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Cheerleaders and Performers: Mental Health Courts in a Midwestern State

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LOYOLA UNIVERSITY CHICAGO

CHEERLEADERS AND PERFORMERS:
MENTAL HEALTH COURTS IN A MIDWESTERN STATE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
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PROGRAM IN SOCIOLOGY

BY
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CHAPTER ONE

INTRODUCTION

Over the past fifteen years an innovation has emerged in the criminal justice system, the mental health court, specifically aimed at dealing with the problem of the presence of large numbers of persons with mental illness being incarcerated in jails and prisons in the United States and elsewhere. Mental health courts (MHCs) originated in the late 1990s following a judicial problem-solving methodology that was developed as part of the innovation of the drug treatment court in Miami in 1989 (Hodulik, 2001). MHCs emerged as the result of several interrelated developments. The criminal courts were faced with large numbers of cases involving persons with mental illness, which presented a challenge to the flow of normal case processing as the court now grappled with the issue of considering treatment for mental illnesses in many more cases. Also, jails in many jurisdictions in the United States faced severe overcrowding in the late 1980s that resulted in a number of lawsuits and reviews of incarceration procedures by state and federal officials. Having large jail populations created an increased need for mental health services, a need that jails were ill-suited to meet. Jurisdictions were pressured both internally and externally to create alternatives to incarceration which were increasingly utilized throughout the 1990s.

This dissertation presents a sociological study of mental health courts in a Midwestern state. I rely heavily on ethnographic methods and analysis in presenting the
study, but also utilize survey data. In the research presented here I focus on how the professionals who run the courts conduct and understand their work activities, and construct and promote the claim that MHCs can address the social problem of persons with mental illness becoming involved in the criminal justice system.

**Definition and Growth of Mental Health Courts**

Mental health courts are criminal courts that adjudicate separate dockets consisting entirely of defendants with severe mental illness. The first mental health court began operation in Broward County, Florida in 1997, and the mental health court model soon spread to other jurisdictions (Redlich et al, 2005). Mental health court models were initially designed to hear criminal, misdemeanor, non-violent cases of persons with severe mental illness, and have these persons agree to follow a treatment plan for their mental illness rather than being incarcerated for their offense (Goldkamp and Irons-Guynn, 2000). More recently a number of mental health courts have been implemented that hear felony cases, and some will accept defendants who have committed violent offenses on a case-by-case basis (Riedlich et al, 2005). MHCs aim to divert offenders away from incarceration and toward community mental health treatment. Cases are processed by requiring that defendants follow a program of mental health treatment that would be monitored regularly by the mental health court, which would impose sanctions in cases where mental health court defendants are non-compliant with treatment plans (Goldkamp and Irons-Guynn, 2000). Although the number of advocates calling for the expansion of mental health court programs is growing, the current numbers served by mental health court programs are relatively small compared to the total population of
mentally ill offenders incarcerated in jails and prisons. Whether or not mental health court programs will dramatically reduce the total numbers of mentally ill persons incarcerated in jails and prisons in the future remains to be seen.

In fiscal years 2002 and 2003, Congress appropriated $5 and $4 million, respectively, for seed grants to help inchoate MHC programs become operational. However, the House of Representatives allocated no funds in fiscal year 2004 for the support of MHCs. Further, the Senate’s Commerce, Justice, State, and Judiciary Appropriations Subcommittees also allocated no money to launch MHCs. Despite the absence of these allocations, the number of MHCs in the United States grew dramatically from 1 in 1997 to more than 100 in 2005. In fact, MHCs are now located in nearly 40 states, such as California, Ohio, Florida, and Washington (Steadman et al, 2005). Since 2005, the number of MHCs nationwide has risen to more than 180 (Council of State Governments, 2009).

*Mental Illness and Criminal Justice Involvement*

The problem of increasing numbers of persons with mental illness being incarcerated in jails and prisons developed as policies of deinstitutionalization were put into effect in the 1960s and 1970s. Hundreds of thousands of persons with mental illness were released from confinement and into communities across the country, ostensibly to be cared for by community mental health centers providing treatment and medications. However, law enforcement officials became the de facto managers of persons with mental illness living in the community who were not receiving enough involvement from community mental health workers (Kiesler et al, 1983). After deinstitutionalization, law
enforcement agencies experienced a subsequent increase in the number of instances of involvement with mentally ill persons, both in their residences and on the streets. Such encounters often led to incarceration in jail or prison rather than treatment for mental illness (Hodulik, 2001). Despite efforts to educate law enforcement officers about mental illness and to encourage them to initiate referrals to mental health treatment when encountering persons with mental illness, officers could not make such decisions if uninformed about an individual’s psychiatric condition or unable to judge whether persons were appropriate for referral to inpatient mental health care (Rumbaut and Bittner, 1979). As a result, many encounters between persons with mental illness and law enforcement officers led to arrest and incarceration, and the criminal justice system began a build-up of increasing numbers of individuals whose behavior was too problematic for independent living in the community (Goldkamp and Irons-Guynn, 2000).

Two other social issues exacerbated this problem over the next three decades. First, many individuals who would have been housed in the era of institutionalization were unable to function in the community and homeless, making their lack of functioning and problematic behavior visible to and a responsibility of law enforcement officers. Second, during the 1980s and 1990s many law enforcement agencies in the United States underwent a philosophical change, stressing proactive involvement of officers in promoting quality-of-life goals for the communities they patrolled, resulting in a crackdown on individuals whose behavior was seen as disruptive and disturbing. This crackdown often targeted substance abusers and mentally ill persons, and included a
significant number of individuals who were both (Goldkamp and Irons-Guynn, 2000; Hodulik, 2001).

Studies of jail populations reveal that somewhere between six and twelve percent suffer severe mental illnesses requiring treatment, including two to three percent suffering from schizophrenia and almost four percent suffering from bi-polar disorder, rates much higher than the general population (Lamb and Weinberger, 2001). Clinical studies conducted in state prisons have found ten to fifteen percent prevalence rates of severe mental illness (Lamb and Weinberger, 2001). Other research has demonstrated that there is a high likelihood of homelessness immediately preceding incarceration for mentally ill jail inmates. For instance, a study in New York found that forty-three percent of defendants entering the city's criminal justice system were homeless when they committed the crime for which they were arrested. Homelessness was grossly overrepresented among both violent and non-violent mentally ill offenders relative to non-mentally ill defendants (Martell, Rosner, and Harmon, 1995).

**Problem-Solving Courts**

Mental health courts are part of a broader category of specialized criminal courts described in academic literature as "problem-solving courts." At various times over the past three decades, specialized criminal courts have been introduced by numerous criminal justice systems throughout the United States. New types of criminal courts have been introduced for handling specific offenses, or for handling specific populations of offenders, including specialized courts for domestic violence offenses, drug offenses, and mentally ill offenders. Juvenile courts are not included as problem-solving courts in most
of the literature because the specialized court approach used for juveniles has a much longer history and is not a product of the recent trend toward specialized criminal courts, though juvenile courts have been somewhat influenced by therapeutic jurisprudence in some jurisdictions (Nolan, 2001). The essential components of problem-solving courts are enhanced judicial oversight, longer periods of case management and post-adjudicative supervision, and a philosophy of administering restorative rather than retributive justice (Butts, 2001). Problem-solving courts represent a shift from an adversarial approach in criminal proceedings to a problem-solving approach that takes into account the needs of the offender, victim, and community (Ostrom, 2003). In problem-solving courts, the offender is still held responsible for her or his actions, but the legal system is extended beyond fact-finding and the imposition of sanctions into addressing problems that contribute to the offending behavior. Problem-solving courts rely on input from victims, community representatives, advocates for social change, and social service agencies when developing approaches for dealing with offenders' problems. By engaging in this process, problem-solving court officials attempt to use the authority of the court to maintain the social health of the community (Butts, 2001).

Many problem-solving courts are based on a juridical philosophy of "therapeutic jurisprudence," in which judges and other court officials aim to solve the social problems that contribute to specific forms of criminal behavior by addressing the needs of the individual offender via therapeutic process. The philosophy developed out of criticism of mental health law as critics identified rulings that produced anti-therapeutic results for the people that mental health law was designed to assist (Winick and Wexler, 2003). Winick
and Wexler (2003) explain the new philosophy of therapeutic jurisprudence:

Therapeutic jurisprudence focuses our attention on the traditionally under-appreciated area of the law's considerable impact on emotional life and psychological well-being. Its essential premise is a simple one: that the law is a social force that can produce therapeutic or anti-therapeutic consequences. The law consists of legal rules, legal procedures, and the roles and behaviors of legal actors, like lawyers and judges. Therapeutic jurisprudence proposes that we use the tools of the behavioral sciences to study the therapeutic and anti-therapeutic impact of the law, and that we think creatively about improving the therapeutic functioning of the law without violating other important values, such as due process concerns. (P. 7)

Mental health courts and drug courts are two types of specialized criminal courts that typically adhere to the therapeutic jurisprudence philosophy. Other specialized criminal courts, particularly many domestic violence courts, do not always rely on therapeutic jurisprudence but still take a problem-solving approach to adjudication of offenders (Berman and Feinblatt, 2005).

A judge and leading advocate for problem-solving courts, Greg Berman (2000), argues that they began to appear in American criminal jurisprudence because of breakdowns among community and government institutions struggling to deal with addiction and mental health problems, a surge in prison and jail populations, societal trends emphasizing the accountability of institutions, advances in treatment and in technology tracking outcomes, and most importantly, the experience of growing frustration among judges and other criminal justice officials due to rising caseloads combined with shrinking resources. The later phenomenon has been referred to as "McJustice," referring to how judges were forced to quickly adjudicate cases in order to accommodate large caseloads, only to recognize the revolving-door phenomenon of the
same individuals being adjudicated repeatedly for continuing to commit the same offenses (Berman and Feinblatt, 2005). Judicial officials who questioned the meaningfulness and efficacy of the fast processing of cases with little preventative result sought to develop a new approach, one that would apply justice in a meaningful way and that would prevent future criminal behavior. Once the idea of a problem-solving court was introduced in practice and shown to be tenable, a movement began among judicial officials, one which over the past two decades has caused a sea change in criminal justice processing in thousands of courts across the United States.

Sociological Analyses of Specialized Criminal Courts

In this section I discuss recent sociological work investigating problem-solving courts. I argue that the driving force in domestic violence court implementation in jurisdictions across the country was a social movement for battered women arising out of the broader feminist movement, rather than the movement among judicial professionals described above.

The Battered Women's Movement and Domestic Violence Courts

Feminists in the United States formed a social movement and attempted to utilize law to transform the criminal justice system and its handling of violence in the home. The battered women's movement developed out of the civil rights movement in the 1960s, and in the 1970s spearheaded significant legal and social change (Tierney, 1982). The goal of the battered women's movement, other than general cultural and ideological change in terms of how women victims of domestic abuse are viewed, was to influence the state to enter the private sphere and be legislatively active at both local and federal
levels in order to combat domestic violence (Tierney, 1982; Dobash and Dobash, 1992; Ptacek, 1999). The battered women's movement was successful in catalyzing major reforms, dramatically altering police practices and prosecutions in response to domestic violence cases and instilling a priority on addressing victim needs (Dobash and Dobash, 1992; Johnson, 2008). Domestic violence courts, which arose as a result of the influence of the battered women's movement, were among the earliest specialized criminal courts to begin adjudication. Officials in Philadelphia introduced a Protection from Abuse Court in 1982, and then officials in Chicago established a special staff for dealing with domestic violence in its court system in 1984 (Mirchandani, 2004). By 2000, over 300 jurisdictions in the United States were operating specialized domestic violence courts (Mirchandani, 2004).

