncompliant behavior. Contrary to Nolan’s (2001) study of drug courts, however, I found that judges do not always follow the treatment provider’s recommendations and, at times, they challenge case managers’ counsel. The data reveal that jail time is a difficult resource to appropriate for case managers seeking to discipline a wayward client, largely due to the therapeutic culture of the courtroom; by its nature, team members are expected to garner participant acceptance of their illness-driven criminality through means other than traditionally imposed sanctions. Judges’ reluctance to jail clients is also tied to their concern for taxing institutional facilities and because they are committed to presiding over a court that represents an alternative to incarceration. Securing a jail sanction demonstrates staffers’ strategies for influencing possibly recalcitrant judges to go along with their recommended court sanction.

One persuasion technique that Wayne court case managers used to augment their jail sanctioning powers is what they call “highballing the judge.” That is, staffers purposely inflate the number of days the offender should serve in jail in anticipation that the judge will lessen the recommended sanction. The following excerpt from the Wayne court provides an example of how case managers strategized to secure a jail sanction against a recalcitrant client. Heather, a forty-six-year-old Caucasian woman, had recently undergone surgery, and her doctor ordered her to be on bed rest for several days. Indeed, since

Heather was unable to drive, to facilitate her recovery, Karen excused her from attending the mandatory group therapy sessions. The following day, however, Marcy Dias, the case manager, and the probation officer saw Heather driving around town with a male companion. They followed her and caught Heather purchasing alcohol. Supervisor Karen Vaughn proclaimed, “If she was able to drive, she should have come to group [therapy].” I recorded the ensuing discussion during the in-house staff meeting.

Karen: We need to narrow down and condense this for the court. Heather is very manipulative.

Probation Officer: This should stick [with the judge]. We caught her buying alcohol at the drive thru [liquor store].

Karen: She should go to jail. That’s a sanctionable offense. Why are we working harder than she is? That’s what’s happening. Heather has to know that there are natural consequences.

Sarah: At least two days in jail.

Karen: I’d go up to three. I’d highball the judge. He’ll tell you one thing [in chambers] and on the bench do something different.

Here case managers impugn both the judge’s capriciousness to follow through on recommended court sanctions as well the client’s tendency

to manipulate circumstances to her own end. This excerpt illustrates how the highballing tactic empowers case managers to subversively negotiate participants' sanctions to help ensure that they are punished. It is important to note that Karen sought to secure the jail sanction by strategically crafting language to limit the possible interpretations of Heather's action in anticipation that Judge Michaels would respond therapeutically to the incident. Because Karen's request for more recommended days in jail would probably be granted by the judge, it would produce an immediate material consequence for the client.

A second strategy that treatment providers use to leverage their ability to punish wayward clients with a jail sanction is what I call entering convincing testimony. Here, case managers cite the opinion of outside psychiatric experts during courtroom negotiations in an attempt to sway the judge that the client's noncompliant behavior merits some form of punishment. As previously noted, there was growing discontent between the case managers and Judge Michaels in terms of appropriate sanctions for clients. According to Karen, "Judge Michaels is not easily convinced; he's not easily convincible. In the last year or so, he has begun to challenge my recommendations." In an example from my field notes, Darren, a forty-eight-year-old Caucasian man, entered the court after pleading guilty to disorderly conduct. He was diagnosed with bipolar disorder and a severe addiction to alcohol. At the Tuesday case review meeting at the mental health agency, Karen told her staff that she was "ready to give up Darren," meaning terminate him from the court program. She summarized his situation in quick order: "[Darren] is still drinking, not treating doctors well, not washing his clothes, or taking

showers." Indeed, Darren's unkempt appearance had earned him the staff nickname of "Mr. Stink."

The weekly court hearings were scheduled the following day. Prior to the proceedings, the team met in Judge Michaels's chambers to discuss the clients on the docket and make recommendations to the judge for handling problem clients. Karen described Darren's willful violation of the program rules to the judge and concluded that Darren "did not want to do the program." Judge Michaels asked Karen how much time Darren would serve in jail if he imposed the terms of his sentence. Karen, who had asked the probation officer to check Darren's file, reported that he would serve twenty-seven days in jail. Karen commented that "at least that would give him time to dry out." In this statement, Karen appeared to support her recommendation to terminate Darren by claiming that the jail sentence might also be a therapeutic solution for his alcoholism. The judge agreed to revoke Darren's probation; however, once in the courtroom, Darren apologized profusely and described his personal hardships, and in the end, the judge gave Darren a stern warning and one week to show that he can "turn this around" and "do the program." As we gathered to leave the courtroom, Karen was irritated but not surprised that the judge had elected not to kick Darren out of the program. Karen noted that Judge Michaels had a tendency to "depart from the script" and issue his own ruling in spite of what the team had discussed in chambers. One note of interest is that Karen based her failed recommendation to terminate Darren on the grounds that he did not want "to do the program." This justification typically holds sway with judges in the study because, as I recorded in my field notes, they commonly subscribe

to the mantra "We can't help people who do not want to be helped." In the example, however, the judge used the case manager's own scripted rhetoric to leverage a warning to Darren rather than as a reason for terminating him from the program. This outcome suggests that perhaps judges, working alongside with case managers, have learned to employ skillfully similar resources to solve client problems.

At the following Tuesday meeting, Karen reported that Darren continued to drink, act belligerent, and fail to follow instructions. Karen said to her staff, "It's time to force our hand," meaning leverage their claim against Darren in order to convince the judge to terminate him from the program. On Wednesday afternoon, the case management staff once again gathered in Judge Michaels' chambers. Karen reminded the judge that, although he had given Darren one week to comply with treatment expectations, Darren continued to defy the basic program rules. She then quoted Dr. Connelly, Darren's psychiatrist, in an effort to seal Darren's fate: "The doctor said that Darren's [behavior] doesn't warrant a get-out-of-jail-free card. These are his [doctor's] words, not mine." Karen cited the opinion of Darren's own psychiatrist as a means to legitimate her assessment that Darren's actions were sanctionable. Judge Michaels nodded as though to consider this information and then asked whether Darren would test positive that day. Karen said that "he probably would" and then instructed the probation officer "to give [Darren] a breathalyzer test now." The probation officer returned shortly thereafter to report that Darren did test positive for alcohol, so Karen surmised for the judge: "[Darren] made his decision for him." In the courtroom, Judge Michaels issued Karen's judgment against Darren from the bench: "A lot of people

tried to help you and you didn't help yourself. I'm terminating you from the program, and you'll report to the jail [to serve twenty-seven days]." This tactic illustrates that case managers invoke the credible testimony of outside experts in courtroom negotiations as a means to augment their judicial recommendation to terminate unmanageable clients. Again, treatment providers were attempting to cap the judge's ability to act beyond his range of legal expertise by citing a second therapeutic opinion that Darren's actions were nonredeemable. In doing so, the outside expert symbolically augmented their own counsel on how to proceed with the manner.

In sum, these empirical examples on sanctioning violations demonstrate how case managers augment their punitive powers by strategically positioning themselves with instruments of legal and therapeutic control. They also draw upon a web of resources to maneuver and manipulate information both to punish wayward clients and to induce judges to carry out their recommended court sanctions. However, as the above example illustrates, case managers' efforts to bring about court sanctions are not always met with success, in part because judges are reluctant to yield their emergent authority to make treatment-based decisions. Staffers' tactics for securing a jail sanction vary according to the particular client's circumstances and court officials' reputations and the nature of their judging style.

CONCLUSION

The Role of Boundary Spanners in Alternative Courts

The emergence of problem-solving courts has fundamentally altered the ways in which criminal defendants

are handled by the judicial system. The historical role of the courts is to formally determine guilt or innocence and administer appropriate sanctions for unlawful behavior. While judges are trained to provide a legal response to criminal matters in the traditional court, their role in these specialty dockets is to attend empathetically to individual offenders' pathologies. As Nolan (2001) points out, the adoption of alternative courts nationwide reflects a therapeutic shift in public responses to crime. Under the therapeutic model, certain criminal behaviors are evidence of drug addiction and psychiatric mental disorders that require active treatment, not punishment. One of the significant aspects of the "pathological shift" (133) in criminal justice institutions is the introduction of a new courtroom authority: the case management professional. Judges and other team members rely on outside providers' expertise in treatment-related matters and frequently follow their recommendations. Social service workers are deeply involved in overseeing the offenders' health and welfare during their tenures in the alternative court. Case managers' treatment authority stems from their occupational training in mental-health-related problems, which warrants the trust and respect of the court team members. Having this trust, in turn, means that they have significant say in the courtroom with regard to handling client problems.

Throughout this article, I illustrate the relative agency of the case managers to finesse the traditional boundaries of treatment and law to effectively respond to client non-compliance. They "ride the fence," in Jaime Evans's words, between the social work and criminal justice worlds to produce treatment outcomes. This research identifies the strategic ways in which persons in boundary-span-

ning positions allocate and employ a range of resources to negotiate programmatic goals associated with the problem-solving courtroom. The data reveal that case managers influence judicial decision making to bring about greater leniency or enhanced punishment for wayward clientele by using resources in both the judicial and clinical fields. First, these staffers treat noncompliance by using factual and symbolic evidentiary tactics to challenge the court's inclination to react punitively to situations the case managers think merit clemency. Specifically, case managers draw on features of formal legal ideals, such as due process and fairness, to promote a client's innocence of wrongdoing. They also develop rhetorical strategies to translate clinical decisions into courtroom capital. In such cases, staffers' adeptness hinges, in part, on their ability to become what case managers refer to as "bi-lingual," meaning that they must learn to talk and interpret the language of both the criminal justice and social work worlds.

Second, case managers sanction program violations by augmenting their discretionary powers to take action against recalcitrant clients. To do so, they align themselves with law enforcement personnel to gain material access to punitive instruments of social control, including drug testing, surveillance, and property searches. To appropriate a turn of phrase, case managers appear to rhetorically devise a "judicial bypass" to overcome the court's general reluctance to jail clients for treatment failures. In short, the data reveal that treatment providers in alternative courtrooms span the boundaries between the therapeutic and legal mechanism of social control to negotiate ongoing and, at times, conflicting relationships

with both client populations and court personnel.

I conclude that case managers act as “double agents,” using resources to challenge the state while enforcing rules to uphold the integrity of the court program. Blumberg (1967b) classified traditional criminal courts as bureaucratically oriented processing units in which legal actors screen cases for various institutional outcomes. An offender’s “career” begins when the police officer makes the arrest, and the prosecutor files formal charges to seek a conviction. The accused is finally betrayed by the defense attorney who uses duplicitous tactics to induce a guilty plea (Blumberg 1967a).²⁹ Thus, Blumberg theoretically positions defense attorneys as double agents: they primarily serve the needs of the court organization to reduce heavy caseloads and feign attempts to advocate zealously for their client. In comparison, treatment providers in the alternative courtroom are double agents because they can ride the fence between advocacy and punishment in a manner that is conducive to reconciling dueling notions of justice. Case managers, unlike defense attorneys, have the occupational incentives and resources to pursue a more autonomous course of action (Uphoff 1992).³⁰ Furthermore, treatment providers are afforded double-agent powers by nature of their ability to recognize possible contingencies to client problems, compile fractured pieces of information, and splice the

real and symbolic disparities between treatment and law.

The case managers in this study, however, faced constraints on their ability to influence judicial decisions in the alternative courtroom. First, the centrality of case managers in court obligated them to market their treatment authority to the other team members and clientele cautiously for fear of alienating either party. As Karen Vaughn said, “I am pretty assertive and will play the clinical card if I feel the court is making a bad decision....I don’t play it often for fear of overplaying it.” This quote suggests that case managers have a vested interest in softening the appearance of taking sides, which could threaten the therapeutic relationship with the client as well as their standing as collaborative team members of the mental health court. Second, I found that judges do not always follow the treatment providers’ recommendations, and at times, they challenged case managers’ counsel. The data illustrate that case managers’ attempts to punish recalcitrance are not always met with success, in part because judges are reluctant to yield their emergent authority to make treatment-based decisions. Staffers in this study carefully scripted a cheat sheet³¹ for the judge to prevent the court from taking his or her own form of “judicial activism,” (Nolan 2001, 94–99) or what case managers called “departure from the script.”

Third, few studies have examined the particular context surrounding the

participatory role of “offenders turned clients” in this new court organization and how these persons influence locally informed decisions with regard to their treatment compliance. While this topic is beyond the scope of this article, the data suggest that defendants seek clemency for their wrongdoing by rhetorically drawing upon the therapeutic ideals of the mental health court and undermining the testimony of the case manager. For example, Katy Trellis, a case manager in the Boone County court, described how clients “play the judge against the case managers” and “use the court hearings to divide and conquer.” As these quotes indicate, clients are aware of the opportunities for negotiating the terms of their court compliance. Case managers also expressed concern that clients were aware of fissures in the court team and exploited such fissures to their advantage. Further research is warranted to understand how offenders justify and explain their recalcitrant behavior and to understand the conditions under which they challenge the treatment provider’s authority (Emerson 1969).

Fourth, the economic downturn and subsequent loss of state and local funding have also resulted in reduced staffing and community resources, which impinge on staffers’ ability to achieve their goals. For example, two nonprofit agencies in this study eliminated the contract positions for full-time court personnel and reassigned the cases to permanent staffers. This shift meant that case

²⁹ The defense attorney’s legal relationship to the defendant is tantamount to a confidence game and the client is the mark (Blumberg 1967a).

³⁰ Uphoff’s (1992) study challenged Blumberg’s (1967a) depiction of defense attorneys as double agents. He argued that defense attorneys are better conceptualized as beleaguered dealers because their ability to mount a legal defense was contingent upon investigative resources and autonomy from the state.

³¹ Staffers prepare what they call a “cheat sheet” for the judge, which is a one-page account of the participant’s progress to date, questions to ask, snippets of good news, and a summary of problem areas they would like the judge to address. This sheet allows the judge to talk with the clients about their lives, such as looking for a job, upcoming birthday plans, or their newly adopted pet, in a casual, conversational manner during the official hearings. Importantly, it also has scripted judicial reprimands, warnings, and sanctions.

managers supervised larger case loads and had less time to focus on issues specific to the court program. More important, however, these case managers may have limited expertise and experiences working across criminal justice and social work systems; in other words, they may well be less adept at the skillful tactics of riding the proverbial fence.³² Case managers' ability to successfully produce client outcomes is not just resource dependent but also hinges on their skillful application and execution of strategies. Thus, to *ride the fence* means that staffers can exploit information and capital without jeopardizing the integrity of the court, public safety, and the welfare of the client.

In summary, case managers are the lynchpins in mental health courts, and it is important to better understand their central responsibilities in relationship to the client, the court, and the community. Using their discretionary powers, staffers influence judicial decision making to treat non-compliance and orchestrate a punitive action against recalcitrant clients. Treatment providers, in effect, construct client outcomes by "riding the fence" between the treatment and legal worlds. Mental health professionals as "double agents" effectively use strategies to be of service to the courts while meeting their professional goals as caregivers to clientele. In short, they exercise their discretionary resources in a manner sufficient to represent both the offender and the state (Dietrich 1979). I conclude that case managers are not just managing clients' treatment welfare; they are in many ways the architects of courts' routine

practices and protocols for facilitating client compliance. Case managers, on the institutional boundaries of treatment and law, effectively define what problem-solving jurisprudence means in practice (Miller and Johnson 2009) and in the everyday lives of justice-involved persons.

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³² In my observation, the court programs able to fund full-time case managers have smaller case loads, spend more time with clients, and work on more extensive treatment plans. At this time, the Circuit Felony SAMI court and the Wayne Misdemeanor SAMI court follow this model.

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THE VALUE OF IMPLEMENTING TARGET WITHIN A TRAUMA-INFORMED JUVENILE JUSTICE SETTING

Monique T. Marrow, PhD¹ • Kraig J. Knudsen, PhD² • Erna Olafson, PhD, Ps-D³ • Sarah E. Bucher, BS⁴

¹Nebraska Department of Health and Human Services, ²The Ohio Department of Mental Health and Addiction Services,

³University of Cincinnati College of Medicine, ⁴Cincinnati Children's Hospital Medical Center

To whom correspondence should be addressed: Monique T. Marrow, 2229 Terranova Ct., Lexington, KY 40513
marrow.traumaticstress@gmail.com

Editor's Note: The Ohio Department of Mental Health and Addiction Services appreciates the willingness of Dr. Monique T. Marrow to allow us to reprint the submitted version of the article "The Value of Implementing TARGET within a Trauma-Informed Juvenile Justice Setting." The accepted version of this article was published in the *Journal of Child & Adolescent Trauma* 01/2012; 5(3):257-270. [copyright Taylor & Francis], available online at: [http://www.tandfonline.com/\[DOI:10.1080/19361521.2012.697105\]](http://www.tandfonline.com/[DOI:10.1080/19361521.2012.697105]).

It is well established that justice-involved youth in the United States report high rates of past and current child maltreatment and other traumatic events inclusive of family and more often community violence, and that these factors also produce an increased risk of delinquency (e.g., Egeland, Yates, Appleyard, & van Dulmen, 2002; Mersky & Reynolds, 2007; Veysey, 2008). Up to 90% of justice-involved youth experience emotional and behavioral difficulties linked to multiple childhood traumas and losses (Garland et al., 2001; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Fisher, & Lucas, 2002). The prevalence of posttraumatic stress disorder (PTSD) in juvenile justice

Abstract: This article describes a non-randomized program evaluation study of a trauma-focused intervention for youth incarcerated for felony-level offenses in a juvenile justice setting. Thirty-eight youth previously assigned to two mental health units were provided with Treatment as Usual (TAU) plus a one day trauma training for staff, while 36 youth placed on three mental health units during the same time frame were provided with the intervention, which included TAU combined with environmental modifications, additional trauma training for staff, and Trauma Affect Regulation: Guide for Education and Therapy group for youth. Results showed significant reductions in depression, youth threats toward staff, use of physical restraints, and seclusion rates for youth on the intervention program units when compared with youth on the TAU program units. The youth involved in the intervention program also reported greater hope and optimism

Keywords: Delinquency • Traumatic-stress • Restraint • Seclusion • Youth threats • Violence • Program implementation

populations was found to be 8 times higher than in a community sample of similar peers (Abram et al., 2004; Wolpaw & Ford, 2004). At least 75% of youth in the juvenile justice system have been exposed to victimization, which is defined as being intentionally threatened or harmed by a trusted person, witnessing a loved one being intentionally harmed, or neglect, separation, or abandonment by trusted persons (Ford, Chapman, Mack, & Pearson, 2006). In 2010, 71% of the juveniles evaluated in one Pennsylvania county had potentially traumatic events (PTEs) documented in their files. These youth were more likely than those without a PTE history to use marijuana, have prior arrests, remain in criminal court, and have mental health diagnoses related to offending behaviors (Riggs, Romaine, Sevin-Goldstein, Hunt, &

DeMatteo, 2011). The likelihood that a youth will be arrested as a juvenile increases by 53% when that child has experienced child abuse and neglect (National Association of State Mental Health Program Directors/National Technical Assistance Center, 2004).