The literature on problem-solving courts generally includes domestic violence courts as part of the same new trend in criminal justice adjudication in the United States. As suggested above, two important social movements contributed to the rise of specialized criminal courts when one includes domestic violence courts as part of the problem-solving court phenomenon, a practice common to the legal and social scientific literature on specialized criminal courts. Domestic violence courts were initiated and largely influenced by the efforts and ideology of the battered women's movement (Mirchandani, 2004). But other problem-solving specialized criminal courts, such as drug courts and mental health courts, were initiated and largely influenced by the efforts of judicial officials who had formed a social movement group from within the institution of criminal justice and at a level of some hierarchical authority, but not at the upper-most
level of law-making or state spending (Berman and Feinblatt, 2005). Miller and Johnson (2009) refer to the problem-solving court movement as a *sociolegal* movement because of its position within the criminal justice institution and distinguished from social movements affecting change from without institutions. Before considering the research implications of recognizing the two movements’ influence on the formation of specialized criminal courts, I review recent sociological analyses of the new courts.

*Analyses of Domestic Violence Courts*

Although the initiation of specialized criminal courts for domestic violence represents a victory for the battered women's movement and for the feminist movement more generally, feminist scholars have identified problematic issues arising as advocates and legal professionals represent battered women in the courts. For example, Wittner (1997) followed the cases of twenty women and two men in a domestic violence court in Chicago in 1993. She explains how those who worked in the court, including the attorneys and advocates, often became frustrated with the women who brought cases to court because it was not unusual for these victims to decide not to continue to follow through with the case after initiating proceedings. She was able to identify primary reasons why women did not continue with cases which centered on concerns in their everyday lives and for their family members. Her research illustrates the disconnection that can occur between professionals and advocates working for victims of domestic violence and these victims' preferences. Battered women may face their abusers by calling on the assistance of the criminal justice system, but often the initial arrest is enough. Many opt to avoid the end result of the men in their lives being limited by
sentencing restrictions and the stigma of a criminal record.

Mirchandani (2004) argues that the presence of domestic violence courts in the criminal justice system is an important culminating success for the battered women's movement, one that inserted the movement's values into the criminal courts system by functioning to assign blame on men batterers' while ensuring that women are not blamed for their victimization. Based on her nine-month qualitative study of a domestic violence court in operation in Salt Lake City, Utah, she found that the ideology and operation of Salt Lake County's domestic violence court relied on understandings of domestic violence developed by the battered women's movement. For instance, the power/control wheel, a symbolic representation of domestic violence developed by a group of battered women in Duluth, Minnesota (Pence and Paymar, 1993), incorporated several radical feminist ideas which informed the rhetoric and practices of the Salt Lake County domestic violence court. The battered women's movement questioned cultural ideas of masculinity as power and femininity as weakness, insisted that wife batterer's be criminalized and required to take responsibility for their crime, and made sure that women did not assume the responsibility for being battered. According to Mirchandani, battered women's movement understandings were readily evident in the rhetoric and practices of the Salt Lake County domestic violence court, which recognized the importance of batterers taking responsibility for their behavior as criminal and emphasized the importance of women not being held responsible for being victimized. She concludes that the new specialized criminal courts, such as domestic violence courts, have made the professional domain of criminal justice more "porous" to the values and
definitions of social movements.

Mirchandani (2005) analyzed the problem-solving court model using the sociology of law developed by Max Weber (1978) and considered whether or not an increasing reliance on instrumental rationalization comes at the cost of value rationality in problem-solving courts. She found that the instrumentally rational operations of the Salt Lake County domestic violence court exist side-by-side with a value orientation drawn from the social movement values of the battered women's movement. In a later article, Mirchandani (2008) develops a multi-theoretical explanation of problem-solving courts, and then reassesses her Salt Lake County domestic violence court data as a case study in which Foucault's individual governance and Habermas' democratic structural change can be recognized. She concludes that her case study does not provide conclusive support for either model, but instead finds both therapeutic and deliberative democratic mechanisms in the Salt Lake County domestic violence court. She suggests that these findings will aid analysis of legal reforms like problem-solving courts. As she explains, the Foucaultian approach allows a researcher to see the unintended consequences of reform movements in which therapeutic techniques designed to empower individuals serve the needs of the state. By contrast, the Habermasian approach allows a researcher to see the intended consequences of reforms as understood from the perspective of reformers, whose goals include the recognition of social and cultural issues.

Nolan's Study of the American Drug Court Movement

The most comprehensive investigation of the advent of drug courts in the United States was presented by Nolan (2001), who conducted an ethnographic study of
American drug courts. Early in the book *Reinventing Justice: The American Drug Court Movement* he identifies three distinct “legitimizing values” that are referred to in public debates and scholarly literature concerning social responses to drug use: the moral/religious perspective, the therapeutic paradigm, and the utilitarian perspective. In American society, different institutions involved in the social control of drug use have relied on one of the three legitimizing values in various ways. For instance, Nolan states that the moral or religious orientation has been most central to the American legal system’s response to drug use during the twentieth century, as the makers and enforcers of law ignored the therapeutic paradigm and its disease view of drug use, choosing instead to view much individual drug use as immoral behavior deserving of punishment. But for much of the 1800s and early 1900s the social control of drug use in America was in the hands of the medical and pharmaceutical communities. During this time, the medical community attempted social control of drug use for therapeutic reasons in order to keep treatment of patients within their sphere of influence, while the pharmaceutical community attempted social control of drug use for utilitarian reasons in order to make a profit.

For Nolan (2001), the advent of drug courts in America criminal jurisprudence represents the meaning systems of two institutional spheres coming together in a way not seen before, with the moral/religious perspective of the legal system merging with the therapeutic paradigm of medicine. In addition, Nolan states that utilitarian arguments are often made for drug courts by policy advocates, who argue that drug courts will be more cost-effective for the state because they are the most efficient way to treat offenders for
drug addiction, representing cost savings in the form of reduced recidivism rates leading to a decrease in incarceration expenses.\footnote{Although some policy advocates have presented early findings backing up the idea that drug courts do indeed represent a cost-effective alternative for government jurisdictions, to date no study has presented conclusive evidence.} Although in the 1960s and 1970s efforts were made to bring treatment for drug offenders into the criminal justice response, these followed a “rehabilitative ideal” which soon came under heavy criticism.\footnote{An influential report on the rehabilitative ideal was written by the American Friends Service Committee, titled \textit{Struggle for Justice}, and issued in 1971. The report strongly criticized individualized treatment, indeterminate sentencing, and judicial discretion, and led to state and federal legislation (Nolan, 2001).} Nolan finds that the convergence of law and therapy in the drug court movement in the early 1990s was a separate, distinct process from the rise of the rehabilitative ideal in the early 1960s, both in theory and in practice. Rehabilitation was understood by progressives as a necessary response to the failings of the penitentiary, which was viewed as problematic because of its inability to reform offenders. Progressives argued that drug offenders could be rehabilitated if the individual needs of the offender could be recognized and dealt with by allowing judges to have more discretion and by providing more alternatives to incarceration. Unlike drug courts, rehabilitation was structurally separated from adjudication, as corrective efforts were conducted after sentencing during probation, prison, or parole. Rehabilitation programs such as Treatment Alternatives to Street Crime (TASC), a federal drug-treatment diversionary program introduced in 1971, were adaptive by design, attempting to teach criminal offenders how to adapt themselves and their lives to a society that does not condone recreational drug use. By contrast, Nolan argues that drug courts follow a “therapeutic ideal” focused on post-modern concerns.
with individual emotional well-being, a therapeutic trend of the past few decades visible in American government and culture. The drug court movement represents the institutionalization of what Nolan (1998) has referred to in previous work as the “therapeutic ethos,” and drug courts follow a therapeutic rationality. In practice, drug courts are not separated from adjudication, as justice and therapy are merged in the courtroom following the influence of therapeutic jurisprudence. Rehabilitative programs like TASC may have laid the foundation for the link between criminal justice and treatment perspectives in the social control of drug use, but the two were not fully merged until the advent of drug courts almost two decades later (Nolan, 2001).

Limitations of Previous Sociological Analyses of Problem-Solving Courts

Mirchandani’s (2008, 2005, 2004) analyses of a domestic violence court contain conceptualizations drawn from feminist legal theory and from social theory of Weber, Habermas, and Foucault. Her case study method finds elements of Foucaultian therapeutic governmentality and Habermasian deliberative democracy operating side-by-side in the Salt Lake County domestic violence court, and her suggestion that battered women’s movement understandings are incorporated in the adjudication of the domestic violence court seems apparent from her examples. She theorizes rather optimistically that deliberative democracy likely occurs in other problem-solving courts as well, not just in domestic violence courts. If deliberative democracy is an apt description of processes occurring as specialized criminal courts continue to operate and expand in American society and elsewhere, then one would have to assume that each group of individuals, or even each individual, involved in specialized courts is able to participate in the dialogue
occurring in the public sphere. But Mirchandani researched only one court program, the Salt Lake County domestic violence court, thus her conclusion that this is true of other problem-solving courts is flawed because she cannot present data beyond her case study to support this conclusion. Mirchandani's data collection, because it was restricted to one domestic violence court program, is not capable of revealing differences between domestic violence courts in various contexts, nor differences between domestic violence courts and other types of problem-solving courts in terms of the character of social movement influence, and the nature of hierarchical power relations among court participants which are largely shaped by such influence.

Mirchandani (2008) conflates social movement processes that shaped domestic violence courts with movement processes that shaped other problem-solving courts such as drug courts and mental health courts. The domestic violence court was largely shaped by the influence of the battered women's movement, and protection of a battered woman victim from her male offender was the key justification for state intervention. Such victimization is not the justification for state intervention initiated in two of the major new problem-solving courts: drug courts and mental health courts. Although organizations claiming to speak for those suffering from drug addiction and mental illness have influenced the ideology and processes of these specialty courts, legal professionals operating in formal roles, mainly judges, were the driving forces behind their introduction (Berman and Feinblatt, 2005; Nolan, 2001). Another limitation of Mirchandani’s analysis of only one court site is that there is no way to investigate the spread of social movement influence through a number of sites, and discover via
comparison what contextual factors might limit the level of social movement influence.

Nolan’s (2001) ethnography of drug courts and his (1998) description of the therapeutic ethos now guiding state institutions enable powerful criticisms of the idea of justice occurring in these courts. He described the major players in drug courts in some detail, describing how they process offenders and how they understand the ideology of the courts. Yet even Nolan’s work describes general sketches of court operations rather than detailed descriptions of everyday work activities of professionals operating specialized courts. Cross-court comparisons are not the focus of his work, rather a general description of drug courts and theoretical analysis of the drug court movement are presented. Currently, there is only limited research available regarding mental health courts, much of it is descriptive, and almost all is written from a legal, psychological, social work, or criminal justice practitioner perspective (see for instance Steadman et al, 2005; Redlich et al, 2006; Goss, 2008).