Rates of current PTSD in juvenile offender populations vary widely, from 24% to 51% among males and close to 49% among females (McMackin, Leisen, Sattler, Krinsley, & Riggs, 2002). One study found that 52% of female juvenile offenders could be considered PTSD positive (Wood, Foy, Goguen, Pynoos, & James, 2002). Even youth in the justice system who

ACKNOWLEDGMENTS

The authors would like to thank the many staff and youth involved in this study.

cannot be diagnosed with PTSD have likely had a traumatic experience, which can influence their behavior and thinking. In this population, internalizing problems (e.g., depression and anxiety) and externalizing problems (e.g., aggression, conduct problems, and oppositional or defiant behavior) appear to be at least partially rooted in disrupted development of appropriate emotional and behavioral regulation skills. This disruption is likely related to neurodevelopmental modifications in the brain and disrupted or chaotic psychosocial development (Putnam, 2006).

Youth involved in the juvenile justice system typically present more severe post-traumatic stress symptoms. An in-depth evaluation of incarcerated youth revealed histories of extensive exposures to violent death and frequent disturbing grief reactions (Wood, Foy, Layne, Pynoos, & Boyd James, 2002). In order to better understand the relationship between the traumatic event and actual delinquency, Becker and Kerig (2011) screened a group of boys assigned to a detention center in Ohio to determine whether they had experienced a traumatic event and then formally assessed them for a diagnosis of PTSD and later correlated symptom severity with degree of delinquency. They determined that the traumatic event itself was not necessarily the predominant variable associated with delinquency but rather that the severity of PTSD symptoms that occurred as a function of the traumatic event the youth identified as the most significant traumatic event was directly associated with the degree of delinquency as determined by arrests and the severity of charges. Similar findings are reported for a detained female adolescent population (Smith, Leve, & Chamberlain, 2009). Although a “causal” link between traumatic

reactions and delinquency has not yet been shown in the literature, the correlations lead many researchers to wonder if there is a causal relationship at least between severity of PTSD symptoms and delinquency.

The current program evaluation grew out of a desire for a large Midwestern juvenile justice system to better understand whether implementing a multifaceted trauma-focused intervention would result in improvements in youth management and treatment outcomes. The project’s goal was to determine whether (a) increasing youth emotional and behavioral regulation skills, (b) providing training for staff on childhood traumatic stress, (c) helping staff problem solve effective ways to intervene with youth impacted, and (d) enhancing the unit environment to decrease noise and provide safe places to practice skills would lead to reductions in youth posttraumatic stress symptoms, youth threats toward staff, and seclusion and restraint rates.

METHODS

Participants

Participants included 74 youth aged 11–19 years committed to state custody as a result of adjudications on a range of felony level offenses. All youth resided in a moderate-high security correctional facility on either an intervention (38 youth; 7 female, 31 male) or treatment as usual (TAU; 36 male youth) mental health unit between October 2005 and August 2008. Participants included 7 females and 67 males. The youth were assigned to these units based upon standard institutional protocol and behavioral health needs and thus were not randomly assigned for purposes of this evaluation. Despite these factors,

youth across units were determined to be reasonably similar in offense type and other demographic variables. All youth were committed for a period of at least six months but could remain in state custody until their 21st birthday. Mean ages for both the intervention group and TAU group was 17.4 years. Self-reported racial identity was not discrepant across units and was as follows: 75% Caucasian, 23% African American, and 2% other. All youth on the units during this time frame self-reported at least one trauma or adversity in their histories.

Program Description

TAU unit programming. The TAU unit staff and administrators received a one-day psycho-educational training, and social workers and psychologists from the TAU units were trained to administer the evaluation instruments necessary to compare programs (described below). TAU consisted of psychiatry services including medication management and consultation, psychological services that included individual therapy focused on the broad mental health needs of the youth, and social work services that included groups. TAU also included case management services focused primarily on thinking patterns that are thought to relate to delinquency and global case management, including both treatment and transition planning.

Intervention unit programming. The intervention was a multifaceted approach designed to infuse a trauma-informed program on a mental health unit and was comprised of three components. The first component was a one-day psycho-educational general trauma training on childhood traumatic stress for all staff that provided services on the mental health units and administrators responsible for those

units. The second component was two-day training on Trauma Affect Regulation: Guide for Education and Therapy (TARGET) principles. This training was followed by three months of supervision and consultation on the implementation of the TARGET group. The third component of the intervention included modifications to the unit environments with a goal of reducing trauma triggers (especially noise) and providing safe places and tools youth could use to practice self-calming skills introduced within the groups. All of the interventions noted above were in addition to all of the services described previously for the TAU program.

General trauma training. The first step in the intervention was to provide general training on psychological trauma for all staff (including juvenile correctional officers, unit administrators, social workers, psychologists, nursing staff, teachers, facility superintendents, and deputies of security and programming) with a primary responsibility on the unit or who provided services to the unit for each of the facilities where the intervention was to be implemented. Four separate full-day trainings occurred between September 1, 2007 and December 30, 2007 and were provided by the first author. Facility staff were required to attend the one day training as a unit team so that the process of developing the environmental changes and practices could begin with brainstorming ways to integrate trauma-focused interventions onto the unit. The training was designed to provide information on childhood trauma and its prevalence in juvenile justice involved youth; the relationship between traumatic events/traumatic reactions and dysregulated emotions and behaviors in youth; potentially traumatizing practices that occur in juvenile justice facilities; an overview of positive

coping strategies youth could use; and planning for and design of trauma-sensitive environments.

TARGET intervention. TARGET is a 10-session manualized treatment and prevention intervention for traumatized adolescents and adults. TARGET teaches a seven-step sequence of skills for processing and managing trauma-related reactions to current stressful experiences (e.g., PTSD symptoms, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential alienation). The skills attained are summarized by the acronym “FREEDOM”: self-regulation via Focusing; trauma processing via Recognizing current triggers, Emotions, and cognitive Evaluations; and strength-based reintegration by Defining core goals, identifying currently effective Op-tions, and affirming core values by Making positive contributions. TARGET is designed to maximize a person’s awareness of the present moment, thereby reducing mental health symptoms commonly associated with trauma, such as rumination, panic, or dissociation (Ford & Russo, 2006).

TARGET is comprised of three main therapeutic components. First, education helps the individual understand the changes that neurobiological research indicates occur in PTSD. This provides participants with an understanding of how PTSD is an adaptive adjustment to threat in the brain that is maladaptive for life circumstances that do not involve danger. Specifically, visual aides are used to show participants how traumatic stress can alter the connecting relationships between key areas in the brain’s emotion system (the amygdala, referred to as “the alarm center” for teaching purposes and the hippocampus, referred to as the “memory filing/retrieval center”) and executive system (the prefrontal

cortex, referred to as “the thinking center”). This information helps youth understand why they feel and react the way they do and provides information on how to regain control of their PTSD symptoms, which leads to the second component: teaching and guided practice of the FREEDOM skills. These skills were first used to help the client reexamine recent stressful experiences, but can also be used to understand trauma memories. Each of the FREEDOM skills is designed to enhance awareness of “alarm” reactions while also enabling youth to recognize their capacity to reset the brain’s alarm by thinking in a highly focused (but not hyper vigilant) manner. The last component is an experiential exercise where the client makes a timeline of his or her life. This helps to organize autobiographical memory (including but not primarily focusing on traumatic events), which often has become fragmented (and therefore prone to intrusive re-experiencing and negative self-attributions) for traumatized youth (Ford, Steinberg, Hawke, Levine, & Zhang, 2012) and adults (Ford, Steinberg, & Zhang, 2011; Frisman, Ford, Lin, Mallon, & Chang, 2008).

TARGET was selected as a treatment protocol because it included a training component for all staff and had shown some promise in juvenile detention settings in Connecticut (Ford & Hawke, 2012). Results from a study funded by the Office of Juvenile Justice and Delinquency Programs showed that TARGET was more effective than relational therapy in decreasing PTSD symptoms and remission from PTSD (77% in TARGET versus 53% in relational therapy) at the end of 12 therapy sessions. In this study, TARGET was used as an individual therapy for PTSD with 61 delinquent girls (Ford et al., 2012). A field study found that rates of seclusion and re-

straint dropped dramatically in Connecticut's juvenile detention centers following implementation of the four-session version of TARGET (Ford & Hawke, 2012).

An important aspect of the TARGET intervention in juvenile justice facilities is the extension of the FREEDOM skills from the educational/therapeutic groups into the entire milieu (Ford & Hawke, in press). As is proposed by the developers, in January of 2008 TARGET training was provided to all staff caring for youth as well as administrators at each of the intervention sites so that all personnel could utilize and reinforce the FREEDOM skills on a 24/7 basis when the greatest amount of learning and generalization is likely to take place.

Environmental modifications. Environmental modifications were suggested in the one-day general trauma training for staff on the intervention programs. Each of the intervention unit teams worked to develop a plan for these modifications that would assist in reducing noise and other triggers and would allow spaces for youth to practice coping skills. Each of the unit teams was permitted, with guidance and support from central office administrators, to implement these plans immediately following the training. Though each of the plans differed based upon the creativity of the unit team, environmental changes across units included painting walls in the main units in warm soothing colors, purchasing comfortable furniture to encourage social interaction between staff and youth, installing carpet and sound panels to reduce noise, and conversion of a youth room into a "comfort room." A comfort room is a comfortable quiet room that could be used to practice self-calming and relaxation skills. The youth were asked to name the rooms and variously re-

ferred to them as the "chill zone," "Zen space," or "comfy spot." There were a variety of tools youth could use in this room, including weighted blankets, fidget toys, video rockers, music, and multiple other sensory-based tools. All tools were reviewed and approved for use by staff and administration and practices and procedures were developed to ensure safety and monitoring for appropriate use.

Design and Procedure

This study was a program evaluation of an intervention that was piloted by the State Department of Youth Services and all procedures were reviewed and approved by the State Department of Youth Service and by the State Department of Health Institutional Review Board. The youths' legal guardians were informed of the program, provided with a written description of the program and its requirements, and asked to consent to participation in the evaluation portion of the program by the social work or psychology staff on the units. The youth were then similarly approached by the psychologist or social worker on the unit; the study was explained verbally as well as in writing and youth under age 18 were asked to assent while youth age 18 or older were asked to consent to the evaluation portion of the program.

The intervention was provided to all youth on the intervention units regardless of whether or not they specifically assented to the use of their data in the study. The youth and legal guardians were both made aware that they could withdraw their consent/assent to allow the youth data to be used at any time and that it would not affect the youth's ability to be provided treatment services or participate in the group. Youth and legal guardians of youth on the TAU units were also

asked to assent and consent to the assessments. All youth approached regarding the study and their legal guardians consented/assented to the study. This resulted in a total of 82 youth who participated in initial data collection. Eight of the youth for whom initial data was collected were released prior to the second data collection point; thus, only the 74 youth who were available for both data collection points are included in this study.

Beginning in April of 2008, baseline evaluations (T1) were administered to all youth on the intervention and TAU units at initiation of the study. These baseline evaluations continued as a standard part of the intake process as new youth were admitted to the unit over the next five months. Instrument administration took between 60 and 90 min. Reassessments occurred for each youth three months following initial assessment (T2) for both the intervention and TAU groups. This interval was preselected to ensure adequate time for youth to benefit from the intervention and participate in the group. Though more data collection points for clinical data were available, the focus of this study was the first nine months, during which we ensured that each youth had at least one three-month follow-up. Unit psychologists and social workers conducted all assessments with youth individually in a private room and assisted youth with low literacy by reading the questions and response options when necessary. For both treatment programs, instruments were scored with electronic scoring systems to reduce error and clinical reports were forwarded to clinicians to use in treatment with youth.

Measures

Trauma exposure and PTSD symptoms measures. Seven measures were utilized to evaluate participants' progress in treatment. The Mood and Feelings Questionnaire (MFQ) (Angold, Costello, Pickles, & Winder, 1987) is a 13-item self-report screening instrument for detecting symptoms of depressive disorders in children and adolescents 6–17 years of age. The Self-Report for Childhood Anxiety Related Disorders (SCARED; Birmaher, Khetarpal, Cully, Brent, & McKenzie, 1995) is a 41-item self-report screening instrument for detecting symptoms of anxiety disorders in children and adolescents 8 years of age and older. The Trauma Events Screening Inventory (Ford & Rogers, 1997) is a 15-item interview that assesses a child's experience of a variety of traumatic events. The UCLA PTSD Reaction Index (RI; Steinberg, Brymer, Decker, & Pynoos, 2004) is a 48-item scale that assesses a child's exposure to 26 types of traumatic events and assesses DSM-IV PTSD diagnostic criteria. The Ohio Scales (OS; Ogles, Melendez, Davis, & Lunnen, 2001) are a 48-item scale that assesses problem severity, functioning, satisfaction with services, and hopefulness. The Generalized Expectancies for Negative Mood Regulation (NMR; Catanzaro & Mearns, 1990) is a 30-item scale that assesses an individual's ability to regulate their negative moods (i.e., when an individual is in a bad mood, they can do something to make themselves feel better). Finally, the Massachusetts Youth Screening Instrument (MAYSI-2) (Grisso & Barnum, 1998) is a 52-question self-report measure designed to identify youth 12 to 17 years old in juvenile justice facilities who have special mental health needs. All instruments used in this study have been used in

past studies of trauma and/or child and adolescent mental health.

Seclusion, restraint, and verbal threats measures. In addition to measures designed to assess posttraumatic stress reactions and mood symptoms, youth incident reports were used to measure frequency of seclusion, physical response(restraint), and threatening behavior by youth.

Data Analysis

For site-specific data, paired samples *t*-tests were used to examine the difference between time points (T1–T2), which were approximately three months apart for all youth. For individual-level data, a repeated measures analysis was conducted to examine comparative treatment effects between the two alternative treatments on a number of resiliency and psychiatric measures (e.g., problem severity, hope, functioning, PTSD, depression, anxiety).

RESULTS

History of Trauma or Adversity

The most common types of abuse experienced were physical abuse (49%), sexual abuse (44%),

and emotional abuse (28%).The most common types of adversity experienced were separation from loved ones (73%), having a family member in jail (63%), and witnessing people using illicit drugs (58%).

Intervention Versus Treatment as Usual Analysis

Use of seclusion and physical response. To examine trends in the use of safety interventions, May-August 2007 data (pre-intervention) was compared to data collected between September 2007 (immediately following initial 1 day training) and December 2008. As evidenced by Figure 1, while both groups used physical response (restraint) at the same rate between May and August of 2007, over time the TAU group used physical response (restraint) at a rate five times that of the intervention group. A similar trend emerged with use of seclusion and the number of menacing threats made by youth (which appear strongly correlated; Figures 2 and 3). As shown in Figure 2, over time the TAU group used seclusion at a rate six times that of the intervention group. Additionally, the intervention group evidenced a continued reduction in the use of seclusion for eight months following the introduction of the intervention.

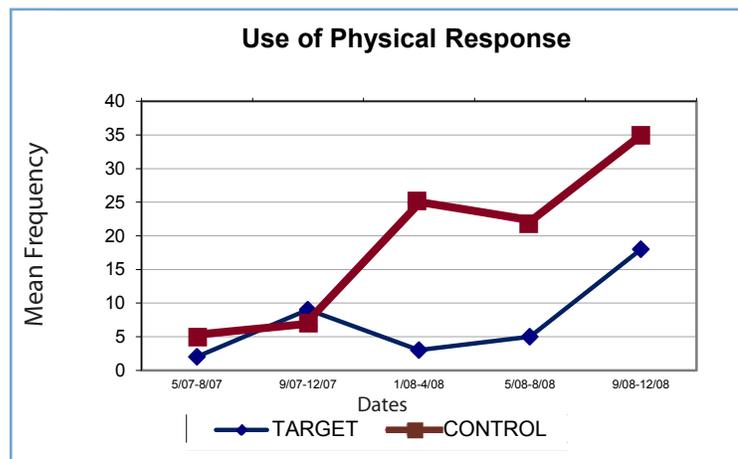


Figure 1. Use of physical response

Symptom and resiliency measures. As shown in Table 1, significant group by time differences were found on the hope ($F[2,72] = 8.78, p < .001$) and service satisfaction factors ($F[2, 72] = 3.81, p < .05$) of the OS, and in depression as measured by the MFQ ($F[2,72] = 3.57, p < .05$), with the intervention group experiencing significantly greater improvement over time than TAU. Significant time effects were also demonstrated on a number of measures, indicating youth noticeably improved over time in both groups. Specifically, improvements over time were noted in the problem severity ($F[2, 72] = 3.44,$

$p < .05$) factor of the OS and the PTSD ($F[2, 72] = 3.43, p < .05$) and anxiety disorder ($F[1, 72] = 29.86, p < .001$) scales on the UCLA PTSD-RI.

CLINICAL FINDINGS

While not all findings were statistically significant, most units evidenced clinically significant improvements in core treatment domains when comparing mean scores to the diagnostic clinical cutoff score (see Figure 4). The intervention group demonstrated superior clinical outcomes when compared to TAU on

scores for depression and perceptions of hope and optimism (clinical cutoff scores are denoted by the bold line on each graph). Mean depression scores on the MFQ for the intervention group reduced over time ($M = 8.62$), while the TAU group experienced an increase ($M = 10.35$). The MFQ diagnostic cutoff score is 8, suggesting the intervention reduced depression symptoms to a level close to the diagnostic cutoff in the intervention group. Symptoms of anxiety reduced significantly for both groups. The mean scores on the SCARED for the intervention ($M = 12.32$) and TAU ($M = 18.13$) reduced over time to levels far below the diagnostic cutoff score of 25. PTSD symptoms also improved over time in both groups. Finally, improvements in youths' perceptions of hope and optimism were higher in the intervention group ($M = 10.62$) over time as compared to TAU ($M = 12.80$). The OS hope measure is reverse scored, meaning lower scores suggest improvement.

DISCUSSION

Preliminary results suggest that a trauma-focused intervention strategy inclusive of training for staff, implementation of a specific trauma focused group treatment, and environmental modification was superior to the TAU program in producing durable improvements in perceived hope and optimism and depression over the course of three months. Additionally, participants receiving the trauma-focused intervention had greater clinical improvement in depression, anxiety, and hope and optimism as compared to TAU when examining clinical cutoff scores. One indicator that also is important to consider from a consumer perspective is service satisfaction. On the service

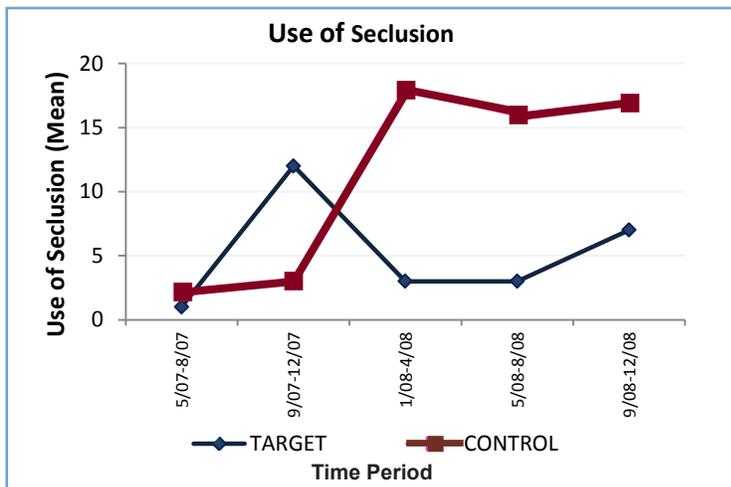


Figure 2. Use of seclusion

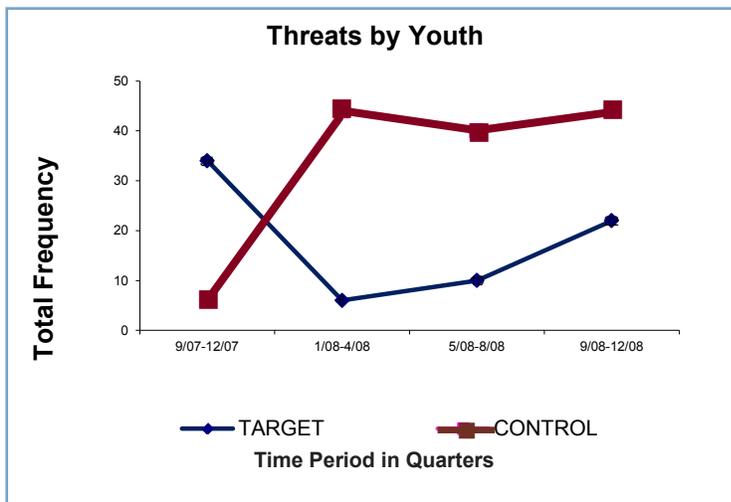


Figure 3. Threats by youth

Table 1
Preintervention to Post Intervention by Time interactions on Outcome Measures

Measure (Source Scale)	T1	T2	Group F	Time F	Group vs Time F
Problem Severity (OS)					
Intervention (N = 38)	39.12 (29.01)	32.23 (21.34)	.17	3.44*	.00
TAU (N = 36)	36.56 (21.52)	29.62 (22.58)			
Hope (OS)					
Intervention	13.33 (4.80)	17.26 (4.96)	.58	2.23	8.78**
TAU	16.00 (4.00)	14.70 (4.47)			
Service Satisfaction (OS)					
Intervention	15.47 (6.82)	19.80 (3.87)	.75	3.44	3.81*
TAU	16.59 (5.04)	16.37 (5.84)			
Functioning (OS)					
Intervention	59.35 (10.35)	57.82 (12.87)	1.47	2.23	1.47
TAU	56.99 (10.74)	51.22 (19.12)			
Negative Mood Regulation (NMR)					
Intervention	91.61 (10.64)	92.47 (10.84)	.58	.33	.43
TAU	96.66 (12.84)	94.68 (14.56)			
PTSD (UCLA PTSD-RI)					
Intervention	45.70 (14.71)	41.35 (20.72)	.04	3.43*	.25
TAU	41.35 (20.72)	38.73 (19.91)			
Depression (MFQ)					
Intervention	9.81 (6.37)	8.62 (5.35)	.06	.71	3.57*
TAU	7.25 (3.90)	10.35 (7.59)			
Anxiety Disorder (UCLA PTSD-RI)					
Intervention	28.48 (16.02)	12.32 (16.17)	2.31	29.86**	.19
TAU	31.86 (13.28)	18.13 (20.15)			
Panic Disorder (SCARED)					
Intervention	5.42 (4.41)	4.71 (4.81)	1.24	.09	1.06
TAU	5.95 (4.46)	7.28 (5.72)			
Generalized Anxiety (SCARED)					
Intervention	7.50 (4.58)	8.42 (4.60)	.18	.10	1.39
TAU	8.85 (4.60)	8.33 (4.57)			
Separation Anxiety (SCARED)					
Intervention	5.71 (2.23)	5.78 (3.11)	.62	.08	.02
TAU	6.42 (3.31)	6.66 (4.02)			
Social Anxiety (SCARED)					
Intervention	5.64 (2.06)	5.71 (3.85)	.23	.05	.12
TAU	5.38 (2.88)	5.04 (3.74)			
School Avoidance (SCARED)					
Intervention	1.28 (1.32)	1.42 (2.37)	1.06	.04	.04
TAU	1.95 (1.60)	1.95 (2.23)			

* $p < .05$; ** $p < .001$

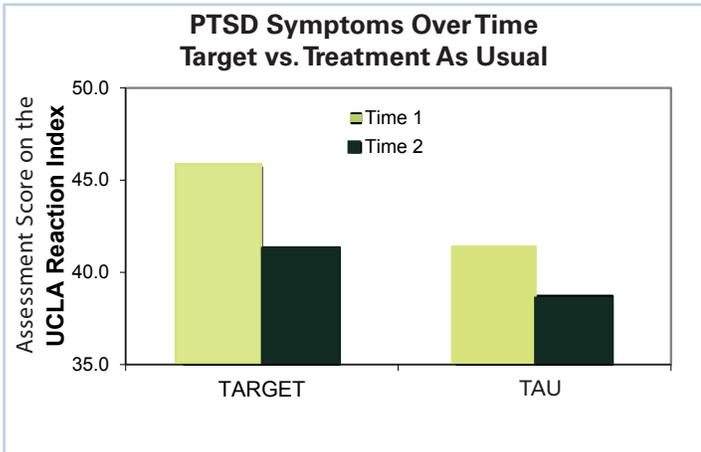


Figure 4. Improvements depression, anxiety, PTSD, and perception of hope and optimism overtime

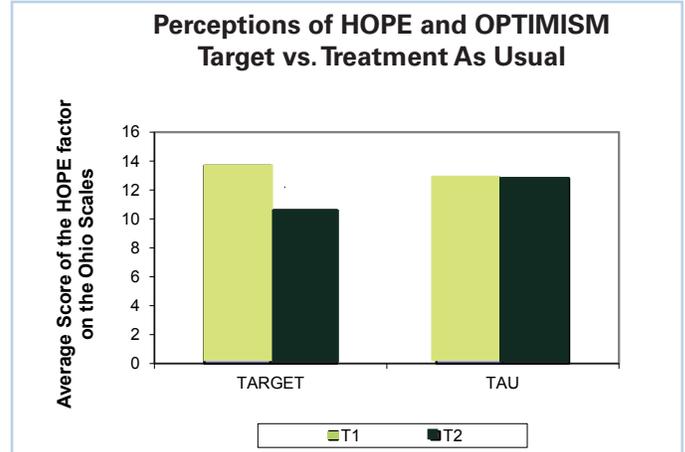


Figure 5. Perceptions of HOPE and OPTIMISM

satisfaction subscale of the OS, youth on the intervention units expressed significantly more satisfaction with the mental health services they were receiving in comparison to youth on the TAU unit who demonstrated no changes in service satisfaction. Although not specifically a clinical indicator, it may suggest that youth felt staff was more responsive to their needs and that the interventions used were helpful.

Though clinical indicators were targeted in this study, other important indicators were the use of seclusion and physical response (restraint). These are always targets for reduction across both juvenile correctional programs and residential facilities. Seclusion and restraint are not only harmful to youth but also have a negative impact on the staff who must respond. This study's results related to seclusion, restraint, and youth threats toward staff suggest that implementation of a milieu-based trauma-focused intervention may have value in assisting juvenile correctional facilities in reducing the use of seclusion and restraint while also reducing the incidents of youth threats. It is believed that these behavioral outcomes are at least partially related to the youth ac-

quiring increased ability to regulate themselves behaviorally and emotionally. It is possible that through training and assisting youth in using effective coping strategies and regulation techniques, the staff also improved their ability to regulate their own emotions and behaviors, which is an equal factor in determining restraint and seclusion use. Though staff regulation skills were not a part of this study, informal interviews with staff working on the intervention units support this hypothesis. Many staff indicated that what they liked about being on the unit was that through the training they had many more "tools" to use, which made working with the youth more rewarding. They could spend less time writing in seclusion logs and more time engaging the youth in activities. Some even commented that they were able to use what they learned in their personal lives outside of the facility. Informal comments from the youth suggested that they also liked the staff more, often indicating they were "more fair." This may be what is contributing to the increase in service satisfaction scores for the youth.

Another element that may have contributed to the success of the program was that by design staff

traditionally referred to as "treatment" or "program" staff and staff who have more frequently been referred to as "security" staff were trained and had to work together to develop the intervention units based upon what they had learned in training. The skills youth were learning in group were also taught to the staff responsible for their care and supervision so that these skills could be reinforced when youth were not in group. The environmental modifications were undertaken as a team project, with all staff, youth, and administrators sharing ideas about placement of the comfort rooms, design of the units, and items to be used.

Limitations

Given that the study was a program evaluation that involved multiple interventions introduced simultaneously, the specific components that were effective in producing outcomes could not be determined. However, it is clear that training alone, which the TAU unit staff received, is insufficient to produce decreases in the use of safety measures and youth threatening behavior. Future studies will be necessary to better evaluate the incremental impact of a trauma-focused group intervention, continued staff

training, and environmental modifications.

Although this study documented reductions in threatening and disruptive behavior by youth and the necessity for staff intervention while still incarcerated, youth were not followed after their release to document whether their subsequent histories showed reduced delinquent behaviors and reductions in recidivism as a function of the skills acquired. This will be an important next step in evaluating the long-term community impact of implementing such an intervention. Other limitations to the study include its relatively small sample size. In addition, because there were only seven females in the study, no comparative gender analyses were possible. At least one of the scales for the selected instruments, the functioning scale of the OS, was geared for a community sample and has limited applicability to incarcerated youth. The functioning scale includes items that are not relevant to detained youth, such as improved dating relationships, earning money, and participating in hobbies, all activities geared toward a community sample. These items artificially reduced the functioning scores for study participants and therefore should be interpreted with caution. Despite these limitations, this study supports the use of a multimodal trauma-focused intervention within a correctional setting and demonstrates that implementing such a system is possible within a correctional environment. It is still extremely important to find ways to replicate and refine these findings with such a population, though randomized controlled studies with dually protected populations (children and the incarcerated) can prove challenging.

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THE EFFECTIVENESS OF A VETERANS TREATMENT COURT: A PILOT STUDY

Kraig J. Knudsen, PhD • Scott J. Wingenfeld MPA

Office of Quality, Planning and Research
Ohio Department of Mental Health and Addiction Services

To whom correspondence should be addressed: Kraig K. Knudsen, Office of Quality, Planning & Research, 30 E. Broad Street, 8th Floor, Columbus, OH 43215. Email: kraig.knudsen@mh.ohio.gov

INTRODUCTION

It is well established that veterans in the United States report high rates of post-traumatic stress disorder (PTSD), and these factors can produce an increased risk of criminal justice involvement.¹ Approximately 18% of veterans experience PTSD and depression symptoms.² Data from Harvard's Comorbidity Study³ suggest PTSD prevalence in the veteran population is around three times higher than in community samples. In terms of criminal justice involvement, roughly 200,000 veterans were incarcerated in U.S. jails and prisons in 2007, accounting for about 10% of the total inmate population.⁴ A large number of these veterans suffer the effects of untreated PTSD. In one study, the rate of positive PTSD screens was as high as 39%.⁵ Studies have also noted significant non-service related trauma in veterans. One study found that 9% of soldiers screened positive for PTSD and 11% screened positive for depression *pre-service*.⁶ These findings suggest that there are likely large numbers of veterans who may

Abstract: Objective: To examine the efficacy of providing a Veterans Treatment Court specialized docket to trauma-affected Veterans. **Sample:** Sixty-one veterans enrolled in jail diversion and trauma recovery Veterans Treatment Court program. **Methods:** Veteran participants were interviewed at baseline, 6-months, and 12-months to determine if the program led to improvements in jail recidivism, psychiatric symptoms, quality of life, and recovery. **Results:** Veterans involved in the Veterans Treatment Court programs experienced significant improvement in PTSD, depression, substance abuse, self-harm, overall functioning, emotional wellbeing, relationships with others, recovery status, social connectedness, family functioning, and sleep.

Key Words: Veterans • PTSD • Veterans Treatment Court • Outcomes • Trauma • Combat Exposure • Specialized Docket .

not be diagnosed with PTSD, but endured a traumatic experience, possibly influencing behavior and thinking. Veterans with PTSD have been shown to exhibit chronic functional impairments in homelessness,⁷ unemployment, income disparities,⁸ relationship problems,⁹ poor problem-solving, aggressive behavior,¹⁰ poor self-care, and quality of life.¹¹ Several studies of combat exposed veterans with PTSD have also shown significant impairment in memory,¹² learning,¹³ and executive function.¹⁴ Anger has also been associated with poorer

therapeutic alliance, adherence to treatment, and associated outcomes.¹⁵ One study found only half of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with a referral for mental health services at post-deployment actually sought and received treatment.^{16,17}

Veterans with combat experience also present more severe PTSD.¹⁸ At present, over 1.64 million veterans have been exposed to combat stress in both OEF and OIF conflicts. Veterans of different theatres present

Authors Note: This project was funded by grant 5SM059274-05 from the Substance Abuse and Mental Health Services Administration (SAMHSA). The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA. The authors thank Helen Anne Sweeney, Carol Carstens, Kwok Tam, and Tracy Plouck for their assistance in manuscript preparation.

Table 1

Intervention/Service Received	N	Percent
Case Management	52	85.2%
Outpatient Mental Health Counseling Treatment	43	70.5%
Self Help/Peer Support Services	39	63.9%
Outpatient Substance Abuse Treatment	38	62.3%
Physical Therapy	37	60.7%
Transportation Support	34	55.7%
Psychiatric Medication	34	55.7%
Inpatient Substance Abuse Treatment	26	42.6%
Trauma Specific Cognitive Behavioral Therapy Treatment	24	39.3%
Housing Support	21	34.4%
ER Services	18	29.5%
Inpatient Mental Health Treatment	16	26.2%

varying degrees of PTSD, with OEF/OIF veterans reporting higher PTSD instances than veterans of other conflicts.¹⁹ Current estimates put the PTSD rate for OEF/OIF veterans at nearly 20%.² Studies examining PTSD effects on veterans have also shown a strong positive association between the presence and severity of PTSD in veterans and increased rates of arrests and convictions.²⁰

Veterans Treatment Court Services

Specialized mental health and drug treatment dockets have proven successful at decreasing recidivism²¹ and improving treatment outcomes, such as reduced psychological distress, fewer drug problems, and improved quality of life.²²

Veterans Treatment Courts (Vet Court) are a recent adaptation of the specialized docket format to meet the needs of veterans involved in the criminal justice system.²³ Often, as a requirement for jail diversion, Vet Court participants are linked to an array of services. In this project, the Veteran’s Administration

(VA) and several other partnering organizations provided most of the services (see Table 1).

The Vet Court served as the main point of contact for all study participants. Vet Court enrollees attended weekly court sessions and meetings with a probation officer. They also received linkage to services by a court team that included the judge, court coordinator, veteran justice outreach officer, and probation officer. The Vet Court’s typical duration intervention was about a year. The court assigned about 62.3% of veterans a Veteran Peer Mentor, a volunteer experienced in navigating the mental health and/or criminal justice system. Core program components included case management and mental health services. Eighty five percent of the participants received case management through either the VA, a community mental health center (Court Clinic), or the court’s Department of Pretrial Services. About 70.5% of the sample received outpatient mental health counseling or other treatment, and 26.2% received inpatient

mental health treatment; 39.3% of the sample used Trauma-Specific Cognitive Behavioral Therapy through the VA or Court Clinic; 62.3% reported receiving outpatient substance abuse treatment, and 42.6% spent at least one night in an inpatient substance abuse of treatment facility. Over half (55.7%) of the participants received psychiatric medications for behavioral health disorders. Other services included physical therapy (60.7%), transportation support (55.7%), housing support (34.4%), and vocational services (29.5%).

The current pilot study in a large Midwestern criminal justice system grew out of a need to understand whether implementing a multifaceted court would result in improved quality of life and treatment outcomes. Based on findings that trauma-focused cognitive therapy and social support significantly influences PTSD symptoms,^{24,25} we hypothesized that involvement in court services would result in a significant decrease in PTSD depression symptoms, substance abuse, and self-harm. We hypothesized that involvement would improve overall functioning, emotional wellbeing, relationships, recovery status, social connectedness, family functioning, and sleep. Improvement in other areas such as reduced recidivism and improved housing were also expected to occur.