**Studying the Power of Professionals: Social Movement, Social Construction, and Social Control**

Research on specialized criminal courts has not fully considered the varying influences on the different kinds of problem-solving courts. Problem-solving courts for domestic violence, drug addiction, and mental illness are currently understood by criminal justice, law, and criminological scholars as following the same model in dealing with a perceived social problem. But the fundamental differences in criminal offense and target population must be described in more detail rather than lumped together under one heading. Berman and Feinblatt (2005) focus on community courts, domestic-violence
courts, and drug courts as following the same problem-solving court model; Miller and Johnson (2009) examine a prisoner reentry court, a forensic diversion program, and a sex offender reentry program as problem-solving courts; Higgins and Mackinem (2009) include articles on adult and juvenile drug courts, DWI courts, mental health courts, and domestic violence courts as problem-solving courts. All of these examples acknowledge the different issues involved with these populations and suggest that the problem-solving courts must adapt. But the same model is considered appropriate for dealing with these various problems in a criminal court setting, thus the overriding concern of these works is determining how to make the model work best for the various types of court participants, rather than a concern for determining the differential effects of the programs on various populations, and for recognizing their very different issues, histories of being socially controlled, and positions in the context of the wider society.

The problem-solving courts literature has not fully explored issues of difference in court programs developed to socially control one population, such as wife batterers, compared to such programs aiming to control another population with a different set of issues and a different history of being socially controlled, such as illicit drug users or persons considered mentally ill. Also, the sociological literature on the problem-solving court phenomenon has not thoroughly investigated the implications of a social movement that is part of an institution constructing a social problem and addressing the problem in a way that socially controls another group of individuals, but is purportedly in their best interests, rather than a social movement such as the battered women's movement forming from without an institution to affect change within it on behalf of victims, many of whom
were part of the movement.

The feminist movement, and the battered women's movement within, represent a social movement made up of an oppressed social group who band together to engage in protest in order to cause institutional change in criminal justice and legal systems from outside of these institutions. The social movement literature typically defines social movements in this way. Snow, Soule, and Kriesi (2004) define social movements as "collectivities acting with some degree of organization and continuity outside of institutional or organizational channels for the purpose of challenging or defending extant authority, whether it is institutionally or culturally based, in the group, organization, society, culture, or world order of which they are a part" (pg.11, emphasis added). The problem-solving courts movement leading to drug and mental health courts, on the other hand, was not a social movement in the sense of an identity movement of an oppressed group from without an institution, but rather a movement of legal professionals that developed from a position of power in the institutional hierarchy, albeit not at the very highest levels of authority. Studying the influence of a movement of judges and other criminal justice professionals must include consideration of power exerted from above and aimed at solving a purported social problem. With the advent and implementation of mental health courts, these professionals exercised power from above and targeted a group who they were socially controlling, mentally ill criminal offenders. Thus, their understandings of the population they consider mentally ill are a crucial consideration when researching how mental health court programs conduct their activities.

The conceptualization of social movements in the present study is drawn from the
social problems perspective (Heiner, 2010), rather than the more narrow conceptualization used in much of the social movement literature mentioned above. Heiner (2010) explains that from the social problems perspective, a "social movement organization" can be defined as a group of people who recognize a phenomenon as bad or undesirable, and then mobilize to remedy it. The social problems perspective was developed by Spector and Kitsuse (1977), who will be discussed in more detail below. Using this perspective, both the battered women's movement and the problem-solving courts movement can be studied sociologically as social movements.

Several prominent sociologists have developed the sociological analysis of how social movements construct and address social problems. For instance, Howard Becker (1963) developed an approach to understanding how social actors are able to influence institutions of law to address problems of crime and deviant behavior. Although he did not specifically refer to the sociological concept of social movements, Becker identified "moral entrepreneurs," who ensure that systems of law are institutionalized and enforced through their enterprising efforts. Moral entrepreneurs play a key role in defining deviant and criminal behaviors in a society, and crusade for action taken against behaviors that they regard as immoral or criminal. Becker identified two types of moral entrepreneurs: rule creators and rule enforcers. His theory has relevance to the study of therapeutic jurisprudence and its influence on the creation of an entirely new type of criminal court for drug offenders and offenders with mental illness. Regarding drug court and mental health court instigation, the rule creators are the judges and legal scholars who recognized the problem of repeat offenders with mental illnesses and drug addictions and then
pushed for the creation of a new type of court based on therapeutic principles. The rule enforcers of drug and mental health courts are the staff operating at each court location, including judges, state attorneys, defense attorneys, probation officers, social workers, and others who work together to ensure that offender participants comply with court-ordered treatment plans. Some judges and officials may even be both rule creators driving the introduction of new problem-solving courts and rule enforcers adjudicating law within one.

Spector and Kitsuse (1977) developed a theoretical perspective for the sociological study of social problems that focuses on the claims-making activities of social movement actors rather than focusing on determining and describing social problems, as traditional sociology had done. By using Spector and Kitsuse's approach, one can analyze how the battered women's movement created definitions and understandings of domestic violence that were eventually communicated to legislators, the police, and the judiciary. Spector and Kitsuse theorized that the study of a social problem such as domestic violence should consist of the study of the entire process of claims making, which they contended goes through a discernible set of chronologically ordered stages that they referred to as "the natural history of social problems." This process includes the initial formation of the movement around definitions of a social problem, followed by initial activity by social movement advocates aimed at influencing a state response, leading to the acceptance of social movement understandings by the state, which then formulates an official response to the problem. The construction of the social problem of domestic violence can thus be studied from its inception consisting of
initial claims making by battered women's movement activists to its acceptance by state policy makers and subsequent state responses to domestic violence, including the formation of specialized courts.

When a group such as the battered women's movement engages in claims making regarding phenomena they view as problematic for society and requiring some sort of action, the group can be said to claim "ownership" of the social problem, referring to the idea that they group claims the right to define a social problem, to control the problem, and to benefit from their particular definition (Gusfield, 1989). As described above, the battered women's movement influenced state intervention in the private sphere of domestic relations. The battered women's movement could not directly control the problem of domestic violence, but working in the domain of the women's movement they were able to influence professionals working in the domain of law who could attempt to directly control the problem by establishing domestic violence courts. Drug courts and mental health courts were created and influenced by professionals working in the domain of law who claimed ownership of the problem of repeat offenders in the criminal justice system understood as suffering from drug addictions or mental illnesses.

Figert (1996) shows how people working in various domains, such as the domain of the women's movement, the domain of law, and the domain of medical science, can come into conflict and create controversy if their respective ownership claims of a social problem do not coincide. She details the controversy involving the inclusion of pre-menstrual syndrome in the Diagnostic and Statistical Manual of the American Psychiatric Association as people operating in the woman domain, the science domain, and the
mental health domain made ownership claims regarding pre-menstrual syndrome that did not agree on what the phenomenon is and how it should be addressed. As discussed earlier, Nolan (2001) suggested that the advent of drug courts in America criminal jurisprudence represents the meaning systems of two institutional spheres coming together in a way not seen before, as the moral/religious perspective of the legal system merged with the therapeutic paradigm of medicine. Rather than ownership claims being made from two separate professional domains, Nolan can be understood as referring to an ownership claim from the domain of criminal justice made in a way that attempts to follow the paradigm of medicine. But he points out that this merging turns away from alternatives proposed by some health and legal professionals, in that drug courts, because they include practices and conceptualizations of mental health professionals regarding drug addiction in court operations, have effectively neutralized the arguments of people working in domains outside of criminal justice who argue for legalizing the use of all drugs and addressing drug addiction as a health problem rather than a criminal justice matter.

Since deinstitutionalization, professionals in the domain of law have worked in a realm of social control previously located within the domain of medicine, and, more specifically, psychiatry. Langman and Richman (1987) explain how in the past American psychiatry played a pivotal institutional role in determining which persons who break laws are willing violators, and thus criminal, and which persons who break laws are unwilling violators, and thus ill, and in providing a social control mechanism for the later. From the early 19th Century until the impact of deinstitutionalization, asylum psychiatry
was largely responsible for the social control of those judged ill rather than criminal, which served the needs of the bourgeois in American capitalist society. Asylum psychiatry provided a relatively cheap and efficient method for managing the population of persons judged mentally ill, the members of which often lacked financial and social resources (Langman and Richman, 1987). Using Foucault's (1978) conceptualization, asylum psychiatry can be said to have exercised bio-power and engaged in a governmental technique for the social control of a population of persons understood as abnormal. After deinstitutionalization, mental hospitals run by psychiatrists were no longer relied upon heavily for the social control of such persons, and many previously residing in state mental hospitals were now residing in jails and prisons, as discussed above. But today psychiatrists and other mental health professionals continue to play a key role for many cases in making the determination of whether an offender should be considered criminal or ill, although now this role is largely played within the domain of criminal justice systems (Erickson and Erickson, 2008). Some psychiatrists continue to work in state hospitals, but state hospital populations of persons with mental illness and, consequently, the numbers of state hospital psychiatrists have declined dramatically (Cockerham, 2006; Langman and Richman, 1987).

Psychiatry as a profession has gone through dramatic changes in the United States over the past one hundred years or so, from the introduction of the "talking cure" of psychoanalysis by Freud to a recommittal to biological explanations of behavior as the influence of psychoanalysis waned in the later 20th century. Psychiatry lost its monopoly on mental health treatment as psychologists and social workers began to make
professional gains in legitimacy as practitioners (Langman and Richman, 1987). But, regardless of trends in theoretical and practical orientation, psychiatry has often been called upon to provide expert opinion to the courts in deciding criminal justice matters (Erickson and Erickson, 2008). At the same time, criminal justice systems rely on psychiatrists and therapeutic psychologists and social workers to provide medication and treatment to incarcerated criminal offenders and probationers mandated to engage in treatment. Today many psychologists and clinical social workers provide therapeutic treatment that has roots in Freudian psychoanalysis. Therapeutic psychologists and social workers have joined psychiatrists in providing explanations of and treatment for problematic behavior to American institutions. Through their work activities, psychiatrists, psychologists, and social workers play an important role in the social construction of mental illness within the criminal justice system (Erickson and Erickson, 2008). Judges, legal professionals, and criminal justice officials are thus affected by behavioral science understandings of behavior, and those who made up the therapeutic jurisprudence movement drew heavily from psychiatrists and clinicians in constructing the problem of mental illness in criminal justice systems and in developing the problem-solving court model to address the issue (Wexler, 1990).

Erickson and Erickson (2008) argue that the meaning of mental illness has been socially constructed from in the past being understood as a medical problem requiring prolonged hospitalization to currently being understood as individual failing often leading to behavior requiring criminal justice intervention. They argue that as a society we have *criminalized* mental illness. They also refer to the work of Penrose (described in Torrey,
1997), who developed the "balloon theory" of social control of the mentally ill. There is a complex relationship between criminal justice and mental health systems over time, but using statistical data Penrose demonstrated that, generally speaking, if prison populations are relatively large, then mental hospital populations tend to be relatively small, and vice-versa. Currently the U.S. is in an era of criminalizing mental illness, with large prison populations and very small mental hospital populations. As social constructionists, Erickson and Erickson (2008) emphasize the importance of "unmasking" the taken-for-granted reality of professional understandings of mental illness to reveal their consequences, both intended and unintended. It is important, then, to thoroughly investigate the social construction of mental illness by professionals who design, implement, and operate mental health courts.