METHODS

Participants

Participants included 61 veterans, 40 male and three female; aged 21 to 65 years involved the criminal justice system due to felony and misdemeanor offenses. A large, urban justice/pretrial services center was the

primary referral source. Veterans were assigned to this program based upon their veteran status and presence of PTSD symptoms, and thus, were not randomly assigned for study purposes. The participants' demographic characteristics are described in Table 2. The sample was racially split, with 50.8% African American, 45.9% White, and 1.6% multi-racial. There were no Hispanic or Latino participants. Veterans also varied in era served and combat experience. Most participants (34.4%) served in Iraq/Afghanistan, and 11.5% served during Operation Desert Storm and/or prior to September 11, 2011. About 23% served in multiple eras, most commonly during both pre and post 9/11 conflicts. Another 24.6% served in the post-Vietnam era (1970s and 1980s), and 6.6% served during the Vietnam conflict. Over half of the sample (55.7%) saw significant combat experience, with an average of two tours of duty. Veterans participated in this study's evaluation, which included in-person interviews. Participants signed a consent form approved by the Ohio Department of Health Institutional Review Board. Consents included agreeing to treatment and filling out baseline, six month, and twelve month follow-up assessments. Inclusion criteria were veteran status and significant PTSD symptoms identified through positive responses to three of four items in the Primary Care PTSD Screen (PC-PTSD)²⁶ at intake. Exclusionary criteria were absence of trauma history, too extensive a criminal history, and other legal considerations. Most individuals screened were excluded for these reasons.

Instruments

Treatment effectiveness was measured with the following:

The PTSD Checklist-Civilian version (PCL-C)²⁷ is a 17-item instrument

Measure	<i>n</i>	%
Gender		
Male	58	95.1
Female	3	4.9
Age $\mu = 40.85$		
18 – 26 Years Old	10	16.4%
27 – 35 Years Old	16	26.2%
36 – 45 Years Old	9	14.8%
46 – 59 Years Old	22	36.1%
60+ Years Old	4	6.5%
Ethnicity		
Multi-racial	1	1.6%
African American	31	50.8%
White	28	45.9%
Hispanic/Latino	0	0.0%
Unknown	1	1.6%
Era Served		
Iraq/Afghanistan	19	34.4%
Gulf War/Middle East	3	11.5%
Post-Vietnam Era	10	24.6%
Vietnam Era	2	6.6%
Multiple Eras	11	23.0%
Combat Experience		
Yes	34	55.7%
No	27	44.3%

designed to measure PTSD symptoms. A total score is an indicator of PTSD symptom severity. Cutoff score for PTSD diagnosis is 44 for nonmilitary samples. Among Persian Gulf veterans, the PCL was significantly associated with another PTSD measure (.85).²⁷ The PCL has shown excellent internal consistency in Vietnam and Persian Gulf veterans, victims of motor vehicle accidents and sexual assault survivors (*rs* ranging from .94 to .97).^{27,28} Test-retest reliability over two to three days was .96 for the Vietnam veterans.²⁷

The Mental Health Statistics Improvement Program consumer survey (MHSIP)²⁹ is a 36-item self-report scale designed to assess the care of mentally ill persons. The MHSIP comprises seven factors: perception of general satisfaction, access to services, quality and appropriateness of care, participation in treatment planning, service outcomes, functioning, and social connectedness. Response options ranged on a 5-point scale from strongly agree to strongly disagree, where higher numbers corresponded with greater disagreement, and thus greater dissatisfaction. Reli-

ability of the MHSIP was high in pilot studies (Cronbach's alpha = .95).³⁰

The 24-item self-report Behavior and Symptom Identification Scale (BASIS-24)³ assesses self-reported symptom and problem difficulty over the course of treatment. There are six subscales, including depression and functioning, relationships, self-harm, emotional liability, psychosis, and substance abuse. The BASIS-24 have been found to have adequate reliability (coefficient alpha for combined clinical sample across subscales ranging from .75 to .91, validity and responsiveness to change (effect size for change was .56 compared with .48 for the BSI Global Severity Index).

The 23 item self-report Recovery Markers Questionnaire (RMQ)³² measures common aspects of a person's recovery, for example, "I'm using my personal strengths, skills or talents," and "I have more good days than bad." Recovery markers are rated on a 4-point scale (1 = strongly agree; 4 = strongly disagree) The RMQ has been found to have strong internal consistency with Cronbach's alpha of .87.³²

The 36-item Short Form-36 (SF-36) is a multi-purpose, quality of life survey with eight subscales measuring functional health and well-being scores as well as psychometrically-based physical and mental health summary measures and a preference-based health utility index. The eight subscales are: physical functioning, role limitations due to physical health, role limitations due to emotional problems, energy/fatigue, emotional well-being, social functioning, pain, and general health. The SF-36 has been found to have strong internal consistency with Cronbach's alphas ranging from .75 to .93.³³

The 12-item Medical Outcomes Study Sleep Measure (MOS) evaluates sleep quality. It provides an assessment of several sleep dimensions, including initiation, maintenance, respiratory problems, quantity, perceived adequacy, and somnolence. Internal consistency reliability estimates for the MOS were high with a Cronbach's alpha of 0.73 or higher.³⁴

The 24-item Questionnaire of Family Functioning (QFF) assess family functioning before and after mental health intervention. It has three core dimensions related to interpersonal family relationships, including problem-solving, communication skills, and personal goals. Responses are scored on a 4-point scale based on the frequency that a positive family related behavior occurs. The reliability estimates, measured by Cronbach's alpha, was 0.84 for the total score of the scale.³⁵

Instrument Administration

The PCL-C, BASIS-24, SF-36, the RMQ, SLEEP, and the QFF were administered to veteran participants before services commenced, after six months, and at 12 months. Instruments were administered by a trained independent evaluator external to participants' court proceedings or behavioral health treatment. The interviewer read each item from each instrument to the participants. If unable to understand an item, the interviewer explained its meaning in simpler terms until the participant could correctly comprehend its meaning.

Procedures

County Justice Center staff explained the treatment study at intake to the veterans identified for participation in the program. Interested veterans were scheduled

for an initial assessment of PTSD symptoms. A minimum of three positive responses out of four on the PC-PTSD was required for study inclusion. Some 715 persons screened did not meet the eligibility requirements and were excluded from the study. Forty-five met program and study inclusion requirements. Services were provided free of charge for all study participants.

Data Analysis

No data were missing as all participants were interviewed individually and required to answer each question. Data analysis was conducted using SPSS General Linear Modeling programs. We used repeated measures analysis of variance to evaluate sequential change over time on all outcome measures (PCL-C, BASIS-24, SF-36, Sleep, Family Functioning, and RMQ). We computed Pearson correlations between service type and participant outcomes factors. The service factors significantly related to participant outcomes were then entered into a multilevel linear regression analysis to predict which services predicted specific participant outcomes. We also conducted exploratory correlational analyses between age, gender, ethnicity, and outcome measures.

RESULTS

Analyses revealed that age, gender, and ethnicity were insignificantly correlated with initial measures.

Symptom and Resiliency Measures

As Tables 3 and 4 illustrate PTSD symptoms as measured by the PCLC decreased significantly during treatment ($F = 31.60, p < .000$). Improvements occurred between

Table 3.
Repeated-Measures Analysis of Variance (SPSS General Linear Modeling)

Measure	Pre-Treatment Mean ± SD	6 Months Mean ± SD	12 Months Mean ± SD	Time F	P	X ² Effect Size
PCL-C	49.02 ± 17.23	37.26 ± 17.40	33.32 ± 16.01	31.60	.000	.38
BASIS – Full Score	1.44 ± .820	.896 ± .710	.803 ± .761	23.30	.000	.30
-Depression & Functioning	1.69 ± 1.11	1.03 ± .946	.823 ± .877	23.55	.000	.29
-Substance Abuse	1.26 ± 1.00	.720 ± .691	.623 ± .738	15.57	.000	.21
-Self Harm	.288 ± .567	.130 ± .406	.116 ± .550	2.35	.100	.04
-Relationships	1.51 ± .967	.929 ± .882	1.10 ± 1.14	7.24	.001	.19
SF36 – Full Score	61.37 ± 18.28	68.02 ± 21.69	69.93 ± 21.16	7.28	.001	.11
-Emotional Limitations	33.89 ± 40.82	57.06 ± 45.51	67.23 ± 41.75	14.86	.000	.20
-Energy/Fatigue	45.93 ± 24.50	55.93 ± 25.87	57.12 ± 23.82	6.54	.002	.10
-Emotional Well-being	52.81 ± 26.25	67.59 ± 22.97	72.41 ± 23.71	22.11	.000	.28
-Social Functioning	47.41 ± 26.15	48.92 ± 23.45	57.76 ± 22.56	3.52	.033	.06
-General Health	61.27 ± 19.75	65.76 ± 24.15	66.61 ± 23.73	2.35	.100	.04
RMQ	2.88 ± .557	3.13 ± .504	3.26 ± .577	15.43	.000	.21
MHSIP						
-Functioning & Outcomes	3.31 ± .814	3.80 ± .677	3.87 ± .751	15.66	.000	.21
-Social Connectedness	3.29 ± 1.05	3.88 ± .837	3.94 ± .971	14.98	.000	.21
-Perception of Care		4.38 ± .717		.021	.885	.00
MOS (Sleep)	4.95 ± 1.48	5.64 ± 1.50	5.66 ± 1.64	8.28	.000	.13
QFF	1.48 ± .471	1.66 ± .478	1.64 ± .506	4.22	.017	.07

pre-treatment and six months and six months and 12 months. We also found significant improvements over the course of treatment in recovery orientation as measured by the RMQ ($F = 15.43, p < .000$), sleep was measured by the MOS ($F = 8.28, p < .000$), family relations (QFF) ($F = 4.22, p < .017$), substance abuse ($F = 15.57, p < .000$), depression and functioning ($F = 23.55, p < .000$), emotional wellbeing ($F = 22.11, p < .000$), and energy/fatigue ($F = 6.54, p < .02$). The MHSIP functioning ($F = 15.66, p < .000$) and social connectedness (F

$= 14.98, p < .000$) measures also evidenced significant improvement over time. The BASIS relationships factor ($F = 7.24, p = .001$) and the SF-36 general health factor ($F = 2.35, p = .10$) each approached significance. At the 12-month post-treatment period, medium effect sizes ($> .38$) were found for PTSD (measured with the PCL-C), depression, substance abuse, emotional wellbeing, and family functioning. All measures showing improvements between pre-treatment and six months also showed further improvement or maintenance of gains between

six months and 12 months. We failed to reject the null hypothesis regarding reductions in self-harm and increased social functioning as measured by the SF-36-Full Score. This finding may be due to the low incidence of self-harm in study participants.

Recovery Indicators

Of the 61 participants, six were rearrested during their time in the program. Four veterans were rearrested after six months, and two after twelve months. In terms of housing, veterans

Table 4
Pairwise Comparisons of Study Measures

Measure	Pre-Treatment- 6 months Mean Difference ± SE	6 Months- 12 months Mean Difference ± SE	Pre-Treatment - 12 months Mean Difference ± SE
PCL-C (N=45)	-11.81 ± 2.59***	-5.39 ± 2.38***	-16.18 ± 2.42**
BASIS – Full Score	-.581 ± .110***	-.006 ± .121***	-.649 ± .126**
-Depression	-.508 ± .142**	-.111 ± .139***	-.757 ± .145*
-Substance Abuse	-.492 ± .105	-.010 ± .122*	-.529 ± .122***
-Self Harm	-1.64 ± .066	.063 ± .100	-1.59 ± .100
-Relationships	.602 ± .142	.240 ± .192 **	.815 ± .190
SF-36 – Full Score	7.32 ± 3.21**	1.80 ± 3.14***	8.93 ± 3.14***
-Emotional Limitations	24.44 ± 6.75	13.64 ± 6.30***	38.0 ± 19.9**
-Energy/Fatigue	9.90 ± 3.91**	-.682 ± 3.81***	8.86 ± 3.81***
-Emotional Well-being	14.22 ± 3.38*	4.55 ± 3.53***	17.73 ± 3.53***
-Social Functioning	-.233 ± 3.18	8.17 ± 3.60	8.43 ± 3.60
-General Health	5.67 ± 3.51***	1.14 ± 3.54***	6.25 ± 3.54**
RMQ	.279 ± .076***	.077 ± .096***	0.364 ± .096**
MHSIP	0.535 ± .102**	0.073 ± .117*	.612 ± .117
-Functioning & Outcomes			
-Social Connectedness	.622 ± .128***	.074 ± .149*	.699 ± .149*
-Perception of Care	N/A	-.145 ± .110**	N/A
MOS (Sleep)	.744 ± .226 **	.047 ± .230***	.829 ± .235**
QFF	.434 ± .073**	-.036 ± .087**	.390 ± .087**

Note: SE = Standard Error. * $p < .05$; ** $p < .01$; *** $p < .001$

were grouped into the following categories depending on their change in residence: stable housing, defined as owning or renting a home or apartment, unstable housing, defined as couch surfing/staying with a friend or family member, homelessness, jail or other institution, and no change to or from either category. Throughout the 12 month study period 55.7% saw no change in housing, 11.5% transitioned from stable to unstable housing, and 32.8% improved from unstable to stable housing. Homelessness, employment and school enrollment remained unchanged.

Service Component Effectiveness

For exploratory purposes, we determined which services predicted positive treatment outcomes. Univariate correlations revealed that peer support, trauma treatment, and psychiatric medication were related to positive clinical outcomes; these were then entered into a multilevel model. As shown in Table 5, receiving peer support positively predicted improvements in social connections and relationships with others and social functioning (approached significance, $p = .08$); receiving trauma treatment

significantly predicted improvements in PTSD ($p = .03$) and self-harm ($p = .005$). Psychiatric medication was related to improvements in depression (approached significance, $p = .06$).

DISCUSSION

Goldkamp and Weiland³⁶ first identified the utility of specialized dockets for persons with drug addiction after the implementation of the first drug treatment court in 1989. Since then, specialized dockets have emerged to address mental health, domestic violence, and presently,

Table 5

Variable	Standard Coeff.	T	P	95% CI	
				Lower	Upper
Peer Mentoring					
Social Connections/Relationships	.47	-2.68	.01	.31	.04
Social Functioning	.33	1.77	.08	.001	.01
Trauma Treatment					
PTSD	.89	2.24	.033	.002	.053
Self Harm	.64	3.01	.005	.795	.153
Psychiatric Medication					
Depression	.52	1.93	.06	.013	.60

veterans.²³ Our findings emphasize the promise of extending specialized dockets to veterans with behavioral health issues as a method to reduce recidivism in jails, and enhance treatment outcomes and quality of life.

Veterans reported better treatment outcomes and quality of life over time when involved in the Vet Court. When provided programs and services that fostered recovery, veterans improved markedly on all study measures. Veterans particularly improved when provided trauma-specific treatment and peer mentor services. The importance of trauma-specific therapy and positive peer role models may be important for veterans with combat exposure who have re-integrated into a society unfamiliar with the struggles associated with combat experience. According to our findings and previous research,³⁷ when veterans receive comprehensive services focusing on recovery, their mental health improves, and they receive tools to rebuild their lives.³⁸ Navigating complex social and mental health systems necessary for recovery is difficult for veterans with PTSD and other mental health conditions. Vet Courts are designed to integrate therapy, social services,

and peer support to help the veteran traverse these systems.

The specialized docket literature suggests that the service array provided has a significant effect on the court participant’s well-being and quality of life.²² Researchers have devoted efforts toward evaluating the effectiveness of specialized dockets because specific criminal justice system populations need unique services not available in local community courts. However, little is known about the impact that Vet Courts have on their participants. This study represents a critical first step toward identifying the Vet Court components and their effectiveness. Changes occurred in the expected time frame of the intervention, particularly within the first six months. Without a control group, it is impossible to know whether significant improvements seen in this study were in response to the service array offered or due to other external factors not considered in this study. A randomized, controlled trial is needed to address that question. However, the fact that the participants had clinically significant levels of PTSD and depression at baseline and improved during their involvement

with court services suggests that the participants needed and benefited from Vet Court services.

When examining specific services, participants receiving trauma treatment and peer support services had greater clinical improvement in PTSD symptom severity, depression, supportive relationships, and self-harm. One important indicator to consider is consumer perception of care, and Vet Court participants were generally satisfied with the services received over the course of treatment.

Limitations

The current study has several limitations due to the lack of a control or comparison group and relatively small sample. A randomized, controlled trial with larger sample sizes is needed to determine if the Vet Court approach is efficacious for veterans with PTSD related to combat exposure. Given the study design is a program evaluation involving multiple interventions introduced simultaneously, the efficacy of specific components could not be fully evaluated. Future studies will be necessary to assess the differential treatment response to various services offered as a part of a Vet Court. While there is

not enough evidence to support the efficacy of Vet Courts as a whole, little evidence exists to suggest that services alone, if delivered in an uncoordinated manner, would produce similar results as those found in the study. In point of fact, peer mentor services provided by a veteran are not generally available in the community but are a specific feature of Vet Courts. Despite its limitations, this study does support the use of these courts and demonstrates that implementing them is possible and beneficial to its participants.

CONCLUSION

The current study is among the first to preliminarily evaluate the efficacy of a Veterans Treatment Court for veterans involved in the criminal justice system. The findings suggest that involvement in Vet Court services may produce sustainable improvements in recovery and PTSD for participants. Despite study limitations, the results support the promise of this treatment approach for justice-involved veterans involved in the criminal justice system and lend a degree of empirical support to providing substance abuse and mental health services under the umbrella of a Veterans Treatment Court. Randomized, controlled trials are needed to further test this multifaceted service model.

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SELF-INJURY IMPLICIT ASSOCIATION TEST: COMPARISON OF SUICIDE ATTEMPTERS AND NON-ATTEMPTERS

Prachi Kene, PhD¹ • Joseph D. Hovey, PhD²

¹Rhode Island College, ²University of Toledo

To whom correspondence should be addressed: Prachi Kene, Ph.D., Department of Counseling, Educational Leadership, and School Psychology, 600 Mt. Pleasant Ave., 120 James P. Adams Library, Providence, RI 02908, pkene@ric.edu
Joseph D. Hovey, Ph.D, Department of Psychology, 2801 W. Bancroft St., MS # 948, Toledo, OH 43606
Joseph.hovey@utoledo.edu

Self-report data are frequently used in assessing suicide risk; however, the ability of suicidal patients to feel, experience, and report their suicidal ideation has been challenged by several studies. The discrepancies between self-reports of suicide risk and actual suicidal behaviors have emerged across several studies. Deisenhammer, DeCol, Honeder, Hinterhuber, and Fleischhacker (2000) examined inpatient suicides and found that 40.9% patients had not expressed any suicidal thoughts.¹ Fawcett et al. (1987)² found that suicidal ideation was more prevalent in individuals that did not complete suicide than those who did. Studies on completed suicides in inpatient psychiatric settings have found that between 22.7% and 51% of patients had an improvement in psychiatric symptoms prior to the completion.^{1,3,4,5} Risk of completions is significantly elevated immediately following discharge, presumably shortly after patients denied suicidal intent.^{6,7}

Abstract: Given the weaknesses of self-report measures, there has been an increased interest in alternative methods of suicide risk assessment, primarily the implicit measures of suicide risk. This study aimed to determine differences in implicit identification with self-injury and implicit attitude towards self-injury between attempters and non-attempters using the Self-Injury Implicit Association Test (SI-IAT). The SI-IAT is a computer test designed to measure the implicit associations about self-injury. Participants were 100 forensic and civil inpatients at three psychiatric hospitals. A history of attempted suicide was very common in this sample. All participants completed the SI-IAT. Attempters and non-attempters did not significantly differ with respect to implicit identification with self-injury and implicit attitude towards self-injury. Implications are presented for assessment of suicide risk and future research.