In terms of Spector and Kitsuse's (1977) natural history of social problems, the development of mental health courts somewhat bypassed the stage of influencing a state response, as the movement pushing for the establishment of the courts contained a number of legal officials who were in a position to introduce a novel state response in those court jurisdictions in which they had influence. Although aware of other factors outside the legal system which affected the revolving door phenomenon, the social problem which the judges and criminal justice officials specifically addressed was contained within their domain of work. Spector and Kitsuse modeled their approach after the sociology of occupations, which focuses on describing work activity, including elaborating on its various forms and developing concepts to explain its content and variations. Just as the sociology of occupations focuses on work activity, Spector and
Kitsuse's approach to social problems focuses on claims-making activity. This point is raised here because, as with the idea that many judges and other legal officials involved with drug and mental health courts may have acted as both the rule creators and rule enforcers of Becker's theory, so too can these judges and legal officials be understood from both a sociology of occupations focus on their work activity, and a social problems focus on their claims-making activity. At times, observable activity of these professionals is both claims-making and work. Judges' and legal officials' claims-making activity which argued the need for specialized courts for offenders with drug addictions and mental illnesses may have preceded the initiation of work activity in specialized courts, but such claims-making is also on-going and often part of work activities of professionals as they keep their specialized courts funded and operating and also influence the growth of specialized criminal courts within their geographic area and nationwide.

The Present Study

In the present study I present ethnography of the mental health courts (MHCs) in a Midwestern state, covering all operating MHC programs from the time a statewide survey was conducted in early 2010. The survey was the initial stage of a funded study of MHCs in the state. Before the survey, I had completed a pilot study in the spring of 2008 at one of the sites, conducting six months of court observations and four individual interviews with professionals who ran the MHC program. Following the survey, I obtained permission from a professional at each of the nine existing MHCs to make site visits in order to observe the MHC in operation as cases were processed, as well as to
conduct individual and focus group interviews with MHC staff. On the invitation of a professional at one of the sites, for two years I attended regular meetings of a professional organization aimed at promoting the use of MHCs. I also conducted survey interviews with participants at three of the MHC programs who made time to speak with me after their court hearings. This dissertation study focuses on analyzing ethnographic data gathered in the field from observations of MHCs and interviews of professionals during the funded study and the pilot study, but I also refer to data gathered from the initial statewide survey, the observations of the professional organization, and the survey interviews of participants throughout this work in order to give a fuller picture of what was happening within, between, and around the nine MHC programs. In addition, I collected available textual materials from the nine MHC programs, including bureaucratic forms, memos regarding operations and numbers, mental health tools, and informational materials distributed by the programs to the public. I recorded the use of such textual documents by professionals in conducting work activities, and included them in the ethnographic data analysis. To the author's knowledge, this dissertation study is the first ethnographic study of an entire mental health court system in a state government-bounded geographical area, unless one has been conducted but is not available among the literature on problem-solving courts.

Below I focus on the work activities of professionals and on their understandings of their mental health court program efforts and of the program participants considered mentally ill, and consider how those understandings and work activities may move from court jurisdiction to court jurisdiction within the state. MHC professional work activities
and understandings are an important area in need of investigation because, as I alluded to above, there is a tendency in the academic literature to view the problem-solving court model as applicable to a variety of social issues and to present how the model can be made to work on any one of various issues, rather than to conduct detailed study of each specific type of program targeting a specific population, such as "the mentally ill," which considers specialized program efforts in the context of a unique history of social control for that population. Studying the transfer of work understandings and activities from site to site is important because the relative newness of mental health courts in this Midwestern state provides an opportunity to investigate the institutional transfer of social movement ideas, from when such ideas were first introduced by actors in the state, to their spread from site to site within an area that is bounded by geographically-based political structure. It is my hope that this dissertation study will contribute to the knowledge gap regarding how workers in mental health court programs understand and affect mentally ill offenders, while also contributing to studies of social movements from the problem solving perspective.

The professional workers who participated in the individual and focus group interviews operate a court program in which the key event can be viewed by the public, meaning that worker names and program participant names are often stated and made part of a public record. Although part of a public record, I adhered to a policy of confidentiality for both workers and program participants in conducting my dissertation research, and will do so in this dissertation presentation. Only job titles are used in the dissertation as they were in the field, and some of these are made more general for
presentation. Throughout this dissertation, I use pseudonyms to present workers, participants, agencies, and government jurisdictions.

*Method and Research Questions*

Ethnography, or field research, is research in which a sociologist engages in present-time, face-to-face interaction in a setting that is the subject of inquiry (Warren and Karner, 2010). The ethnographer enters into the setting and spends time interacting with people in the setting and observing what is going on among them. Some ethnographers jot brief notes while in the setting and combine these with more extensive notes made soon after leaving the setting; these field notes become the data for ethnographic analysis (Emerson, Fretz, and Shaw, 1995). Ethnographic research can enable an understanding of the mundane, everyday operations of a type of problem-solving court that goes beyond the institutional descriptions provided by judges, legal officials, and other professionals, allowing for a fuller understanding of court processes drawn from the perspective of all types of persons involved in mental health courts as they conduct work activities, not just judges and lawyers, but probation officers, social workers, community activists, and, where possible, program participants. I aimed for the field notes data to provide a level of detail enabling meaningful cross-jurisdictional comparisons of the mental health courts.

Doing ethnography, a researcher does not test hypotheses, but can enter the field asking basic research questions (Warren and Karner, 2010). For this study I attempted to answer the following research questions:

- How do professionals in mental health courts operate the programs?
• How do these professionals understand and coordinate their everyday work activities?

• How do the professional workers understand and process the criminal defendants they encounter?

• What are the results of such processing for MHC participants and for those defendants who do not eventually enter a MHC program?

• How do the professionals promote the use of MHCs?

In trying to answer these research questions, I was influenced by several important qualitative researchers, yet was not wed to any one specific method or theory drawn from their work. I was much more interested in finding out what people were actually doing in programs referred to as mental health courts than in displaying the steps of a specific methodological practice or in verifying a pre-existing theory. I borrowed from the work of several researchers as needed in carrying out my project.

One important influence came from the work of Dorothy Smith (1990; 2005). In Institutional Ethnography: A Sociology for People, Smith (2005) explained her method focuses on discovering the everyday work activities of research subjects as they live and understand those everyday activities, their "lived actualities." For example, a work setting can be researched sociologically by discovering the everyday lived actualities of workers, including their everyday work activities, their institutional discourse often represented textually, and their understandings of their everyday activities and discourse. The workers become a source of knowledge, and everyday local relations between
workers can be "mapped," working through and outwards from a local site, discovering trans-local connections, and tracing upwards hierarchically in terms of power to the "ruling relations," which are present in and organize the workers' experience, but are not always visible. Smith (1990) describes the concept of "ruling relations" as "that total complex of activities, differentiated into many spheres, by which our kind of society is ruled, managed, and administered" (page 14). In further elaboration Smith (2005) describes them as "textually mediated" connecting people across time and space thus organizing everyday life - "the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them" (page 10). Smith argues that sociological inquiry beginning from the standpoint or position of the worker can make visible how extralocal ruling relations organize the everyday.

Smith's (2005) method is grounded in materialism drawn from Marx and aims to describe actual social relations as they occur in the everyday. I found that the idea of describing everyday social relations when conducting field work was particularly appealing, as I was studying people engaged in the work of newly established organizations within government institutions. Social scientists often refer to 'the state,' or 'the government', or 'the criminal justice system' as if speaking of monolithic entities, thus denying the messy reality that 'the state' is many individuals engaged in living their everyday lives spread over a number of organizations. If we as researchers want to best understand what exactly the state is doing in establishing mental health courts, then we should start by detailing the everyday lives of people who are engaged in work as
representatives of the state at various sites.

Influenced by Smith's (2005) approach to data collection in the field, I refrained from designing data collection to look for specific theoretical concepts, and instead focused on recording the observable everyday work activities of professionals who operate the mental health courts and interact with each other and with persons whom they consider offenders with mental illness. Of course, in the field, as a graduate student who had studied the work of a number of researchers and their methods, I found that observations and interview comments at times reminded me of sociological concepts, such as "moral entrepreneurs" and "claims-making" described above. But I refrained from looking for or recording such concepts during observations and interviews, and instead focused on describing how professionals, some from mental health and others from criminal justice backgrounds, operate the mental health court programs. This included observing and noting the everyday operations of each mental health court as the professionals processed offenders, observing and noting the work of these same professionals in organizing a professional association, asking the professionals to describe their work activities in focus group and individual interviews, and gathering available textual materials which they rely upon in operating MHC programs and in promoting their use.

When writing of "everyday work activities" Smith (2005) - an important feminist who developed theory recognizing women's standpoint in society - includes non-paid work activities outside of employment. She refers to this as the “generous” definition of work activity which includes any human activity that takes time and effort. She
advocates especially exploring the work activity of persons on the bottom of the institutional order, whose knowledge and standpoint is often ignored by institutional actors in higher hierarchical positions and by researchers studying institutions. I did obtain some data from observing, speaking with, and conducting brief structured interviews with thirty-two participants, but I gathered most of the data from observing and interviewing over eighty professionals who worked in the MHCs. My analysis of professional work does not include Smith's (2005) generous definition of work, and I did not focus on exploring the everyday work activities of professionals beyond working at MHC sites with participants and each other. Many work activities of professionals alone, away from the court, or with participants were not observable given limits on my data collection to staff meetings and court calls. But during interviews and times of informal contact with professionals I was able to gain information about activities that I could not actually observe, such as meeting in private with a participant for evaluation or counseling purposes, taking participants to other organizations to receive services, reading over information about cases in one's office, sharing e-mails and telephone calls with each other to discuss participants throughout the week, and others. My observations also included recording activities and interactions at times of work before and after events, what I refer to as in-between times, such as the time professionals spend chatting with each other before the start of a staff meeting, or waiting in the audience area of a courthouse with participants before a hearing begins. I found that during in-between times the professionals I studied displayed work activities and made candid statements that were sometimes more revealing than what was observed during staff meetings and
court calls and what was said during the focus group and individual interviews.

There were several reasons for the research being focused on professionals. First, like all research studies, this one was limited by time and resources. The study was funded for the purpose of comparing the structure and operations of the MHC programs, which meant researching how professionals had organized and were running them. Although I attempted to also research participants, at several sites I was unable to receive permission to interview them, and those sites that did give permission to interview participants would only allow me to do so with those attending hearings. I was not allowed any contact with the participants in rehabilitation facilities or in jail. Second, I was not a participant-observer as I did not actually work at the mental health courts, but, as a way to gain entrée, I would talk with professionals at the sites about my past work in rehabilitation programs as a way to develop rapport and make them comfortable with my attending staff meetings. I was able to gain a behind-the-scenes, insider's view of the professionals' work world in a way that would not have been possible with mentally ill offenders. Finally, my past research interests focused on the police and how they work with persons with mental illness when encountered. The present study was a further exploration of workers in the criminal justice system and how they process persons with mental illness. I recognize the power that criminal justice and mental health workers wield in defining and affecting the lives of persons with mental illness, and study such exercises of power out of concern for how persons with mental illness are treated by people working in institutions of society.