Keywords: Suicide Attempts • Implicit Attitudes • Risk Factor • Inpatient

American Association of Suicidology (AAS, 2005) emphasizes that patient's self-report of suicidal ideation is not always accurate.⁸ Purposeful concealment of suicidal ideation and plans, exacerbation of suicidal symptoms following a suicide risk assessment, and unawareness or lack of insight into suicidal thoughts may interfere with a more realistic self-report of suicidal ideation.⁹ Given the weaknesses of self-report measures, there has been an increased interest in alternative methods of suicide risk assessment, primarily the implicit measures of suicide risk. "Implicit attitudes are introspectively unidentified (or inaccurately unidentified) traces of past experience that mediate favorable or unfavorable feeling, thought, or action toward social objects."¹⁰ Implicit attitudes are assessed using performance-based measures. Implicit

measures are believed to tap into automatic processes without an opportunity to edit the responses. Implicit attitudes have been hypothesized to guide behavior in a spontaneous and affective manner, independent of deliberate and conscious processes.¹¹

The Self Injury-Implicit Association Test (SI-IAT) is a computer test designed to measure the implicit associations about self-injury. The Implicit Association Test (IAT) measures the strength of automatic association between representations of concepts by requiring rapid categorization of various stimuli. It is based on the assumption that easier pairings and the associated faster responses are indicative of stronger association than difficult pairings and the associated slower responses. Nock and Banaji (2007a) found that self-injurers strongly asso-

ciated self-injury with self while non-injurers did not.¹² Nock and Banaji (2007b) found significant differences between non-suicidal adolescents, suicide ideators, and attempters on the identity version of the SI-IAT. Of particular importance, identity version of the SI-IAT was more important than demographic and psychiatric risk factors in predicting non-suicidal self-injury, current suicide ideation, and attempt status.⁹

It is of interest to know whether these differential implicit perceptions co-occur with varying intensities of distress, nature and number of prior suicidal attempts, clinical variables, and overall suicide risk. Insight into implicit attitudes towards self-harm and suicidality can indicate differential prognostic expectations and thereby entail different therapeutic interventions. Thus, the inclusion of implicit attitudes in psychological theorizing about suicidality is expected to serve as a means to link our current understanding of the risk and protective factors and the actual suicide potential. By linking suicidality to issues that concern the self, psychological theories of suicidality will potentially be able to make better sense of the maladaptive behaviors and symptoms and the co-occurring risk and protective factors. Given the extent of distress inherent in suicidality as a major health problem, it is important that theories and research explore all possible mechanisms relevant to the maintenance or development of suicidality. It is hoped that this broader focus in conceptualization of suicidality will lead to newer and/or better prevention and treatment strategies.

This study aimed to determine differences in implicit identification with self-injury and implicit attitude towards self-injury between attempters and non-attempters.

METHODS

Participants

One hundred patients were recruited from February 2009 through June 2009 from three psychiatric hospitals. The sample consisted of 63 males and 37 females ranging in age from 18 to 63 years ($M = 35.84$, $SD = 11.44$). The sample was 64% Caucasian, 29% African American, 4% Hispanic, and 3% biracial. Years of education ranged from seven to 17 ($M = 12.11$, $SD = 1.86$). Seventy-three percent of the patients were single, 5% were married, 16% were divorced, and 6% were separated. Among all 100 patients, 55% were involuntarily civilly committed, 11% were committed pursuant to judicial proceedings, 1% were voluntarily admissions, 21% were admitted by criminal courts as Not Guilty by Reason of Insanity (NGRI), and 12% were admitted during the pretrial phase of the criminal justice process as incompetent to stand trial. Among the 33 forensic patients, 91% were charged with a felony and 9% with a misdemeanor.

The patient's psychiatrist assigned diagnoses following the intake interview. Of the sample, 25% had a diagnosis of Major Depressive Disorder (MDD), 22% were diagnosed with Schizoaffective Disorder, 21% with Schizophrenia, 18% with Bipolar Disorder, 11% with Psychotic Disorder Not Otherwise Specified (NOS), 1% with Oppositional Defiant Disorder, 1% with Unspecified Episodic Mood Disorder, and 1% with Impulse Control Disorder. Eighty-two percent of the patients were diagnosed with a comorbid substance abuse/dependence disorder. Personality disorder diagnosis was present in 39% of patients, deferred in 51% of patients, and absent in 10%. The most common primary Axis II diagnosis was Antisocial

Personality Disorder (59%), followed by Borderline Personality Disorder (18%) and Personality Disorder NOS (18%); and the least common were Narcissistic Personality Disorder (2.5%) and Paranoid Personality Disorder (2.5%). Fourteen percent of the patients had two personality disorder diagnoses; the most common secondary personality disorder diagnosis was Borderline Personality Disorder. Axis V Global Assessment of Functioning (GAF) level at admission ranged from 10 to 65 ($M = 37.17$, $SD = 12.77$). The number of days of hospitalization ranged from one to 3391 ($M = 202.89$, $SD = 570.44$).

Nonparticipants

Of the patients who participated in the study ($N = 205$) approximately 51% were excluded. Primary reasons for exclusion included aggressive behavior or the inability to complete the IAT. The mean age of participants ($M = 35.84$, $SD = 11.44$) was significantly lower than the mean age of nonparticipants ($M = 47.02$, $SD = 12.25$), $t(203) = -6.75$, $p < .0001$. Similarly, the mean educational level of participants ($M = 12.11$, $SD = 1.86$) was significantly higher than the mean educational level of nonparticipants ($M = 8.67$, $SD = 2.23$), $t(203) = 11.97$, $p < .0001$. With regards to the duration of hospitalization, there was no significant difference between the participants ($M = 202.89$, $SD = 570.44$) and nonparticipants ($M = 140.53$, $SD = 464.70$), $t(203) = .942$, $p = .35$. Like the participants, the majority of the nonparticipants were males (66%). Sixty-seven percent of the nonparticipants were Caucasian, 31% were African American, and 2% were Hispanic. Of the nonparticipants, 35% had a diagnosis of Bipolar Disorder, 30% were diagnosed with Schizophrenia, 19% with Major Depressive Disorder, 13% with Schizoaffective Disorder, and 3% with

Psychotic Disorder Not Otherwise Specified. Sixty-three percent of the nonparticipants were diagnosed with a comorbid substance abuse/dependence disorder. Personality disorder diagnosis was present in 53% of the nonparticipants, deferred in 26% of patients, and absent in 21%. The most common primary personality disorder diagnosis was Borderline Personality Disorder (26%), followed by Antisocial Personality Disorder (21%) and Personality Disorder NOS (53%). For the nonparticipants, Axis V Global Assessment of Functioning (GAF) level at admission ranged from 10 to 65 ($M = 36.37$, $SD = 12.81$) and this was not significantly different from the participants ($M = 37.17$, $SD = 12.77$), $t(203) = .45$, $p = .66$.

Measures

Self-Injury Implicit Association Test (SI-IAT, Nock & Banaji, 2007a). The SI-IAT is a computer test designed to measure the implicit associations about self-injury. The Implicit Association Test (IAT) measures the strength of automatic association between representations of concepts by requiring rapid categorization of various stimuli. Stimuli were presented one at a time in the center of the computer screen, and participants were instructed to classify them to the group labels appearing on the top half of the screen. Participants were instructed to press keys "e" (for stimuli to be classified on the left) and "i" (for stimuli to be classified on the right) immediately following the presentation of a stimulus. Following correct responses, participants were presented with the next stimulus. Following an incorrect response, a red "X" appeared below the stimulus and remained on the screen until the correct key was pressed. The importance of both speed and accuracy was emphasized.

In the present study, three different IATs were administered: The Flowers-Insects/Good-Bad IAT involved presentation of Flower names or Insect names along with Favorable words or Unfavorable words. The Identity version (i.e., the extent to which self-injury is associated with self) involved presentation of self-relevant words (e.g., *Myself, I*) or other-relevant words (e.g., *Their, Them*) along with self-injury images (e.g., pictures of skin that has been cut) or neutral images (i.e., pictures of non-injured skin). The Attitude version (i.e., the extent to which self-injury is associated with being a favorable vs. unfavorable behavior) involved the presentation of favorable words (e.g., *Relief, Peace*) or unfavorable words (e.g., *Incorrect, Ineffective*) along with self-injury or neutral images. The administration of the Flowers-Insects IAT always preceded the two SI-IATs. For counterbalancing, the presentation order of the identity and attitude versions varied across patients. Furthermore, the presentation of pairings within the attitude and identity versions of the IAT was counterbalanced. For each of the pairings of the attitude and identity versions of the IAT, patients were presented with one practice and one test trial block.

Inquisit 3.0 recorded the accuracy and the response times (in milliseconds) to each trial. Following the recommendations of Greenwald, Nosek, and Banaji (2003), response latencies of the practice and test blocks that involved pairings were analyzed using the most recent IAT scoring algorithm in Statistical Package for the Social Sciences (SPSS). Standardized D score was obtained by subtracting the mean latency of one pairing (e.g., *Cutting/Me*) from the mean latency of opposite pairing (e.g., *Cutting/Not Me*) and dividing this difference by the single standard deviation of both pairings. D score in-

dicates the relative strength of the association between the concepts relative to the inverse pairings. Following recommendations of Greenwald et al. (2003), a patient's D score was eligible for further analyses if the following conditions were satisfied: (1) the average latency of a patient was not greater (too slow responding) or lesser (too fast responding) than two standard deviations from the mean D score of the given IAT, (2) less than 11% of the trials were faster than 400 milliseconds, and (3) error rate was less than 33.3%. None of the patients' scores needed to be deleted for these reasons.

Procedure

This study was approved by the Institutional Review Boards and the three hospitals where data were collected. All patients were informed of the study and were invited to participate during on-unit groups or individually. The investigator explained the nature, purpose, and goals of the study, and potential risks involved in participation. To be included in the study, patients were asked to provide informed consent. For patients with guardians, consent was obtained from the legal guardians. Patients were excluded from the study if they refused to provide informed consent, were identified as having a developmental disability or dementia, were unable to complete the IATs, or posed a danger to the investigator.

Patients were administered the IATs by the investigator (clinical psychology doctoral student). The IATs were administered on a Dell Inspiron 630m personal computer using Inquisit 3.0 purchased from Millisecond Software. The investigator was passively present in the room during the administration of the IATs. All patients that participated in the study were debriefed and were reimbursed with hygiene items worth \$1.

Table 1
Comparison of Demographic and Clinical Characteristics of Attempters (N = 60) and Non-Attempters (N = 40)

<i>Variable</i>	<i>Attempters</i>	<i>Non-Attempters</i>
Mean Age	36.13	35.40
Gender (% Male)	55	75
Ethnicity (%)		
Caucasian	71.7	52.5
African American	20	42.5
Hispanic	6.7	0
Other	1.7	5
Marital Status (%)		
Single	73.3	72.5
Married	6.7	2.5
Divorced	16.7	15
Separated	3.3	10
Sexual Orientation (%)		
Heterosexual	95	100
Homosexual	5	0
Mean Years of Education	12.33	11.93
Axis I Diagnosis (%)		
Schizophrenia	13.3	32.5
Schizoaffective	23.3	20
Bipolar Disorder	21.7	12.5
Major Depressive	35	10
Psychotic Disorder NOS	3.3	22.5
Other	3.3	2.5
Substance Abuse (%)		
Present	81.7	82.5
Axis II Diagnosis (%)		
Antisocial	28.3	15
Narcissistic	0	2.5
Borderline	11.7	0
Paranoid	0	2.5
Other	8.3	5
None/Deferred	51.7	75
Mean GAF	37.4	36.83
Mean Days since Admission	121.9	324.38

Note. GAF = Global Assessment of Functioning; Other Axis I diagnosis included Oppositional Defiant Disorder, Unspecified Mood Disorder, and Impulse Control Disorder; Other Axis II diagnosis included Personality Disorder Not Otherwise Specified and Cluster B Traits.

RESULTS

Descriptive Statistics

Mean average latency for the Attitude version of the SI-IAT was 1655.79 milliseconds (*SD* = 460.13) and for the Identity version was 1704.37 milliseconds (*SD* = 536.13). The mean error percentage for the Attitude version, as recorded by the computer, was 6.25 (*SD* = 5.84) and for the Identity version 7.02 (*SD* = 6.71). As previously noted, none of the patients had an error percentage greater than 33.33. None of the patients had more than 6.67% of latencies less than 400 milliseconds. Greenwald et al., (2003) indicate that latencies less than 400 milliseconds imply too fast responding and latencies more than 10,000 milliseconds imply too slow responding.

Incidence of Suicidality

The majority of patients (60%) had attempted suicide at least once. The number of suicide attempts ranged from a minimum of 0 to a maximum of 55 (*M* = 2.22). Among the patients with at least one suicide attempt, 41.67% had attempted suicide in the 18-day period prior to the survey date, 5% had attempted suicide in the 19-day to two-month period prior to the survey date. A

much larger percentage of patients (53.33%), however, attempted suicide in the 60-day to 10-year period prior to the survey date. In terms of methods of attempt, overdose/poisoning was most common (71.67%), followed by cutting (35%), hanging (23.33%), and jumping (13.33%). The least common methods were car exhaust (3.33%), firearm (1.67%), and drowning (1.67%).

Differences between Attempters and Non-Attempters

Table 1 summarizes the demographic and clinical characteristics of attempters and non-attempters. Both attempters and non-attempters had fairly similar characteristics with regards to mean age, sexual orientation, marital status, mean education level, and mean GAF score. With regards to ethnicity, 71.7% of attempters and 52.5% of non-attempters were Caucasians. Fifty-five percent of the attempters were male, whereas 75% of the non-attempters were male. Attempters were more likely to be given a diagnosis of Bipolar Disorder and Major Depressive Disorder compared to the non-attempters. Schizophrenia and Schizoaffective Disorder were more common in the non-attempters. Substance abuse was equally prevalent in both the groups. With regard to personality disorder diagnoses, An-

tisocial Personality Disorder was the most common diagnosis in both the groups. Attempters were more likely to be given a diagnosis of Borderline Personality Disorder compared to non-attempters. There was a trend for Narcissistic and Paranoid Personality Disorder diagnoses to be more common in the non-attempter group. The inpatient mean length of stay for the attempters was 122 days and for the non-attempters was 324 days.

Attitude Version of the Self-Injury Implicit Association Test

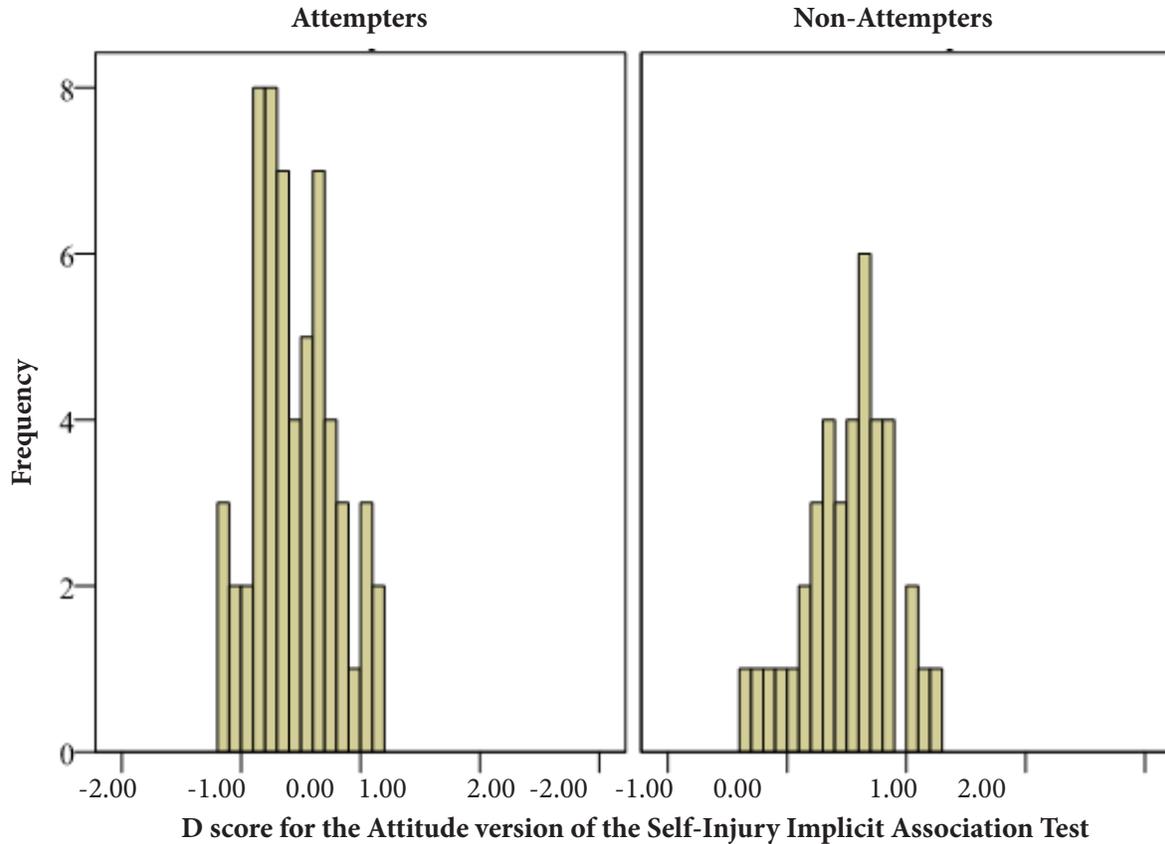
An independent samples t-test was conducted to determine if attempters and non-attempters showed different associations on the Attitude version of the SI-IAT. The mean score for attempters (*M* = -.56, *SD* = .34) was not significantly different from the mean score of non-attempters (*M* = -.49, *SD* = .38), $t(96) = .93, p = .35$. These data are presented in Table 2. Although the sizes of the two groups were imbalanced (58 attempters, 40 non-attempters), the Levene's test was not significant, $F = .19, p = .66$. The 95% confidence interval for the difference in means between attempters and non-attempters was -.08 to .21, thus including the expected value of 0 and thereby indicating that the difference was not statistically significant. Therefore, there was no statistically signifi-

Table 2
Summary of T-Tests for the Attitude and Identity Versions of the Self-Injury Implicit Association Test for Attempters (N = 58) and Non-Attempters (N = 40)

	<i>Attempters</i>	<i>Non-Attempters</i>	<i>t</i>	<i>df</i>
Attitude	-.56 (.34)	-.49 (.38)	.93	96
Identity	-.30 (.44)	-.29 (.36)	.11	96

* $p < .05$, ** $p < .01$
 Note. Standard deviations appear in parentheses below means.