Smith (2005) states that the institutional ethnographer should avoid constructing
theory based on the ethnography, as this may cause the researcher to stop exploring the wide variety of perspectives and experience of different persons in different positions of the institutional order. This dissertation focused on professionals, but considered their activities and understandings from various work roles at nine different sites, thus a multitude of professional perspectives informed the data analysis. Smith (2005) also criticizes how the theoretical concepts of sociological researchers objectify the experience of informants in a way that separates researchers from the informants’ actual, everyday experiences. I did find connections and map outward from everyday activities of the professional workers in MHC programs to the trans-local institutional relations around them, including to the ruling relations as Smith instructs. These connections will be discussed in later chapters. But as I coded ethnographic data over time, I began to recognize an organizing principle (Murchison, 2010) of MHCs recognizable in the language and work activities of professionals I studied. I saw no reason to avoid exploring a concept that explained what was going on at the mental health courts, despite Smith’s objections that this causes a researcher to bypass investigatory work discovering social organization.

In my opinion, if a concept is drawn from ethnographic data that may be worked into a theory, it is a matter of trying to include multiple viewpoints in developing a theory, while recognizing its limitations in terms of what it does or does not explain, rather than avoiding development of a theory during data collection in the name of recognizing and exploring many different viewpoints. Any theory can be evaluated by other social researchers in terms of how much it does or does not explain the everyday
activities of persons at sites of investigation, in terms of how much it includes multiple viewpoints, and in terms of how much it explains social organization from points of hierarchically-exercised power or relations of ruling. In other words, the problem with the development of theoretical concepts in social science is largely one of validity, rather than objectification. But Smith's (1990; 2005) concern that objectification is problematic when it causes researchers to fail to recognize the everyday reality of informants is an important one, and part of her broader critique of male-dominated knowledge. If the ethnographic researcher develops a theory, then it should be based on the actual doings and understandings of actual people at sites of investigation, rather than minimizing, ignoring, or misrepresenting them.

The analysis of professional work presented here also includes consideration of the importance of institutional texts used, produced, and altered by professionals. The social problems perspective (Spector and Kitsuse, 1977) recognizes the importance of textual documents in making claims, while Smith (2005) explicates the importance of including and analyzing institutional text in her ethnographic method. I include consideration of the use of text in this study in a way similar to that suggested by Smith.

In addition to work activities, I also focused on how professionals understood their work and the program participants, whom they referred to as “clients.” I observed and recorded common understandings shared by mental health and legal professionals during interactions occurring at staff meetings and court hearings, and explored these understandings during interviews. Generally, an aim of ethnography is to see the field setting through the eyes of the people engaged in social action there (Hammersley and
Atkinson, 1995), so my aim was to understand the activities of mental health courts from the perspective of people who organized and engaged in them. Both legal and mental health professionals have an understanding of participants that shapes their everyday work activities. At their work sites they interact with each other and participants and engage in the specific workplace culture (Volto, 2008) of their MHC program. The workplace cultures present in organizations of criminal justice and mental health institutions become in the mental health court a culture of what I will refer to as a “blended organization,” a model of organization attempting to solve a social problem thru linkages between multiple institutions, and thus sharing ideas from the culture of those institutions. Because the mental health court staff at the each of the nine sites included both legal and mental health professionals, the research questions stated above enable investigation of Erickson and Erickson's (2008) contention that social constructions of persons with mental health issues in criminal justice contexts are cast from a moral perspective of individual failing rather than a medical perspective of treating disease.

The presence of recently organized mental health court programs throughout Midwestern state offered a unique opportunity to explore professionals from two institutional backgrounds sharing a newly developed workplace culture at a variety of sites, and centered on understandings of mentally ill criminal offenders.

Generally, ethnographic researchers begin doing qualitative analysis shortly after they initiate data collection, as ethnographic data analysis is an inductive process that develops continually throughout field research, although it may not be concluded until well after data collection in the field has ended (Hammersley and Atkinson, 1995;
Warren and Karner, 2010). The research questions stated above were general enough that I was able to explore how best to answer them during my field work. I pursued more specific questions as ideas were introduced to me by professionals either in conversation or during observation.

My process of analyzing the field notes and interview transcripts as I conducted the study was similar to the grounded theory approach (Glaser and Strauss, 1967; Strauss and Corbin, 1990). Proponents of grounded theory stress using a comparative method which may compare among humans grouped at any level - individual, organizational, institutional, or societal (Glaser and Strauss, 1967; Strauss and Corbin, 1990). When conducting data analysis, I recognized the viewpoints of multiple informants and made comparisons among the nine sites. During graduate education I had been trained in basic methods of doing qualitative research, such as writing field notes, interviewing, and coding data. As Charmaz (2001) explains, when Glaser and Strauss (1968) introduced grounded theory they made explicit specific procedures and strategies that had previously been implicit among qualitative researchers. As I gathered data, I conducted initial open coding, and developed categories and subcategories from the initial codes. I tried to develop my theoretical sensitivity to the data unbiased by preexisting literature on mental health courts. I discovered linkages between categories and subcategories based on the actions and interactions of professionals as they worked for and with participants, and eventually found a story line that relied on a specific core category (Strauss and Corbin, 1990). I was not focused on developing an explanatory theory until near the end of data analysis, and the theory I present is restricted to the micro-level of interaction.
The grounded theory method (Glaser and Strauss, 1967; Strauss and Corbin, 1990) proposes inductively developing a single theory to explain the data collected. The theory I developed during ethnographic data analysis explains the mental health court at the micro-level of interaction among professionals and participants, but then I use it to criticize the claims-making (Spector and Kitsuse, 1977) of the professionals whom I observed promoting the use of MHCs, as well as to criticize claims-making published by scholars and other proponents of mental health courts nationwide. Thus I did not develop a theory explaining all of my data as proponents of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990) suggest a researcher should do. The theory I developed is not explanatory of but rather enables criticism of claims-making at the meso-level of interaction (Fine, 2012) among the Midwestern MHC organizations, and at the macro-level of interaction between the socio-legal movement promoting "problem-solving courts" (Miller and Johnson, 2009), the federal government, and state governments nationwide, including Midwestern state.

My methodological approach to data collection and analysis on this study was influenced by institutional ethnography and grounded theory, but the theoretical approach was largely influenced by the perspective of symbolic interactionism, which studies how human actors construct and respond to their worlds on the basis of meanings about phenomena that they develop through shared symbols, such as language, in interactional processes (Rudy, 1986). Another important researcher who heavily influenced my work on this study was Erving Goffman, whose ethnography of a mental hospital in Asylums (1961) is a classic work of the symbolic interactionist perspective. The observational
methods of field research are particularly suited for research from the perspective of symbolic interactionism (Rudy, 1986). The professionals whom I studied operate the MHC program through processes of interaction which rely upon shared language, which contains their understandings. One aim of this study is to analyze the shared language and processes of mental health court interactions in order to discover the meaning of their work for the professionals.

*The Theory of Performance*

As I gathered data from the various sites I began to recognize that one of the initial categories developed through coding, and drawn from the language of informants, explained much of what was going on at the MHCs. I named this category *performance* which refers to *how professionals primarily understand participants and referrals in terms of their ability to perform in the program* - their ability to follow guidelines of the MHC while not getting into further trouble. Performance understandings organize how professionals do the work of the mental health court, which includes deciding which referrals to accept into the program, determining how best to provide services for and influence the behavior of participants, evaluating which participants are doing well and which are doing poorly in the program, and making decisions affecting participant outcomes based on these evaluations. After about a year of collecting data for the statewide study I began to recognize the importance of performance and began to explore it further during later observations and interviews.

Professionals develop understandings of performance during two modes of interaction with each referral or participant of the mental health court program: personal
and textual. Personal interaction refers to professionals engaging in direct, shared communication with the referral/participant, primarily face-to-face conversation. Textual interaction refers to professionals reading, relying upon, and adding to bureaucratic documents that are each tied to an individual referral/participant, such as court filings and case files, through which professionals from both criminal justice and mental health perspectives share understandings about referrals and participants and accomplish their processing. An institutional image of each individual criminal offender in a court jurisdiction is constructed through textual interaction of workers in the local criminal justice organization. This image construction represents an official version of who the offender is and what specific crime events he has enacted. Similarly, through textual interaction workers in mental health agencies create an institutional image of each person with mental illness whom they encounter which represents the specific medical illnesses, behavioral actions, service needs, and program outcomes for each individual. In the blended organizational environment of Midwestern MHCs, the criminal justice and mental health images of the offender-as-case are merged for both types of professionals, such that they do not see contradictions in their respective approaches to the individual offender.

As I explain in more detail below, I utilize the thought of Goffman (1959) and of Smith (2005) in theorizing the notion of performance as an organizing principle of the work activities of professionals in Midwestern mental health courts. One can analyze professional understandings of participant performance emerging in personal interaction using Goffman's (1959) dramaturgical method, which relies on analogy of the theater.
Dramaturgical analysis is a useful way to illuminate the structure of social interactions occurring in institutional environments, provided the researcher recognizes the limitations of theory based on the approach (Goffman, 1959). On the other hand, one can analyze professional understandings of participant performance emerging from the textual documents that represent the individual referral/participant using Smith's (2005) institutional ethnography, which includes discovering how text enables the accomplishment of work in institutions and mediates power relations. Smith (2005) describes how workers engaged in "text-reader conversations" use institutional discourse in texts to describe actualities of experience so that they become institutionally actionable. As she puts it, in this process the worker and the subject of institutional work "disappear" into institutional discourse, which often ignores actualities of situations, race, class, and gender. I modify the idea of the subject disappearing, arguing instead that the professional worker in criminal justice institutions may disappear, but the subject does not disappear. Rather, the subject is continuously reconstructed into an institutional image, the offender-as-case, recognizable to the professional as representative of an embodied individual who is the subject of work, the "client" as professionals say. The individual criminal offender performs in personal interaction when applying to the program as a referral on meeting social workers, public defenders, and the judge, and, if admitted, when participating in the program. Also, the individual offender-as-case existing in textual documents performs during referral to and participation in the MHC.

Performance understandings organize the mental health court as a filter, allowing some referred offenders to be admitted into a program that provides a wide variety of
mental health services and oversees their implementation, whereas other referrals are not accepted and, if they do not have their charges dropped, or are not acquitted, or are not given probation, then they must receive limited mental health services, if they receive any at all, while incarcerated in jail or prison. After some offenders are accepted into the program and become participants, the filtering process of the mental health court based on performance continues, as some participants stay in the program for a year or two and then “graduate” successfully, whereas others are considered unsuccessful, and terminated from the program. Some who are terminated as unsuccessful are not given further supervision under probation and their case processing ends, others are put into regular probation, and still others are sent to incarceration in jail or prison for not successfully completing the mental health court program. I contend that all of these processes occur as a result of performance, the fundamental organizing principle of mental health courts. Much of the dissertation that follows is presented to support this basic contention.

Limitations of the Present Dissertation Study

This study focuses on how professionals understand and conduct their work in mental health courts with criminal offenders diagnosed with mental illness. It does not include measures to investigate whether or not the criminal offenders have valid mental illnesses. I make no claims in this research regarding the validity of mental illness among the referrals and participants involved, rather I analyze what was observed and comment on the implications of actions taken by professionals if the persons they process do have valid mental illnesses.

My view toward what I refer to as 'the reality of mental illness' has been shaped
by seven years of professional experience as a mental health worker in rehabilitation programs working with adults diagnosed with severe mental illness, and by ten years of studying the phenomena of mental illness from a sociological perspective at the graduate level. These time periods ran consecutively rather than concurrently, thus through work or through scholarship I have considered the reality of mental illness for seventeen years. Through work and scholarship I have come to recognize that the reality of mental illness includes people in our population having diseases that are severe mental illnesses (SMI): schizophrenia, bi-polar disorder, and major depression. My current view toward the reality of mental illness has been influenced significantly by the sociologist Allan V. Horwitz (2002) whose work investigates the validity of mental illness in the American population while also detailing the ways that our society socially constructs mental illness beyond the boundaries of validity. This view toward mental illness is one of "weak" social constructionism (Lee, 2012), meaning Horwitz and others recognize that knowledge, including knowledge about mental illness, is "not disinterested and apolitical" (Lee, 2012), but some constructions of phenomena are better than others. However, my graduate training in qualitative research methods enabled me to recognize that to do a proper ethnography of the mental health courts I must set aside my preconceived notions regarding the reality of mental illness while conducting the research. This is what proponents of grounded theory refer to as developing 'theoretical sensitivity' (Glaser and Strauss, 1967; Strauss and Corbin, 1990), which I mentioned above. Thus, the ethnographic data collection and analysis did not attempt to discover the validity of severe mental illness among the MHC referrals and participants who were
observed and interviewed. Some sites did provide de-identified participant data regarding mental illness diagnoses, which will be referred to later. After presentation of data analysis below, the implications of ethnographic findings are discussed, and MHC programs criticized, in terms of there being a population of persons in Midwestern with severe mental illness, whether criminalized or not.

As stated above, like any study this one was limited by time and resources. An agency provided funding for a state-wide study in part so that a qualitative researcher could make three to six site visits to all existing MHCs in Midwestern as of spring 2010 in order to compare the programs, with data collection to be conducted within one year. Bureaucratic delays caused the funding agency to eventually extend the data collection period to two years, but it did not increase funding. As the qualitative researcher solely responsible for making the site visits, I had to pay for travel for on-site data collection out of my own pocket after funding ran out, and I also paid for travel for the pilot study and for observations of the professional organization. Being a graduate student with limited means and temporal limitations on earning a degree, I did not have the money and time to do as much ethnographic observation and interviewing as I would have preferred. This is one reason that the study is limited mostly to professionals, rather than also focusing on participants, as I described above.

Researchers utilizing ethnography as a method typically focus on one site; such researchers may criticize my dissertation study for not conducting an in-depth ethnography at one site and for gaining limited ethnographic data at a number of the sites. I would address such criticisms by contending that doing a multi-site ethnography greatly
increased the richness of the ethnographic data overall and allowed for important site-to-site comparisons of professionals' actions and understandings that would not be possible if focusing on only one site. Even though three of the nine MHC sites significantly limited my access to data collection through bureaucratic delay, at each of these programs I was still able to interview professionals and observe them in action at work, and this provided valuable ethnographic data despite the limitations.

*The Dissertation Chapters that Follow*

In this first chapter of the dissertation I introduced the reader to the topic of mental health courts and how they may be studied sociologically, described how I used ethnographic methods to investigate all existing MHC programs in a Midwestern state starting from the level of everyday work activity and micro-interaction, and introduced the theory of performance as the organizing principle of Midwestern MHCs. In the second chapter I provide detailed description of methods utilized for this study, and describe the basic organization of Midwestern MHC programs and professional roles. Chapter Three is where I present ethnographic and survey data describing the program structure, professional work activities, and community context of each MHC program. In Chapter Four I describe how mental health courts were established in Midwestern as a particular organizational form, and focus on more extensive investigation of professional work roles, describing and analyzing how work activities associated with professional roles compared and contrasted across sites.

The work activities and understandings of MHC professionals are presented in Chapter Five, where I rely on narrative descriptions from field notes to display how
professionals understand their work. In Chapter Six I present the theory of performance, using narratives to display the professionals' crucial judgments of referral and participant performance, and explaining how performance organizes the work activities of professionals at the MHCs. In Chapter Seven I discuss the implications of what was discovered about mental health courts in Midwestern for its population of persons with severe mental illness, and conclude with suggestions for change. I utilize Foucault's concepts of bio-power and governmentality to analyze the exercise of power by professional actors on behalf of the state, and describe how their MHC programs consume limited mental health services in a way that can be criticized in terms of social justice. I conclude the dissertation by considering findings about performance in MHCs and their implications, and present alternatives to MHCs which would treat the population of persons with severe mental illness more justly and more humanely.
CHAPTER TWO

METHOD OF RESEARCH AND GENERAL DESCRIPTION OF

MIDWESTERN MENTAL HEALTH COURT PROGRAMS

In this chapter, I discuss methods used to conduct the study of Midwestern MHCs, describe their basic organization, and present details of community context, program organization, and work activities associated with professional roles for each of the nine programs. As I will show below, each MHC program has a similar organization of program structures and professional roles centered on court hearings, but there are variations among the programs. I present some of these variations below in discussing the organization of programs, but describe each and analyze them more extensively in later chapters.

Methods

Data Collection

I gathered the data presented below between January of 2008 and February of 2012. During this time I conducted a pilot study of a mental health court program in a highly populated county in Midwestern state, Waters County, and then worked with other researchers in conducting a funded statewide study of all existing mental health court programs in Midwestern court jurisdictions. (All names of counties, towns, organizations, and workers are pseudonyms.) The later study aimed at discovering, detailing, comparing, and contrasting all operational and planned mental health court
(MHC) programs in the state, with a particular focus on how each operational program was organized, enacted, and understood by the various professionals involved. At the beginning of this study I oversaw a state-wide survey of Midwestern criminal court jurisdictions which identified six planned MHC programs and nine existing MHC programs; each of the later had been in operation for at least a year. These nine mental health court (MHC) programs were each located in one of eight counties in Midwestern state: Waters (2 programs), Ferry, Manzanera, Gabriel, Gilmour, Collins, Hackett, and Lynne. Once the statewide survey had been conducted, my primary responsibility for the funded study was visiting all MHC sites for data collection.

After receiving permission from court officials at each of these sites to conduct further data collection, I made multiple site visits to each of the MHC programs between May of 2010 and February of 2012. During the site visits, I gathered most of the data from three sources: field observations of MHC operations, on-site focus group interviews of professionals who operate the MHC programs, and individual interviews of key professionals following up on the observations and focus groups. I transcribed the interviews and typed up the field notes from observations for qualitative analysis. At the invitation of some of the professionals, I also began attending regular meetings of a professional organization that they had formed to promote the use of MHCs in Midwestern. These meetings were held once every three months, and as with court observations I recorded field notes when observing the meetings which were typed up for qualitative analysis. In addition, I gathered textual materials such as official forms and court literature, some of which was used by professionals in their work with participants,
while other materials were presented to the public to explain and promote the programs. These textual materials were added to the observational and interview data for analysis. I also conducted brief survey-interviews with thirty-two participants who each participated in one of three MHC sites selected for more intensive comparison per the funded study research plan. Although I refer to some of the court survey data to present details about the various programs, and occasionally discuss findings from the surveys of participants, the focus of this dissertation is on the various forms of ethnographic data collected from the MHC sites and professional meetings: the interviews of professionals, observations of their work activities, and textual materials that they utilized and shared.

I conducted ten focus group interviews at the nine MHC sites between June 2010 and April of 2011. These focus group interviews included a total of 82 workers in the MHCs, a large majority of whom were professionals, including judges, assistant state's attorneys, public defenders, probation officers, court administrators, social workers, and nurses. One focus group interview was conducted at each of the sites, with the exception of Gabriel County, at which I conducted two focus group interviews on different dates at the request of the Gabriel County MHC program coordinator so that all involved workers could participate. I asked open-ended questions of the interviewees based on an interview schedule that asked about the following:

- The creation of the mental health court, including which professionals acted as the main driving forces for program implementation and their stated reasons for their actions.

- Each professional's role in operating the mental health court program,
including the division of work activities, and their understandings of the purpose of the various work activities.

- The process by which an individual becomes a participant in a mental health court program.
- The process by which participants are assessed and service plans are developed for them.
- The process by which participants are monitored, judgments are made regarding misbehaviors, and sanctions are issued in instances of misbehavior.
- Specific instances of a gap in services needed for a participant, and how the gap was addressed.
- Participants considered difficult cases, and how their issues were resolved.
- Participants considered successful, and how their cases were successful.

The questions used for all of the focus groups are presented in Appendix A at the end of this dissertation. I made audio recordings of all but one of the focus group interviews, which were then transcribed for analysis. One judge asked that I not record the focus group interview in which he participated; for this group of MHC workers I wrote down responses to the interview questions I asked, but the flow of conversation was significantly limited. However, for only this focus group, another researcher was asked
to assist who took notes during the interview to ensure that the entirety of responses was recorded, and these two sets of recorded responses were combined, typed, and added to the other interview transcripts for qualitative analysis.

Including the pilot and state-wide studies and the professional meetings, I made a total of ninety-eight site visits for ethnographic observation, taking field notes that focused on the work activities of MHC professionals. As related above, professionals at three of the MHCs significantly limited my ability to make site visits for observation, yet I was still able to observe each of these programs in action twice. Professionals at the other six sites were more accommodating to my requests, allowing me to make multiple visits with relatively short notice, rarely denying a request to come on a specific day, and letting me observe staff meetings and court calls almost as often as I wanted.

Field notes of observations that I wrote aimed to describe how the professional workers engage each other in staff meetings and operate the courts to process offenders, how professionals fulfill their roles in the court, and how a particular day's docket occurs in terms of interaction between professionals and between professionals, participants, and referrals. At appropriate times during observations, I made open jottings (Emerson, Fretz, and Shaw, 1995) focusing on describing the activities of workers and court participants and the scenes in which they interacted. Shortly after making court observations, I read through jottings and added more field notes to provide detail and clarification for thick description (Warren and Karner, 2010). A similar process was followed in gathering field notes at the professional organization meetings. Eventually I analyzed field notes and constructed them into narratives for presentation here.
Throughout the process of writing field notes and turning them into narratives, I tried to follow strategies of vivid description, dialogue through indirect and direct quotation, and full characterization of workers and participants, and avoided summarizing and evaluative wording (Emerson, Fretz, and Shaw, 1995). I tried to present detailed description of professional interactions during staff and professional organization meetings, professional and participant verbal reports to judges regarding participants' successes or failures in following the program guidelines during court calls, judges' responses and use of sanctions (positive and negative) to motivate participants, uses of texts by professionals in doing their work, and specific institutional discourse that they share.