Figure 1
Comparison of Performance of Attempters (N = 58) and Non-Attempters (N = 40)
on the Attitude Version of the Self-Injury Implicit Association Test



Note. Negative or positive values indicate the direction of the association (negative = *Cutting/Bad*, positive = *Cutting/Good*)

cant difference on the Attitude version of the SI-IAT between attempters and non-attempters. The histograms (Figure 1) show a similar distribution for the standardized *D* score for the Attitude version of the SI-IAT for attempters and non-attempters. The distribution is positively skewed for both the groups thereby indicating that most individuals in the two groups associated “Cutting” with “Bad.”

Identity Version of the Self-Injury Implicit Association Test

An independent samples *t*-test was conducted to determine if attempters showed a stronger associa-

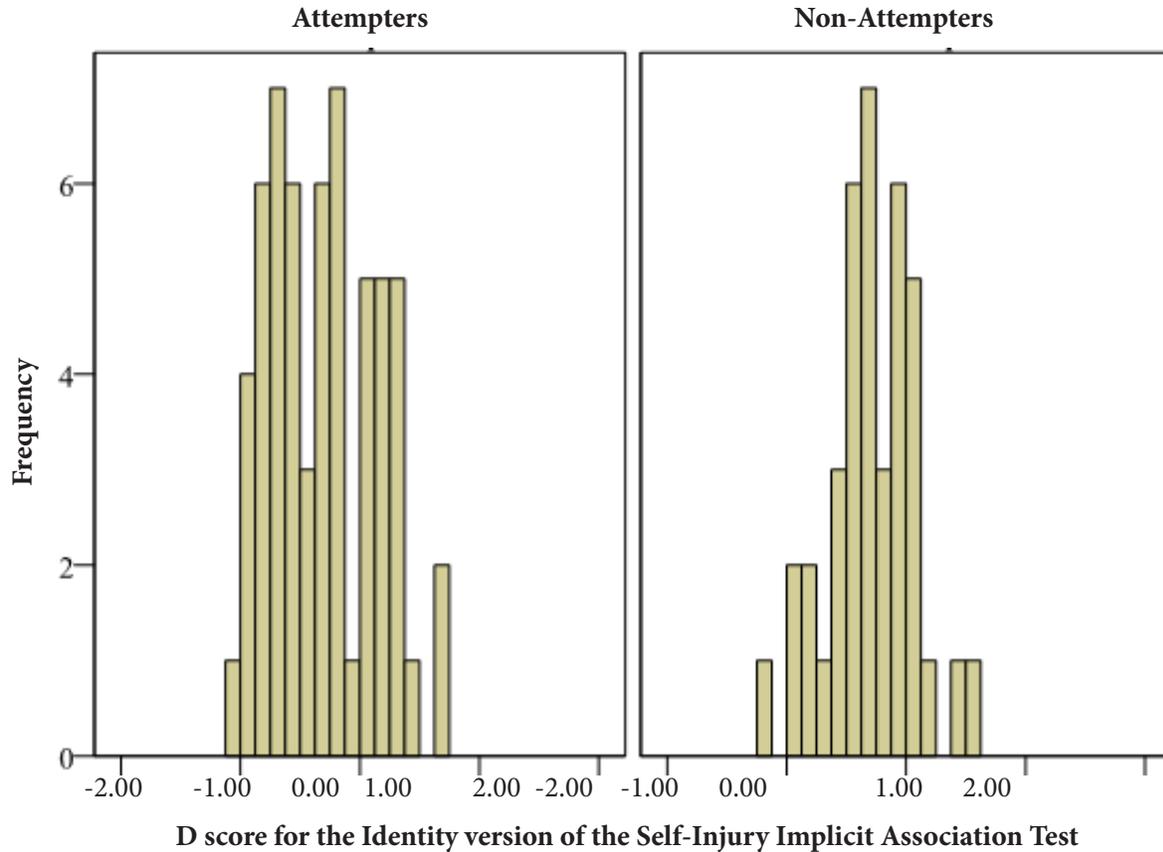
tion between “Cutting” and “Me” than non-attempters. The mean score for attempters ($M = -.30, SD = .44$) was not significantly different from the mean score of non-attempters ($M = -.29, SD = .36, t(96) = .11, p = .91$). These data are summarized in Table 2. Although the sizes of the two groups were imbalanced (58 attempters, 40 non-attempters), the Levene’s test was not significant, $F = .357, p = .06$. The 95% confidence interval for the difference in means between attempters and non-attempters was $-.16$ to $.17$ which contains the expected value of 0 thereby indicating that the sample statistic belongs to the null distribu-

tion. Therefore, there was no statistically significant difference on the identity version of the SI-IAT between attempters and non-attempters. The histograms (Figure 2) show a positively skewed distribution for attempters and non-attempters thereby indicating that most individuals in these two groups associated “Cutting” with “Not Me.”

DISCUSSION

It was hypothesized that attempters would show a stronger positive association between “Cutting” and “Me,” and “Cutting” and “Good,” whereas

Figure 2
Comparison of Performance of Attempters (N = 58) and Non-Attempters (N = 40)
on the Identity Version of the Self-Injury Implicit Association Test



Note. Negative values indicate association between *Cutting/Not Me* and positive values indicate association between *CuttingMe*.

non-attempters would show a stronger positive association between “*Cutting*” and “*Not Me*,” and “*Cutting*” and “*Bad*.” However, most patients in the present sample demonstrated lack of identification with self-injury and demonstrated unfavorable attitude towards self-harm. This pattern of associations is consistent with prior research on the SI-IAT.¹²

The absence of an association between the implicit and explicit measures of suicide risk warrants discussion. Given the distinct nature of explicit and implicit mental representations, low correlations are expected.^{13,14} Previous research has shown that the correlations between implicit and ex-

PLICIT measures depend on the psychological attribute being examined¹⁵ and structural fit between the implicit and explicit measures.¹⁶ Egloff and Schmukle (2002) argue that low correlations between the implicit and explicit measures are not likely to be the result of methodological issues because both implicit and explicit measures usually show a good distribution and adequate reliability.¹⁷

In previous research, non-suicidal individuals, ideators, and attempters have been found to significantly differ in terms of the association between self-injury and oneself.⁹ In the present study, neither implicit identity

nor implicit attitude distinguished between attempters and non-attempters, and this pattern of results was not consistent with expected findings. Nock and Banaji (2007b) suggest that images of skin cutting unambiguously represent the construct of self-injury. In their investigation, images of skin cutting predicted suicide criteria beyond the relation of these images to non-suicidal self-injury.⁹ However, all the suicide attempters in their study had a history of non-suicidal self-injury, and most of these attempters had engaged in cutting. On the contrary, the majority of patients in the present study had used overdose/poisoning as a method of attempting suicide. It is

possible that the differences in the nature of suicide attempts accounted for this unexpected finding. Given that the majority of patients in the present sample had used methods other than cutting, images of cutting may not have tapped into the associations between self-injury and oneself. Furthermore, the relationship between self-harm and suicide is complicated.

Another possible explanation for the failure of the implicit measures to predict attempter and non-attempter status is the prevalence of *recent* suicidality in the present sample. Although suicidality was very common in the present sample, only 18 patients had *recently* attempted suicide. In fact, the majority of patients had attempted suicide in the 6-month to 10-year period prior to the survey date. This is a particularly important consideration because IATs have been hypothesized to predict actual behavior only when the behavior results from *recurrent* impulsive behavioral activation.¹⁸ According to the Behavioral Process Model of Personality (BPMP),¹⁹ indirect tests like Thematic Apperception Test and IAT assess impulsive processes, wherein automatic processing of situational cues and automatic actions create associative representations of the self (e.g., “Me” – “Cutting”). Back et al. (2009) argue that the strength of these associations depends on the frequency of the behavior - “The more often an individual executes such a course of action, the stronger her/his association between the self and the respective trait concept will be” (p. 534).¹⁸ In the present study, a relatively low number of patients had *recently* attempted suicide, and this may have made the impulsive processes tapped by the IATs less pronounced in the present sample. Perhaps this result may be counteracted by studying a large sample of suicidal individuals with recent attempts.

Limitations

The findings of the present study should be interpreted in the context of several important limitations. First, psychotropic medications could have influenced performance on the IATs; however, medication information was not recorded for the patients. The potential of medications on suppressing suicidality cannot be dismissed. Although the investigation of the effect of psychotropic drugs on this measure was not the primary aim of our study, the influence of drug treatment is a relevant issue that deserves further investigation. Second, some patients who were severely ill because of psychiatric symptoms were unable to complete the IATs, which could have biased sample selection.

Future Research

A completed suicide is one of the most dreaded outcomes in the field of mental health. Studies that examine implicit attitudes in combination with transient risk factors of depression and hopelessness may lead to a more comprehensive understanding of suicide risk. Researchers could attempt to determine how these three variables interact with depression and hopelessness. It is possible that interactions among these variables result in an increased likelihood of suicidal attempts and eventually, completions.

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A COMPARATIVE STUDY EXAMINING PARENTAL PERCEPTION OF CARE AND TREATMENT OUTCOMES FOR JUSTICE INVOLVED YOUTH WITH MENTAL ILLNESS

Kraig J. Knudsen, PhD, LISW • Joseph Perzynski, MSW • Carol Carstens, PhD, LISW

Office of Quality, Planning and Research
Ohio Department of Mental Health and Addiction Services

To whom correspondence should be addressed: Kraig Knudsen, PhD, Kraig.Knudsen@mha.ohio.gov

INTRODUCTION

The mental health community has long known that there is a significant association between involvement in the juvenile justice system and the existence or development of behavioral health disorders. Recent epidemiological studies document a high prevalence of mental illness among youth in juvenile justice populations. Currently, 60% of males and 75% of females held in detention centers meet diagnostic criteria for one or more psychiatric disorders.¹ The most prevalent of these diagnoses include substance abuse disorders (estimated Male 50.7%, Female 46.8%), anxiety disorders (21.3%, 30.8%), and affective disorders (18.7%, 27.6%).² When compared to community samples, these individuals have higher rates of suicidal ideation, lifetime suicide attempts and trauma exposure.^{3,4,5}

Despite this high prevalence, many individuals involved in juvenile justice systems do not have access to adequate care for their con-

Abstract: This article describes a program evaluation of a collaborative care model for treatment for youth with severe emotional disorders involved in the juvenile justice system. Some 115 youth with police encounters received Treatment as Usual (TAU), while 115 youth were provided with the collaborative care treatment model known as the Behavioral Health/Juvenile Justice Initiative (BH/JJ). The BH/JJ group received coordinated wrap-around services, culturally sensitive evidence-based behavioral health interventions, and family/support system engagement in the treatment process. All BH/JJ services were mobile and provided in the home of the participant. The TAU group with police involvement received a variety of services, but did not receive the coordinated BH/JJ combination of interventions. Results showed that parents of BH/JJ participating youth saw reductions in police contacts and arrests, and increased social functioning, social connectedness, and school attendance when compared with youth that received TAU. The parents also reported that the intervention program was more sensitive to their culture and felt that treatment access and appropriateness improved for their participating youth.

Keywords: Juvenile justice • Outcomes • Evidence-based treatment • Coordinated care

ditions once reintegrated back into the community. One study found that less than half of juvenile justice facilities offered mental health services besides mental health screening and medication adjustment. The study also revealed that less than one half of the facilities that offer mental health services collaborate with local mental health agencies or providers to offer services upon release.^{6,7} This results in high rates of re-arrest, recidivism, and engagement with the

adult correctional system. Reasons for this lack of access include insufficient screening and assessment, difficulties in engaging young people in services, a lack of convenient, suitable treatment in the youth's community, and the loss of connection with their

ACKNOWLEDGMENTS

The authors wish to gratefully acknowledge the assistance of Lara Belliston, PhD for assistance in preparation of this manuscript.

established social network, including parents, teachers and guidance counselors.^{8,9,10,11}

In addition to access issues, when treatment is provided, it often fails to recognize and treat the co-occurrence of substance abuse problems and address psychosocial challenges that can affect the outcomes for the involved youth.¹² Instead, available treatment employs a “one size fits all” approach rather than matching services to the strengths and needs of the youth and family. When substance abuse or family treatment is offered, it is typically separate from the mental health treatment delivered to the youth, resulting in services that are fragmented and lack cohesion.¹³

Re-arrest rates for affected youth are also alarmingly high. Studies examining recidivism among youth taken from their homes and placed in juvenile justice care centers have found a 50-70% re-arrest rate within the first two years following release.¹⁴ One contributing factor posited is unsuccessful family reunification. Studies have consistently found that upon exiting juvenile facilities or foster care homes, youths experience difficulty maintaining stable reunification with their families. Issues with youths’ families are often considered secondary and services to enhance successful family reunification are rare.¹⁵ For these reasons, a system-wide, community-based treatment model that includes the family and other extended community resources has been recommended to ensure successful community reintegration post-release.¹³

System-wide community-based treatment models of care for justice involved youth are being established in communities across the United

States.^{14,15} While varied, these models typically provide a minimum of mobile wrap-around services and culturally competent evidence-based treatment that is tailored to the youth’s needs. While these systems are being implemented, there is surprisingly little available literature on their effectiveness. In fact, the vast majority of the extant literature on collaborative care models is “lessons learned” descriptive case studies examining the factors that affect coordinated care for justice involved youth from the worker’s perspective. We found no studies that evaluated a statewide program that was designed to alleviate issues of system collaboration and increase treatment satisfaction and outcomes with juvenile populations. The one study that did examine a coordinated model of care for children and youth, was the landmark Fort Bragg Demonstration project.¹⁶ The study found that modifying the child-serving system and increasing coordination and collaboration between agencies decreased wait times, increased treatment retention, reduced length of stay in hospitals, and fewer disruptions in services were reported. While improving access to services, the researchers also found that treatment became more expensive and there was no discernable impact on treatment outcomes when compared to traditional services. In other words, modifying the system had no impact on the actual clinical services offered to the children. Ohio’s Behavioral Health/Juvenile Justice (BHJJ) project is an attempt to address this gap by pairing modifications in service coordination and collaboration with evidence-based practices proven to be effective with justice-involved youth. We believe this study to be the first to evaluate a statewide collaborative model of care for treatment of

justice-involved youth re-integrated into the community. The primary aim of this study was to examine the parents’ perception of care and treatment outcomes for their youth when provided a system-level coordinated model of care. We hypothesized that parents of youth provided coordinated care would report superior perception of care and treatment outcomes compared to those receiving treatment as usual.

Overview of the Behavioral Health Juvenile Justice Initiative

The BHJJ initiative was created to enhance and expand the local systems’ options for providing services to serious juvenile offenders with serious behavioral healthcare needs. The projects were designed to transform child-serving systems by enhancing their assessment, evaluation, and treatment of multi-need, multi-system youth and their families. In addition, they provide the Juvenile Court judges an alternative to incarceration. BHJJ has been shared statewide initiative between the Ohio Department of Mental Health and Addiction Services (OhioMHAS), Ohio Department of Youth Services (ODYS), and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) from 2000 to 2013. (In July 2013 ODMH and ODADAS were combined into the Ohio Department of Mental Health and Addiction Services.) This initiative consisted of community programs that were initially pilot projects in a few Ohio counties in early 2000. These “pilots” eventually grew into a statewide initiative with strong support from the participating state departments and numerous additional state and local stakeholders.

All county-based BHJJ projects were required to provide evidence-

based interventions (i.e., Multi-systemic Therapy, Hi-Fidelity Wrap-around, Integrated Co-Occurring Treatment, and Trauma-Focused Cognitive Behavioral Therapy) and to engage the youth and their family/support systems in the treatment process. Most of the treatment services were mobile, intensive and provided in the youth's home. Additionally, providers were required to address the needs of the cultural and ethnic populations that their county has historically admitted to juvenile detention centers. Although each program was different and based on local needs and resources, each program offered at a minimum assessment, evaluation, and coordination of appropriate services and supports for the youths and their families.

Table 1 outlines the evidence-based practices and services provided by the different pilot sites. Four of the six counties mention wraparound services as an element of their treatment. Two counties, Cuyahoga and Lucas, used Multi-systemic Therapy (MST) as their main evidence-based practice for treatment. Cuyahoga also employed Integrated Co-Occurring Treatment (ICT) when it was deemed appropriate; Summit County also used ICT. Summit and Franklin Counties both used Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Three counties (Franklin, Hamilton, and Montgomery) employed Family-Focused Therapy (FFT) and intensive case management. Franklin County also mentioned using Multidimensional Family Therapy (MDFT) and Adolescent Community Reinforcement Approach (ACRA) for its transitional age youth population with severe mental illness and/or substance abuse.

Table 1
Evidence-Based Practices and Services Provided at Different Pilot Sites

	Wrap-around	MST	ICT	TF-CBT	FFT	Intensive Case Management
Cuyahoga	X	X	X			
Franklin				X	X	X
Hamilton	X				X	X
Lucas	X	X				
Montgomery					X	X
Summit	X		X	X		

METHODS

Participants and Procedures

The BHJJ group consisted of 557 parents and guardians reporting on perception of care and treatment outcomes for their dependent children. Cohort recruitment took place between 2009 and 2011. Participants came from six of the state's major metropolitan areas. (See Table 1.) Assignment to the BHJJ treatment group was decided by judges based on need. Eligibility was determined by a number of factors, including diagnoses, age, level of impairment, nature of charges, threat to public safety, history of trauma, and multi-system involvement. If youth met program eligibility criteria and the court felt the BHJJ program could be of benefit, the judge made a referral.