I also conducted fourteen individual interviews of MHC professionals, each of which lasted about an hour. Four of these interviews took place during the pilot study. After the focus groups and most observations were completed in the funded study, I conducted ten follow-up individual interviews with key players such as judges and program administrators in order to clarify items and delve deeper into processes discussed during the focus group interviews and observed during staff meetings and court calls. The individually interviewed professionals included two judges, five program coordinators/administrators, four probation officers, two social workers, and a psychologist. I audio recorded nine of these interviews and subsequently transcribed them for analysis, while I recorded verbal responses in writing for the others. I constructed a specific set of open-ended questions for each individual interview, but on interviewing I followed the questions loosely and launched a general conversation aimed
at understanding more fully how the interviewees conducted their everyday work activities, how they worked with other professionals to operate the mental health court, and how they viewed their work and the program participants or ‘clients’ with whom they worked.

Over the course of the research I collected a wide variety of textual materials from the various MHCs. At each site I requested informational literature about the program and data of program numbers and of de-identified individual participant cases, if available. Not all of the requests for data were met. For example, most of the sites were either unable or unwilling to provide individual case level data on participants. But professionals at each of the sites supplied me with one or more of the following textual materials: official state forms used for formal court processing; blank contracts specifically used with MHC program participants; staff meeting agendas which included reports on participants and referrals (with identifying information removed); data set displays of cases, which included individual details about referrals, participants, and their outcomes (again with identifiers removed); data sets of overall program numbers including measures of referrals and outcomes; official letters and staff memos regarding program numbers and policies; and publicly distributed pamphlets and other forms of information about their MHC programs. The analysis of professionals' use of text presented in this dissertation is drawn from field note observations, interviews, and from the textual documents collected. The later data were analyzed with the other data through qualitative coding.
Data Analysis

I performed a small amount of initial open coding (Emerson, Fretz, and Shaw, 1995) on data from the pilot study, but refrained from developing this coding further, although some of these codes were eventually used in data analysis for the funded study. The pilot study was helpful in designing and obtaining funding for the later statewide study, but I did not want to have coding from the pilot study significantly shape data collection and analysis of the later study. This was because the pilot study data came from one site, and I wanted to ensure that the statewide study was fully exploratory in data collection, and that data from all sites impacted the analysis.

Researchers often present data collection and analysis as discrete, consecutive stages, but with qualitative, ethnographic research data collection and analysis often occur in a back-and-forth process as the ethnographer observes in the field, develops field notes over time, and begins to recognize categories of explanation in looking over data throughout the research study (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Emerson, Fretz, and Shaw, 1995). I moved back and forth between collecting and analyzing data throughout much of the statewide study, although I conducted six months of further data analysis to fully develop the story line (Strauss and Corbin, 1990) or thematic narrative (Emerson, Fretz, and Shaw, 1995) after data collection ended in February of 2012. Throughout the project I read over recently collected data and performed initial open coding (Strauss and Corbin, 1990; Emerson, Fretz, and Shaw, 1995) on it, keeping transcribed interviews and typed field notes in a computer file so that all data and coding were in one place.
After a few months into the funded study I began to develop categories and subcategories of codes by comparing actions of MHC professionals across sites, focusing on their process of operating the MHC program through their work activities with participants and referrals. I began to discover how categories are related, or the linkages among them, an analytic process Strauss and Corbin refer to as "axial coding" (1990, page 96). Emerson, Fretz, and Shaw (1995) describe a two-stage process of open and focused coding of field notes that is simpler than the grounded theory method presented by Strauss and Corbin (1990). I went through similar stages of coding, progressing data analysis from initial open coding to focused coding based on topics, or categories, recognized as important. After discovering linkages between categories and subcategories based on the actions and interactions of MHC professionals as they worked with participants and referrals, I eventually found a story line that relied on a specific core category (Strauss and Corbin, 1990), the category of performance described above, which I will present and analyze in more detail in following chapters. Before doing so, I present a general description of the basic organization of Midwestern MHCs.

**Results: General Description of Midwestern MHC Programs**

The results presented below and in the following chapter are largely descriptive of MHC workers, work activities, and programs. These results are drawn from ethnographic and survey data. In later chapters of this dissertation I will present more complete analysis of professional workers' understandings and work activities, and consider their actions in the programs in the state and national context of service provision for persons with severe mental illness.
The Basic Organization of Midwestern MHC Programs

Here I describe the general organization of mental health court (MHC) programs, and briefly describe the various professional roles involved in operating the MHCs. In Chapter Four I describe these professional roles and their variation in more detail, comparing differences among sites. The term "professional" in this work is used to describe each of the essential work occupations present in Midwestern MHC programs, including judges, attorneys, probation officers, social workers, psychologists, and program administrators. The early trait approach in the sociology of professions was used by academics to differentiate professional work occupations such as doctor, judge, and lawyer from non-professional work occupations (Pavalko, 1988). Eventually, researchers in the sociology of professions moved away from the structural-functional approach toward an approach focusing on the power professionals held over clients, and in institutions (Dingwall and Lewis, 1983; Freidson, 1970), but still focused on traditionally-recognized professions such as doctor and lawyer. Later, feminist researchers identified "caring professions" such as social worker, probation officer, and nurse (Abbot and Wallace, 1990). In studying the workers in Midwestern MHCs I recognized that almost all of those I observed and interviewed were professional occupations as presented in sociological research, thus I focused this dissertation on workers as professionals.

For the professional work roles, I describe the basic work activities associated with each, which includes the frequent use of texts. As Smith (2005) explains, texts in institutions coordinate everyday work activities, as well as the subjectivities of persons
performing or affected by them. When official documents contain institutional language such as "misdemeanor" from the criminal justice realm or "bi-polar disorder" from mental health, a specific understanding of this individual-as-case is communicated to all of the institutional workers involved, professional and non-professional, and to the person so labeled through the institutional language. Such labels may be resisted by the person being labeled, as well as an institutional worker, but even this resistance is shaped by the specific understanding that has been shared. The production and usage of textual documents containing specific language are crucial to the institutional processes of the mental health court, both as an everyday operation of workers and extending translocally, beyond the local MHC to different mental health, criminal justice, or other institutional realms. For example, an individual criminal record is altered and shared beyond the mental health court when a judge sentences an unsuccessful participant to prison who will then be processed by prison workers. In observing MHC professionals I noted that their usage of bureaucratic documents was a large part of their everyday activities, and make note of the use of texts when describing the basic organization of mental health courts and each of the roles below.

The periodic mental health court hearing was the organizational basis for each of the nine programs, but there was variation among the programs in the specific organizational structure of court processes and in the work activities of professional role players. Each of the programs followed a general model in which one of the professionals, typically holding a job title of "Program Coordinator" or similar, accepted written applications from offenders charged with crimes to participate in the program.
Next, through a process of textual and face-to-face interaction, a variety of professionals conduct a process of selecting among referrals a limited number of offenders to become participants in the MHC. This is the first stage of the performance filter, which I will analyze in detail below. Newly-selected offenders then agree through signed documents formally recognized by the judge during a court hearing to participate in the program for a year or more by following a number of requirements. Participants are required to meet regularly with probation officers, and to meet regularly or as needed with social workers and other mental health professionals. The later may directly provide mental health treatment services to participants, or may serve as case managers linking participants to mental health and other services. Participants are also required to attend periodically-held mental health court hearings and appear before the judge to discuss progress in following program treatment guidelines since the most recent court appearance.

Generally participants begin the program by being required to attend every MHC hearing, which may be weekly or bi-weekly. The MHC professionals get together in a staff meeting before each court hearing to discuss characteristics of referrals and debate whether or not to accept them, and to discuss the recent progress of participants and determine how the judge and others should respond to them during the court hearing. If performing adequately in the program, judges allow participants to attend MHC hearings less frequently as they progress, changing requirements from having participants attend hearings every week or two, to having them attend every two or three weeks, then to every month, even to every six weeks or two months in some cases. Some of the programs have these required attendance periods match formal stages of progress in
program participation, which the judge communicates to the participant during hearings when progressed from one stage to another through formal documents. Over time a participant either succeeds in the program in the eyes of the professionals and graduates in court during a formally documented ceremony, or the participant is terminated from the program and considered an unsuccessful outcome by professionals. The judge may terminate the unsuccessful participant and consider his time served on probation as adequate and requiring no more supervision by criminal justice workers, the judge may transfer the participant's case to another type of probation for further supervision, or the judge may sentence the unsuccessful participant to incarceration in jail or prison. The judge may enter a sentence to incarceration in the official record on the basis of violating probation or on the basis of conviction for the criminal charge that brought the offender to the program in the first place, depending on the litigation model of the MHC program. As will be explained further below, one Midwestern MHC is structured by professionals as a "pre-plea" program, meaning the participant enters the program before pleading guilty or not to the criminal charge. Other MHCs are "post-plea" meaning to become a participant the offender must plead guilty to the criminal charge, but among these, judges in some programs sentence the offender to participation in the MHC program, whereas judges in other programs withhold sentencing until after participation in the MHC.

There are a number of specific professional work roles which were common to all of the Midwestern MHCs: judge, Assistant State's Attorney, public defender, program administrator, probation officer, and social worker. These roles vary in terms of the amount of personal interaction with participants and referrals and the amount of textual
interaction with the offender-as-case. Some of the roles often share work activities, whereas others are more narrowly construed so that only one role accomplishes specific work activities.

Each MHC program was organized around hearings before a judge. The MHC judge's work role was narrowly construed, as he must process cases during organized hearings in an official capacity for the state, and has the ability to exercise power by changing the legal status of each participant and referral through processing a conviction, probation, or the dropping of charges. The judge textually interacts with referrals- and participants-as-cases in processing documents, and personally interacts with each called referral and participant face-to-face, but only during hearings. These two types of interaction were a common part of judges' work activities in all of the MHCs. The most important documents for the institutional construction of the offender-as-case, the ones affecting the offender's legal status, were formally enacted by the judge. Appendix B contains the Waters County MHC court order and the program's contract used to legitimate and institutionally define the mandated treatment of select referrals.

Each Midwestern MHC also had an assigned Assistant State's Attorney, who kept files for each referral and participant, and, as needed, formally brought criminal charges during the hearing on behalf of the state through textual documents provided to the judge and entered into the official record. At all but the two MHCs in Waters County the role of the Assistant State's Attorney also included acting as gatekeeper of referrals' entry into the program, making a decision about each referral's acceptability by looking over textual documents containing criminal history and current criminal charges, including police and
victim statements. ASAs were restricted to textual interaction with the participant-as-case, and did not engage in personal interaction with embodied referrals or participants as ASAs considered personal interaction to be inappropriate given their role.

Public defenders were present at every Midwestern MHC, although in some of the programs a few referrals and participants with the ability to pay were represented by private attorneys. Public defenders engaged in textual interaction with the offender-as-case, looking over criminal records, arrest reports, and charges in order to defend a client, and also engaged in personal, face-to-face interaction, getting to know defendants, meeting some of them in jail, determining their desire to participate in the MHC, explaining the program to possible referrals in terms of how it would affect their legal status, and often engaging in a motivational relationship with participants while also advising them during their time in the MHC. MHCs and other problem-solving courts have been described as non-adversarial programs because ASAs and public defenders are thought to work together with the rest of the specialty court professionals for the benefit of the participant, rather than engaging in an adversarial relationship as in regular adjudication (Nolan, 2001). Public defenders I observed worked as members of a team with other MHC professionals, but a couple of them were adversarial in doing their work activities in staff meetings and, occasionally, in court.