The Treatment as Usual group (TAU) consisted of 141 youth who received unspecified mental health services during state fiscal year 2011. The TAU group was recruited through a stratified, randomized mail sample of 1,354 youth as part of the department's health services oversight responsibility. Selection into the TAU group of 141

youth occurred if the parent or guardian responded positively to questions about police involvement (arrests) occurring prior to beginning treatment, within a 24-month treatment episode, or after treatment began. TAU participants came from all regions of Ohio, including rural, suburban, and urban areas.

For the purposes of this study, randomization was not possible in the BHJJ group because treatment assignment was decided by judges based on need. To reduce selection bias, BHJJ and TAU participants were matched across age, gender, race, and length of time in service. This resulted in matched samples of 115 youth in each group or a total of 230 youth. All youth in the matched samples met criteria for serious emotional disturbance. The matched BHJJ and TAU sample of 230 included 158 males and 72 females. Mean age for both BHJJ and TAU groups was 15. Self-reported racial identity of the matched samples was as follows: 58.3% Caucasian, 35.7% African American, 6.1% other. In terms of service duration, 23.5% of the matched sample was new to services within the past year, and 76.5% received services for longer than one year.

INSTRUMENT

The Substance Abuse and Mental Health Administration's (SAMHSA) Youth Satisfaction Survey for Families (YSS-F) was used to survey parents' or guardians' perceptions of their child or adolescents' mental health services and treatment outcomes. The YSS-F is used by all 50 states to determine treatment effectiveness for youth receiving behavioral health services. THE YSS-F is a 15-item parent-report that assesses perception of services, including: general satisfaction and appropriateness of care, access, participation, and cultural sensitivity. The instrument also uses a 7-item post-hoc outcomes scale that asks parents to rate results of treatment such as whether the child is a "getting along better" with family, friends and other people, and coping more effectively "when things go wrong." In addition, the YSS-F contains a 4-item social connectedness scale that measures family and community support as a consequence of treatment. Items are answered on a 5-point Likert scale, from 1 = "Strongly Disagree" to 5 = "Strongly Agree." The YSS-F has high internal consistency (Cronbach's Alpha range: .82-.93). The scales' validity, and concurrent and convergent validity were found to be acceptable when administered to family members of youth receiving behavioral health services.¹⁷

Parents in the BHJJ group completed the YSS-F perception of care and outcomes scales at discharge or termination from the program. Parents in the TAU group completed the YSS-F perception of care and outcomes scales in through a randomized survey administered six months after the treatment episode on which their case was selected.

In addition to the YSS-F's four perception of care and two treatment outcomes scales, the randomized survey and BHJJ evaluators measured school disciplinary actions (suspensions and expulsions) that had occurred prior to or during treatment. Parents of youth new to treatment were asked whether disciplinary events had occurred prior to treatment, while respondents for youth in treatment over one year were asked whether disciplinary events had occurred in the preceding 12 to 24-month period. Respondents for new-to-treatment youth were asked whether disciplinary events had occurred since treatment began, and respondents for longer-term-treatment youth were asked if such events had occurred in the last 12 months. Accounts of school disciplinary events were self-reported by parents in both groups, with BHJJ measurement made at time of discharge and TAU measurement done at time of survey administration.

The BHJJ and TAU groups differed on measurement of police involvement, as BHJJ program evaluators provided arrest information from court records in contrast to the TAU group parents who self-reported. All members of the BHJJ group had arrests reported at Time 1 due to criteria for program inclusion. The TAU group may have arrests reported for Time 1 and/or Time 2 as any history of police involvement was the basis for study inclusion. Information on arrest incidents in the BHJJ group was collected at intake, six and 12 months' post-intake, and/or at discharge. Arrest incidents in the TAU group were reported through two cross-sectional measures similar to the school disciplinary events questions. To structure the multiple BHJJ arrest measures for comparison, calculation of Time 2 police involvement depended on

whether the youth was "new" to services (i.e., in treatment 12 months or less), or "long-term" (i.e., in treatment more than 12 months). In the event where a new-to-services case had two positive indicators of police involvement at six, 12 months or discharge, both measures were calculated as "an arrest since beginning services." Similar logic was used to structure a comparable Time 2 arrest measure for the long-term-service cases.

Both groups also were measured on the parent's perception of treatment effectiveness using rank-order questions that asked whether school attendance had increased, stayed the same, or decreased as a result of services. A similar question ranked perceptions of whether police involvement had decreased, stayed the same, or increased as a result of services. BHJJ respondents completed these questions at discharge, while TAU respondents were measured six months after the treatment episode on which group selection was based.

DATA ANALYSIS

Independent samples *t*-Tests were used to examine the differences between the BHJJ and TAU sample on means on the four perception of care and two treatment outcome subscales of the YSS-F. Chi-square tests were used to explore relationships between the samples with regard to the categorical outcomes including disciplinary events and arrests before and after treatment. Mann-Whitney U tests were performed to examine the relationship between the groups with regard to ranking police involvement and school attendance as a result of treatment.

Table 2
A Comparison of Parent Satisfaction Levels

Subscale	Group	N	<i>x</i>	SD	<i>t</i>	<i>df</i>	α
Consumer Perception of Care Subscales							
Access	TAU	113	3.75	0.97	6.62	199.48	0.000
	BHJJ	115	4.48	0.67			
Participation	TAU	112	4.06	0.70	1.93	225	0.05
	BHJJ	115	4.24	0.71			
Cultural Sensitivity	TAU	113	4.13	0.76	5.15	226	0.000
	BHJJ	115	4.59	0.57			
Appropriateness	TAU	114	3.70	1.03	4.70	207.67	0.000
	BHJJ	115	4.26	0.76			
Parental Perception of Treatment Outcomes Subscales							
Social Functional Outcomes	TAU	114	3.13	1.09	4.15	220.1	0.000
	BHJJ	115	3.68	0.92			
Social Connectedness/Support	TAU	113	3.88	0.80	3.95	226	0.000
	BHJJ	115	4.27	0.67			

Table 3
Comparative Change in Expulsion/Suspension and Arrest Events Over Time

	Time 1				Time 2				Time 2 to Time 1 Percent Decrease		Time 1 Comparison Across Tx Groups	Time 2 Comparison Across Tx Groups		Comparison Within Tx Group Across Time
	TAU		BHJJ		TAU		BHJJ		TAU	BHJJ		TAU	BHJJ	
	N	%	N	%	N	%	N	%	%	%	X ²	X ²	X ²	X ²
Expelled	54	47	76	66	40	35	41	36	12	30	12.48***	.16	3.80	24.57***
Arrested	80	70	115	100	65	56	51	44	14	56	38.25***	3.96*	4.75*	88.68***

Note. Numbers and Percents represent the number of people that were expelled or arrested (yes response).

*** indicates chi-square statistic significant at $p < .001$; ** indicates chi-square statistic significant at $p < .01$; * indicates chi-square statistic significant at $p < .05$

Table 4
Comparative Perception of Treatment Effectiveness

	Increased Since Tx		Stayed Same Since Tx		Decreased Since Tx		N	Z	<i>df</i>	α
	N	%	N	%	N	%				
School Attendance							199	1.57	1	0.05
	TAU	34	30	35	30	22	19			
	BHJJ	44	38	54	47	10	8.7			
Police Involvement							203	4.78	1	<.001
	TAU	18	16	26	23	45	39			
	BHJJ	4	3.5	18	16	92	80			

RESULTS

As Table 2 illustrates, parents in the BHJJ group were significantly more satisfied when compared to TAU parents on treatment access, $t(228) = 6.62, p < .001$, participation, $t(227) = 1.93, p < .05$, cultural sensitivity, $t(228) = 5.15, p < .001$, and appropriateness, $t(229) = 4.70, p < .001$. When considering self-reported outcomes as a result of treatment, the BHJJ group demonstrated significantly greater improvement on social functioning, $t(229) = 4.15, p < .001$ and social connectedness, $t(228) = 3.95, p < .001$.

A chi-square test for independence was used to compare school expulsions/suspensions and arrests in the BHJJ and TAU groups to estimate the significance of reductions in social problem severity (see Table 3). Of those for whom complete data were available, there was a 30% decrease in school expulsions in the BHJJ compared to 12% in the TAU group, and a 56% decrease in arrests compared to 14% in the TAU group. These differences were statistically significant for both school expulsions, $X^2(1, N = 88) = 38.25, p < .001$, and arrests, $X^2(1, N = 116) = 3.96, p < .05$. It is important to note that at T_1 , the BHJJ group evidenced more severe problems with school expulsions, $t(1, N = 94) = 12.48, p < .001$, than the TAU group, $X^2(1, N = 94) = 12.48, p < .001$. Additionally, the BHJJ group experienced more arrests at T_1 than the TAU group, but this difference was not statistically significant. While both groups reduced the number of police contacts since treatment began, the BHJJ group saw a more significant reduction (80%) compared to the TAU group (39%), ($Z = -4.782, df = 1, p < 0.001$). This same pattern existed for school attendance, where there was a 38% increase in attendance since treatment began for

the BHJJ group compared to a 30% increase in the TAU group, ($Z = -1.571, df = 1, p = 0.05$) (see Table 4).

DISCUSSION

As measured by parent/guardian report, the majority of the youths assigned to the BHJJ group evidenced post-treatment improvements. Regarding perception of care, BHJJ parents reported that the family had better treatment access and participation and that services were more culturally sensitive and appropriate than those in the TAU group. Additionally, the BHJJ parents reported better treatment outcomes in social functioning and social connectedness than those in the TAU group. Although parents in both groups reported fewer school disciplinary events and perceptions of improved attendance and less police involvement as a consequence of treatment, the BHJJ group experienced larger gains in these areas. These findings alone support the use and implementation of a collaborative care model of treatment for youth with severe emotional disorders involved in the juvenile justice system and suggests that such a model may be beneficial in improving treatment retention and reducing antisocial behaviors which can lead to re-incarceration.

Not surprisingly, we found that at pre-treatment that BHJJ parents reported more school disciplinary events than those in the treatment as usual group. They had 19% more parent-reported expulsions. However, after receiving treatment, the BHJJ and TAU groups produced statistically similar results regarding expulsions/suspensions. In fact, the TAU parents reported 18% fewer positive changes on this measure at post-treatment than the BHJJ group.

This study has a number of strengths not found elsewhere. First is the use of a comparison group which was matched demographically. Past studies looking at wraparound and coordinated care treatment success and recidivism rates have lacked a comparison group.^{18,19} Second, this study examined both service access and treatment outcomes. Previous research has typically examined treatment penetration rates and has not evaluated treatment outcomes.^{1,3,4,5} Third, to our knowledge, this is the first study to examine a statewide collaborative care model to reduce re-incarceration of justice involved youth that have mental health difficulties.

Limitations

Our study has restrictions concerning the comparability of post-treatment arrests as an outcome. The BHJJ participants were selected according to strict criteria through the juvenile justice system, meaning at one point in time before or during treatment all participants had been arrested. The entire BHJJ sample had history with the criminal justice system prior to treatment, whereas the TAU group may or may not have had criminal justice involvement reported as having occurred prior to receiving treatment or within a prior 12 to 24 month period. This not only made the groups non-random, it also made comparison on arrest history somewhat problematic. The comparison of BHJJ and TAU arrests is that of a longitudinal measure of post-treatment events reported by the court versus a cross-sectional measure of timed events reported by parents or guardians. This makes the study results even more surprising, because the BHJJ group had post-treatment arrest histories that were in most cases better than what parents reported for the TAU group. Given the issue of stigma

and recall bias, we might expect TAU parent/guardians to minimize rather than maximize their report of arrests that occurred prior to and during the surveyed treatment episode. However, we can also speculate that troubled youth without arrest histories may act out during treatment in such a manner as to increase the probability of police involvement. BHJJ youth, already having had an arrest as a pre-cursor to court-ordered treatment, may have had greater motivation to stay out of trouble.

It is somewhat unclear exactly what treatment was used at each of the BHJJ pilot sites or in the TAU group. In terms of the BHJJ group, we know that each site was required to employ an evidence-based practice, but each site used a different combination of referral, wrap-around, and other treatment. Given the lack of additional funding that went into reimbursement of treatment as usual, we can speculate that fewer evidence-based practices or “premium” services were provided to the TAU group. Future studies need to be conducted to determine which critical treatment components of the BHJJ intervention contributed more significantly to improved outcomes. That said, given the results, it is still possible to argue that treatment delivered in a coordinated manner can lead to better outcomes than those found in traditional services.

The study measures parental perception of care and self-reported outcomes, which offers one individual’s view of treatment quality and success. On all but one measure (arrest events), treatment outcomes were measured cross-sectionally, and the two groups are comparable. Because parents in both groups were asked to report the current state of their child’s behavior and social interactions compared to their perceived history, the

study introduces problems of recall bias. We can think of no reason why the recall biases of the TAU parents should be substantially different than those of the BHJJ group, but concede that differences in survey administration—program evaluation versus randomized mail—may have contributed to differences in measurement error.

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BEHAVIORAL HEALTH IN OHIO: TRENDS FROM THE FIELD



The above illustration is a detail of an untitled image (see complete image below) from the Nick Egglinton Photography collection. Mr. Egglinton is a professional photographer in Adelaide, Australia. He counts the American photographer Ansel Adams among his greatest influences. The following remarks were downloaded from Egglinton's Facebook page.

...Ultimately every up and down I have experienced has encouraged me to respond in a visual or artistic way. Of course sometimes I am so paralysed I can't respond artistically at all, and these would have to be my darkest times...My images are an insight into ... times I feel trapped and my only way to alleviate it is to visually express myself visually.

Contact info: nick.egglinton@me.com
<http://www.nickegglinton.com>



CHARACTERISTICS OF ADOLESCENT MARIJUANA ADMISSIONS IN OHIO FY 2008 AND FY 2011^a

Rick Massatti, PhD, MSW, LSW • Laura Potts, MA • Surendra Bir Adhikari, PhD MedSoc

Ohio Department of Mental Health and Addiction Services
Office of Planning, Outcomes and Research

To whom correspondence should be addressed: Rick Massatti, 30 E. Broad St., 8th Floor, Columbus, OH 43215 P: 614.752.8718 F: 614.488-4789 Rick.Massatti@mha.ohio.gov

Keywords: Marijuana • Adolescent • Substance Abuse • Treatment Outcomes • Criminal justice

BACKGROUND

Marijuana (aka: pot, weed, diesel, loud and kush) is a psychoactive drug that can have a psychological and physical effect upon individual users. It is not uncommon for marijuana users to believe that they need the drug to feel well. Users may eventually become tolerant to the chemical delta-9-tetrahydrocannabinol (THC) in marijuana and begin to use larger and larger doses for the same desired results. Marijuana can cause serious health complications and possibly result in shortening users' life spans through the development of respiratory ailments and lung cancer. Marijuana can also diminish quality of life through decreasing users' motivation and interest in life, which can lead to clinical depression.¹

Nationally, among adolescents who use illicit substances, marijuana is the most frequently used drug. The National Survey on Drug Use and Health (NSDUH) reported that 7.4% of all adolescents ages 12-17

used marijuana in 2010. From 2002 to 2010, adolescents who reported marijuana use were more often males (8.3% in 2010) rather than females (6.4 percent in 2010).² The Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Reporting Network explains that the rate of marijuana use among youth ages 12 to 17 appears to be increasing. Data gathered from hospital emergency departments throughout the nation indicates that marijuana-related emergency-room visits have increased more than 50% from 154.0 per 100,000 in 2004 to 240.2 per 100,000 in 2011.³

In Ohio, data shows that marijuana is frequently used by adolescents. The Youth Risk Behavior Surveillance System (YRBSS) collects statewide data on adolescents in the ninth through the 12th grades.⁴ YRBSS data from 2010-2011 show that 23.6% of Ohio's youth had used marijuana in the past 30 days. Similar to the national data, more males (27.7%) than females (19.0%) had reported marijuana use. Early initiation of marijuana use (i.e., use before age 13) in Ohio has been

above the national average since 2003 (9% vs. 8%). Adolescent males were more likely to have an earlier initiation than females (10% vs. 6% in 2011). Typically, marijuana use among Ohio high-school-age adolescents became more prevalent as grade level increased. In 2011, 17% of ninth graders, 24 percent of 10th graders, 22% of 11th graders and 31% of 12th graders used marijuana within the past 30 days.

While many national- and state-level statistics present an overview of marijuana use, there is much that still needs to be explored. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has the unique opportunity to analyze health disparities among marijuana users because of the treatment data it collects through the Ohio Behavioral Health (OHBH) dataset. The purpose of this study is to examine trends among adolescents ages 12 to 17 who report marijuana use and determine whether any health disparities exist among different ages, races/ethnicities, and sexes.

^aThis report contains some of the highlights from the full report, available at <http://mha.ohio.gov/News/NewsEvents/tabid/349/ArticleID/28/Adolescent-marijuana-use-examined-in-new-bulletin.aspx>

METHODS

The Ohio Health Disparities Bulletin (OHDB) analyzes Ohio’s state-wide treatment episode data to investigate behavioral health disparities among clients in the public behavioral health system. Analyses may range from age, gender, and race/ethnicity disparities to drugs of choice, clients with mental health history and other areas of interest. This study is patterned after SAMHSA’s Treatment Episode Data Set (TEDS) analyses, but it presents in-depth analyses on trends and disparities unique to Ohio. The study also expands upon traditional TEDS analyses by incorporating information to the OhioMHAS data system and through reporting on statistically significant differences among client profiles when possible.

Data for the following study are extracted from the OHBH dataset. OHBH data are collected at admission, transfer and discharge and contain a variety of socio-demographic items and fields used to report federally mandated treatment outcomes. Using information from the OHBH dataset, this study examines trends among youth ages 12 to 17 from state fiscal years (FY) 2008 to 2011. All youth who reported marijuana as a primary, secondary, tertiary, or quaternary drug of choice during their admissions process were included in the analyses. OHBH data are continually updated because claims may be submitted over a long period. Data for this study were pulled from the OHBH dataset between January 7, 2013 and January 23, 2013.

A variety of statistical tests are used throughout this analysis to indi-

cate whether meaningful differences occur among variables (e.g., between treatment length and race/ ethnicity). These statistical tests and some of their numerical results are not mentioned by name to make the document more reader friendly; however, more information is available from the authors upon request.

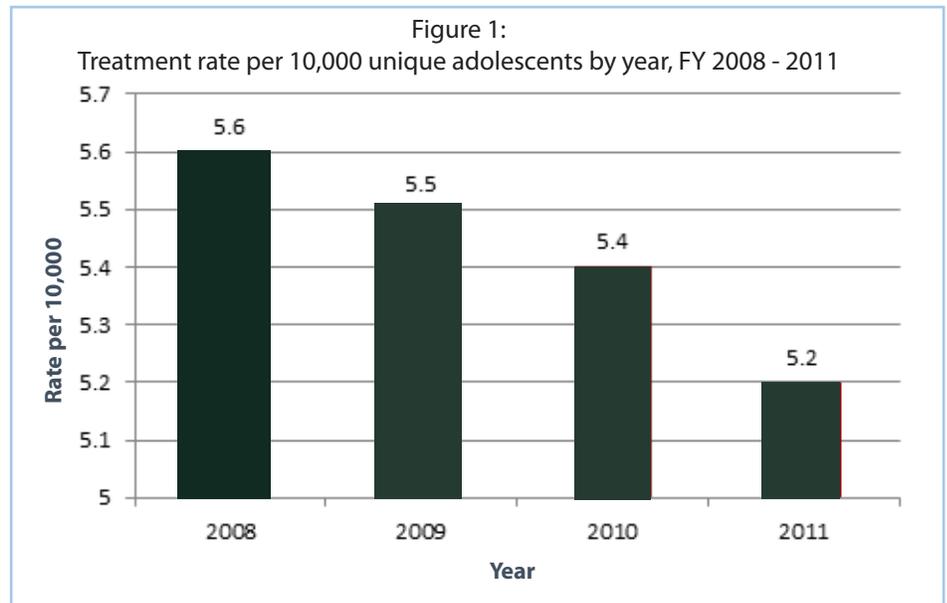
RESULTS

Marijuana is the most frequently abused drug among Ohio’s adolescents seeking treatment in the publically funded system. During FY 2008 and FY 2011, almost 21,000 adolescents (73% of all adolescents served) reported marijuana as either a primary, secondary, tertiary or quaternary drug of choice. More than half of all admissions were associated with marijuana, and the percentage of adolescents reporting this substance as a drug of choice rose from 70% in 2008 to 77% in 2011. Figure 1 displays the treatment rate for Ohio adolescents reporting marijuana use from FY 2008 to

FY 2011. The treatment rate for adolescents reporting marijuana use has decreased over time, going from 5.6 per 10,000 adolescents in FY 2008 to 5.2 per 10,000 adolescents in FY 2011.^b

Age of First Use

On average, males and females reported they were 13 years old when they first used marijuana, with most adolescents (72%) reported beginning marijuana use between ages 12 and 15. Typically, the average age of first use is slightly younger among males than females, and this difference was statistically significant every year except 2008 (e.g., 13.2 years for males vs. 13.4 years for females in 2011). There were some racial/ethnic differences within the age of first use. Non-Hispanic Whites were significantly younger than African-Americans when they first tried marijuana in FY 2008 (13.3 years vs. 13.6 years) and FY 2010 (13.2 years vs. 13.4 years); other years showed no significant differences.



Source: ODADAS Behavioral Health Data

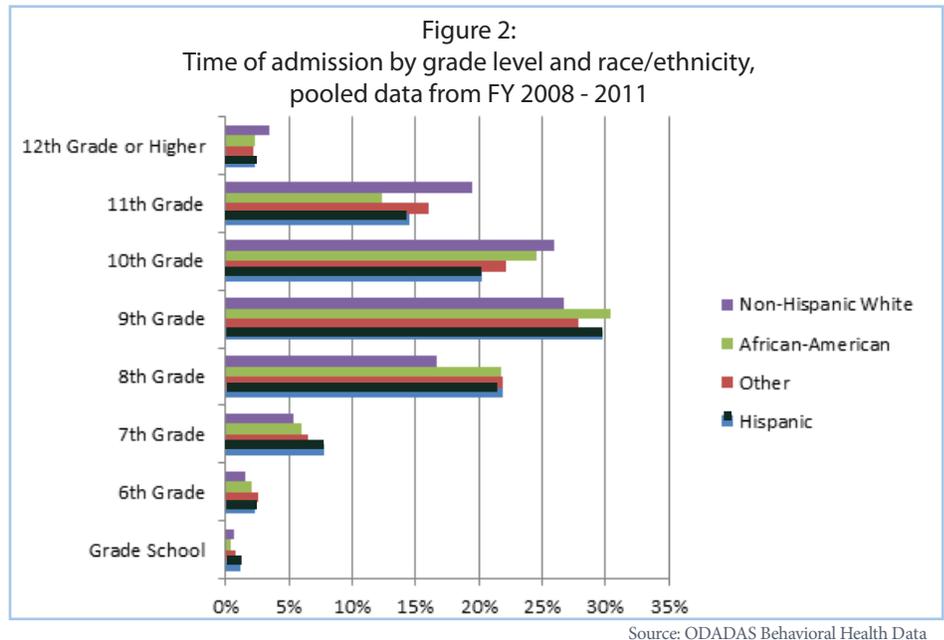
^bAdults (18 and older) reporting marijuana as a drug of choice also experienced a decrease in admissions from FY 2009 - FY 2011.

Age at Admission

At time of admission, most adolescents (87%) reporting marijuana use were between the ages of 15 and 17 from FY 2008 to FY 2011. The average age of admission for males and females was roughly the same, being about 16 years of age every year. Females were significantly younger than males when they entered treatment in 2008 (i.e., 16.2 years for females vs. 16.4 years for males), but this difference did not hold true in other years. Hispanics and other races were significantly younger when they entered treatment compared to African-Americans and non-Hispanic Whites in 2009, but this statistical significance was not present in FY 2008 and FY 2011. Other races were also significantly younger when they entered treatment than all three groups in FY 2010.

Polysubstance Abuse

Between FY 2008 and FY 2011, most adolescents (58%) reported using marijuana in combination with one (48%) or two (10%) other drugs, but a sizeable percentage (42%) used only marijuana. The number of adolescents using other substances with marijuana fell slightly from 60% in FY 2008 to 56% in FY 2011. Alcohol was the most frequently used drug with marijuana. Of adolescents reporting polysubstance use, 76% used alcohol in 2008, but this percentage decreased to 69% in 2011. Other substances were infrequently used with marijuana although there was some variation over time (Figure 2). Concurrent cocaine use and other drug use decreased while concurrent pharmaceutical opioid use increased from 2008 to 2011. Nicotine use appears to have increased the most from 1% in 2008 to 8% in 2011, but these results may be a reporting artifact due to the addition of the nicotine variable around



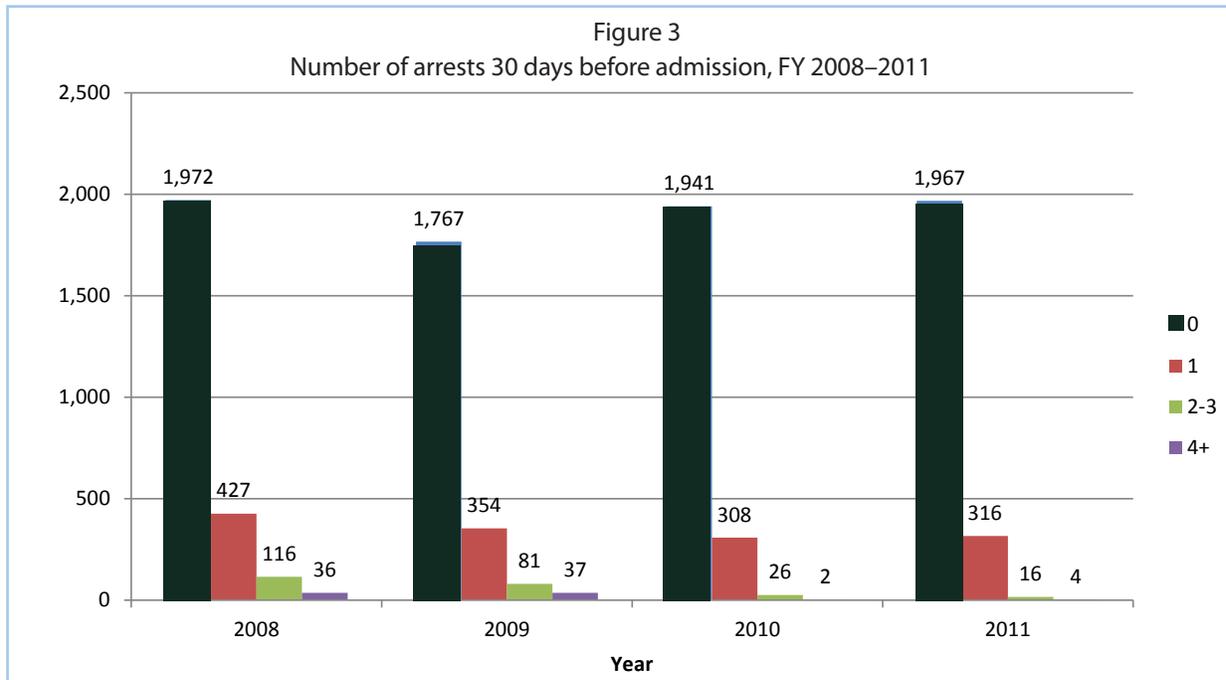
FY 2009 and greater awareness in the field about the dangers of nicotine abuse and dependence.

There were statistically significant differences in polysubstance abuse between the sexes and among racial/ethnic groups. Between FY 2008 and FY 2011 females were more likely to use two or more drugs concurrently and less likely to use marijuana alone, while males were more likely to use marijuana alone and less likely to use two or more drugs concurrently. Every year, non-Hispanic Whites were more likely to use two or more drugs concurrently and less likely to use marijuana alone, while African-Americans were always more likely to use marijuana alone and less likely to use two or more drugs concurrently. No significant differences were found for other races.

Arrests Prior to Admission

Between FY 2008 and FY 2011, most adolescents (81.6%) reported no arrests 30 days before admission (Figure 3). Only a minority reported either one (15.0%), two to three (2.5%), or four or more (0.9%) arrests.

The number reporting no arrests grew over time, from 77.3% in FY 2008 to 81.6% in FY 2011. For those adolescents reporting arrest, there was variation by sex of the adolescent. More males were arrested 30 days prior to treatment admission than females over the four year period (75.2% vs. 24.8% respectively). The percentage of males and females arrested changed over time; in 2008, 73.3% of arrests went to males compared to 84.2% in 2011. The number of arrests also varied by the race/ethnicity of the adolescent for adolescents reporting arrest. On average, more non-Hispanic Whites reported arrests 30 days before admission (71.2%) than African Americans (24.6%), Hispanics (1.5%), and other racial/ethnic groups (2.7%). The percentage of races/ethnicities reporting previous arrest also changed over time. Of those reporting arrest 30 days before admission, nearly 74% were non-Hispanic Whites in FY 2008; whereas, only 66% were non-Hispanic Whites by 2011. In contrast, the number of African Americans grew from 23% in FY 2008 to 28% by FY 2011.



Source: ODADAS Behavioral Health Data

TREATMENT OUTCOMES

During FY 2008 and FY 2011, a majority of clinicians (68%) reported that the adolescent’s disposition at discharge was either positive (37%) or negative (31%). A smaller percentage of clinicians reported adolescent’s disposition at discharge was either neutral (14%) or referral (18%). Adolescents who remained in treatment longer were more likely to have positive outcomes. Only 23% of adolescents remaining in treatment fewer than 60 days had a positive disposition at discharge; whereas, 44% of adolescents remaining in treatment more than 60 days had a positive disposition at discharge.

Some statistically significant differences became apparent when comparing positive disposition at discharge to racial/ethnic groups. Figure 4 shows the odds of a successful treatment outcome for adolescent non-Hispanic Whites compared to other races/ethnicities. Between FY 2008 and FY 2011 non-Hispanic Whites

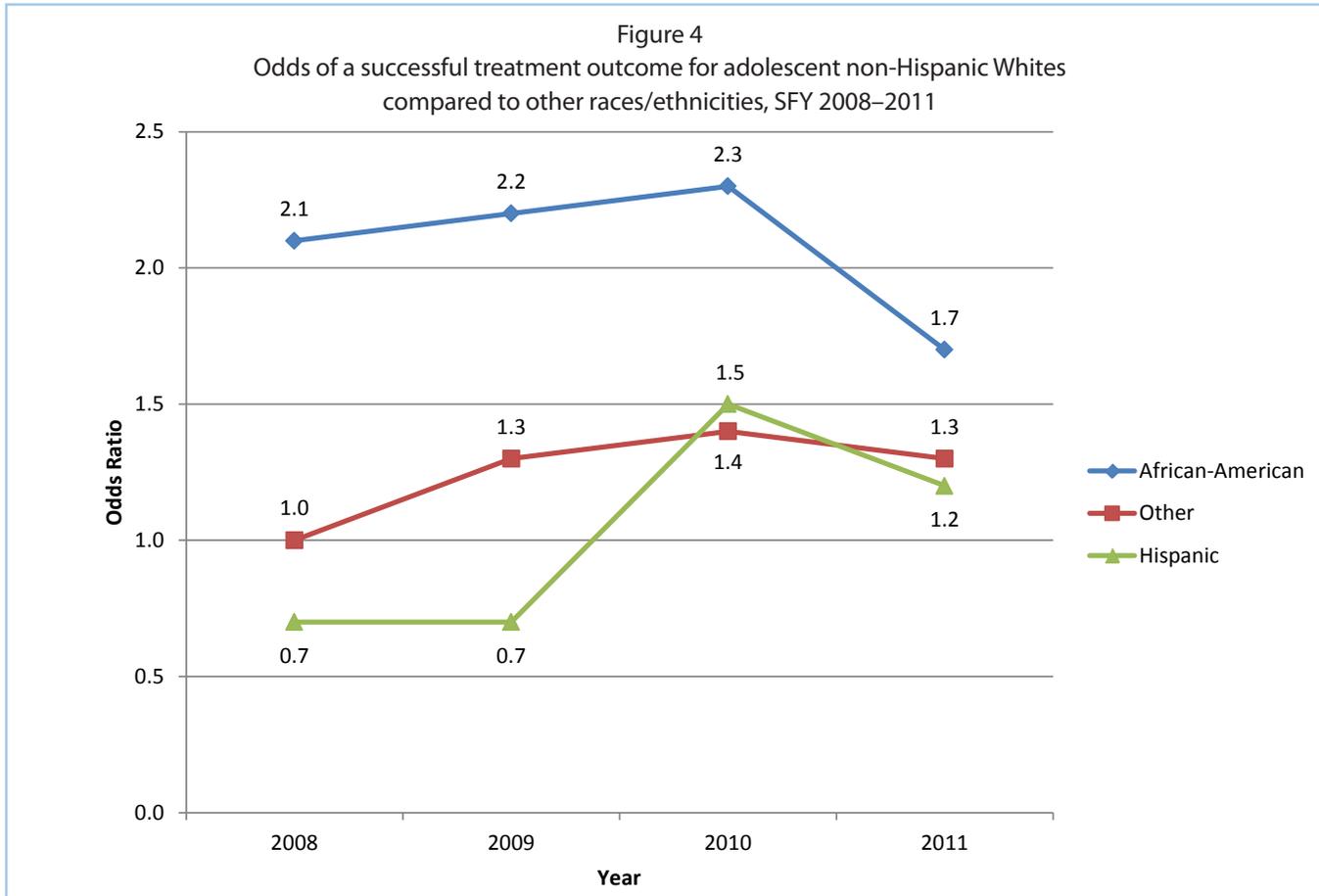
were typically more likely to have a positive disposition at discharge compared to other racial/ethnic groups. For example, odds of a positive discharge for non-Hispanic Whites were 2.1 times higher than African-Americans in 2008. The odds decreased in FY 2011, but the difference was still statistically significant. Non-Hispanic Whites were also more likely than other races to have a positive disposition at discharges, but none of these odds ratios was statistically significant. In FY 2008 and FY 2009, Hispanics were more likely than non-Hispanic Whites to have a positive disposition at discharges, but none of these odds ratios were statistically significant.

LIMITATIONS

This study has several limitations. Results from this study only reflect marijuana use among adolescents treated in the public alcohol and drug treatment system and may not be generalizable to the general population of adolescents in Ohio.

Many children are treated in the private health system, but similar data on health disparities is not tracked for that group. Also, more than half of the adolescents in this study are referred from the criminal justice system, leading to results that may not be similar to youth in the private health system because of the unique behaviors and/or demographics for the criminal justice population. Finally, most of the adolescents served in this public system are covered by Medicaid, and any health disparities found amongst adolescents enrolled in Medicaid may not be the same as health disparities in the general population.

This study may also be limited due to several potential forms of bias. Sample bias is possible in the data because service providers and community boards may not have contributed information to the OHBH dataset. Were the missing data from these areas combined with other statewide data, then the findings may have been different. Social desirability bias may also have impacted the findings if



Source: ODADAS Behavioral Health Data

adolescents told the clinicians what they wanted to hear. Research has shown that adolescents, in particular, are prone to this type of bias, so results may have some degree of error. Generally, it is more likely that the results underestimate some of the trends in marijuana use because adolescents may not accurately self-report their drug history.

IMPLICATIONS FOR HEALTHCARE AND SUBSTANCE USE TREATMENT

Marijuana is the most frequently abused drug among Ohio’s adolescents seeking alcohol and drug treat-

ment in the publicly funded system. Prevention activities should be targeted toward youth about the dangers of substance use, especially because they may not understand the consequences of alcohol and drug use. The demographic make-up of adolescents reporting arrest has changed over time. Researchers may want to investigate why more African Americans are reporting arrest 30 days prior to admission now than in FY 2008. Further research is also necessary to discover why non-Hispanic Whites perform better in treatment than other racial/ethnic groups. A recent national study found that African-Americans who use alcohol and drugs were less likely to successfully complete treatment than non-Hispanic Whites, and it suggested that unemployment and

housing instability were part of the reason.⁵ Other studies have suggested that cultural sensitivity and training could be used to encourage better outcomes.^{6,7} Researchers can build on these findings to discover the causes of the disparity and develop solutions to help racial minorities successfully complete treatment.

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BEHAVIORAL HEALTH IN OHIO: CURRENT RESEARCH TRENDS

The Ohio Department of Mental Health and Addiction Services
Office of Quality, Planning and Research
30 East Broad Street, 8th Floor
Columbus, Ohio 43215
mha.ohio.gov



Promoting Wellness and Recovery