Each Midwestern MHC had a professional worker who served an administrative and organizational role on the MHC team, organizing staff meetings by preparing a weekly agenda of referrals and participants to be discussed, and keeping records of these individual cases, as well as records of overall program numbers and funding. There were
several variations in job title such as "Program Director" or "Specialty Courts Administrator" but all of the programs had some type of this role which I will refer to as "program coordinator." At some sites this was a full time position working solely for the MHC, whereas at others those who served this role also worked in other capacities, usually involving the local drug court. At four of the sites this position was a part of the probation department, at three of the sites it was a part of the court administration office, and at two of the sites, those in the in the largest urban county, one person served this role for the local state's attorney's office. These were blended organizational work roles, and meet Steadman's (1992) concept of "boundary spanners". At all but two MHCs the program coordinator attended all staff meetings and court calls and provided input on participant cases from her mental health or criminal justice professional background, while displaying understandings from both institutions. Most of the program coordinators engaged in textual interaction with the referrals- and participants-as-cases, but engaged in little personal interaction with the embodied offenders. These program coordinators conducted work activities of an administrator, focusing on textual representations of individuals and of program processes. But at several of the sites the program coordinator engaged in both textual interaction with the offender-as-case and personal interaction with the embodied individual. At two of these sites the program coordinator also worked as the probation officer for MHC participants, while at one of these sites a program coordinator met with referrals and participants on occasion working from a mental health background to evaluate or counsel.

There are variations in staff composition recognizable when comparing the
programs, but in all nine MHCs at least one probation officer and one mental health worker work together and share responsibility for between-hearing monitoring of participants, resulting in much personal interaction which may be weekly or even daily with a participant. The probation officers and mental health workers are the *monitoring dyad* of Midwestern MHCs. The probation officers focused their work on meeting criminal justice monitoring objectives, while mental health workers such as social workers and psychologists focused on service and treatment provision and regular personal contact with participants. The professional workers shared textual information with each other and with other MHC professionals. Probation officers have access to criminal records, report on meetings with participants, and often conduct and document drug testing through urine screening of participants. Mental health workers developed service plans after determining participants' needs, and often conducted mental health assessments with referrals and new participants. These were textual instruments which involve verbal or written questioning of individuals, such as the Hamilton Rating Scale for Depression, the Mini Mental State Examination, and the Wechsler Adult Intelligence Scale. The textual documents that the monitoring professionals work with and share and which describe the offender-as-case are produced for either a criminal justice or mental health process, but probation officers and mental health workers in the MHC programs described and displayed a sharing of responsibilities and teamwork between them, which includes sharing a blended organizational vocabulary, in order to meet participants' service, treatment, and monitoring needs.

The number and type of mental health workers varied when comparing the sites,
much more so than probation officers, who numbered one to three among sites but were all state employees monitoring for criminal justice reasons. In several of the programs, one or two local community mental health agencies had employees who were regular members of the MHC team attending all staff meetings and court calls. These were most often social workers, and they spent much of their work time for their agency with MHC participants. In other MHCs mental health workers were employees of the court or county government, including clinical social workers from the county health department and court psychologists. This occurred in counties with more wealthy citizens as measured by annual household income,\(^1\) which suggests that wealthier counties had well-staffed county health departments which could staff their MHCs rather than having to rely on local community mental health agencies as in less wealthy counties. Two of the programs had a nurse employed by a local community mental health agency dedicated to the MHC team to work specifically with participants and their medication needs, keeping medical records while interacting personally with participants to advise them and encourage them on taking psychotropic and other medications. These nurse positions were funded through grants obtained by the respective program coordinators.

Not all mental health professionals observed were regular MHC workers. In a number of programs, a mental health worker from a community mental health agency, hospital, or residential program came to the MHC staff meeting to report on a specific participant but was not a member of the MHC work staff. These mental health workers

\(^1\) Median annual household income measures for each county were drawn from the 2010 U.S. Census. I ranked the counties from most to least wealthy but do not present exact figures to protect confidentiality of informants.
only occasionally attend staff meetings as needed, and many times there is no need as
many participant issues can be briefly discussed over the telephone with one of the
monitoring dyad who can report at staff meetings.

Four of the MHC programs utilized personnel who worked in the jail in their
jurisdiction, employed by the county or by a community mental health agency. These jail
liaisons discovered and approached possible referrals who were incarcerated, assessing
some detainees in person, or looking over arrest records for persons also listed in records
of mental health agencies. Jail liaisons met with new participants not yet released from
jail to maintain contact for the MHC, and checked on participants who had become
incarcerated, noting their mental health condition for other MHC professionals.

Although every MHC had a similar organization based on professionals evaluating
referrals and monitoring participants who were required to appear periodically before the
judge in a court hearing, there was a significant amount of variation discovered when
comparing the organization of program structures and professional roles. Further
description and analysis of professional role variation is presented in later chapters.

Redlich et al (2005) identified two generations of MHC development nationwide
using a sample of eight MHCs begun during the 1990s, and another seven MHCs begun
after the Bureau of Justice Administration offered their first round of MHC funding in
2002. The first generation MHCs mostly heard only misdemeanor cases, had more pre-
adjudication than post-adjudication court models, and rarely used jail as a sanction. Half
of them relied on supervision external to the MHC by community providers rather than
supervision internal to the court by probation officers and other court personnel. By
contrast, all of the second generation MHCs accepted felony cases, and all but one utilized a post-adjudication model. The second generation used jails as sanctions more readily, and a majority viewed court personnel and/or probation officers as being responsible for supervision.

The survey of the nine Midwestern MHCs, which were established between January of 2004 and August 2008, revealed some but not all second-generation MHC trends (Redlich et al, 2005). Midwestern MHCs reflect the second-generation trends (Redlich et al, 2005) toward hearing felony cases, utilizing post-adjudication models, and utilizing jail as a sanction for noncompliance, but not the trend toward relying on court personnel supervision models. All of the Midwestern MHCs accepted offenders with mental illness charged with felony violations, with the two programs in Waters County accepting only felony cases and the rest accepting both misdemeanor and felony cases. In addition, only one Midwestern MHC had a pre-adjudication model, the Ferry County MHC. Four MHCs utilized both pre- and post-adjudication models, and the remaining four MHCs utilized only post-adjudication. Two of the later MHCs, the ones in Collins County and in Gabriel County, utilize a post-plea but pre-sentence model, meaning participants plead guilty to enter the program but have their sentences deferred. Charges are dismissed or reduced for participants who successfully complete the Collins County MHC or Gabriel County MHC. The two Waters County programs utilize post-plea adjudication in which defendants with mental illness plead guilty and then are sentenced to participate in the MHC as a term of probation for their offense. A focus group interview question asked about sanctioning, and only one program, the Gilmour County
MHC, did not utilize jail as a sanction for participants. But unlike second-generation
trends identified by Redlich et al (2005), only three of the nine MHCs relied primarily on
court personnel and/or probation officers for monitoring and supervision of participants.
The remaining six programs relied on a combination of court personnel and community
or county mental health workers external to the court for monitoring and supervision of
participants.

The smallest of the nine programs was the Gilmour County MHC, which had five
active participants at the time of the survey, while the largest was the Ferry County MHC
with 102 active participants. The Ferry County MHC accepted its first participant in
2004, and the Waters County MHC in Bevan City did so a few months later. Four of the
courts accepted their first participant in 2007. The most recent to accept its first
participant of the nine MHCs was the other Waters County MHC, the program in Tandy,
beginning in 2008. All nine of the programs had been in operation for at least a year-and-
a-half at the time of the survey, and all were in urban counties per Office of Management
and Budget criteria (Cromartie and Bucholtz, 2008). According to survey responses, two
programs were located in mixed suburban and rural environments, five programs were in
suburban communities, and the MHC program in Bevan City was in an urban
environment. In the next chapter I provide detailed description of each of the nine
programs, including information about community context, professional workers
involved, and specific court processes.
CHAPTER THREE
DETAILED DESCRIPTION OF
THE NINE MENTAL HEALTH COURT PROGRAMS

In this chapter I describe each of the nine mental health court programs as organized and operated by professionals. Some of the data presented below is from the statewide survey, but much of it was obtained during ethnographic observation or interviews. At every mental health court site, I interviewed the staff in a focus group, conducted some individual interviews, and observed at least one staff meeting and one court call. All but one of the sites allowed me to observe multiple staff meetings and court calls.

Goffman (1963), whose dramaturgical analysis influenced this study, differentiates between a “front region” and a “back region.” The front region or front stage serves as the staging area for performance before an audience, while the back region or back stage “may be defined as a place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course” (Goffman, 1963, pages 112-113). The back stage, in other words, is where the performers do not have to take such care in presenting the front, where they can relax and allow for behavior that may differ or even contradict the front performance. Nolan (2001) studied drug court processes of staff meetings and subsequent hearings using Goffman's dramaturgical analysis of front stage and backstage. By attending staff
meetings and court calls, I was able to observe the MHC professionals at work in the back stage of the mental health court, where they hold a staff meeting, talk informally, and plan the judge's performance at the court hearing, and at work in the front stage of the mental health court, where the hearing is conducted, professionals perform as planned, and referrals and participants appearing before the judge engage in performances of their own.

In reading the description of each mental health court below, the reader may note translocal connections (Smith, 2008) with other organizations and institutional actors, including the influential professionals and advocates who worked to establish MHCs in their jurisdictions and who were part of the socio-legal movement promoting problem-solving courts. The reader should also note the interactional processes at each of the sites by which professionals select appropriate referrals for the MHC - the first stage of the performance filter - as well as interactional processes occurring as professionals work with participants over time during the participation stage of the filter to identify the successful MHC graduate - the final stage of the performance filter. Throughout these processes by which professionals engage in work activities to narrow down a relatively large pool of referrals to a small select group of MHC graduates, they rely on bureaucratic documents and textual interaction with the offenders-as-cases, as well as personal interaction with the embodied participants, to make program entry and outcome decisions.

In studying the nine different MHCs in the Midwestern state I discovered similarities among them but also variability in organizational structures and professional
roles. In later chapters I present in-depth analysis of structures and roles, including a focus on performance as an organizing principle of Midwestern MHCs. But first I detail the nine MHC organizations below utilizing survey, interview, and field note observation data collected at the nine sites in eight Midwestern counties: Collins, Ferry, Gabriel, Gilmour, Hackett, Lynne, Manzanera, and Waters (in large Bevan City and Tandy suburb).

Collins County Mental Health Court

Collins County is a mixed area of several small cities and rural areas. The county is relatively affluent, with median annual household income roughly twenty thousand above the Midwestern state average. Over ninety percent of the 2010 population was white, while less than five percent were black, and roughly ten percent was Hispanic of any race. In the spring of 2010 the Collins MHC had nineteen active participants, six males and thirteen females. Sixteen participants were white and two were black, while the other two were listed as "other" and "Hispanic" on the survey question on race, and listed on the separate question asking about Hispanic/Latino ethnicity. All of the MHC professionals were white.

The idea for beginning a MHC program first emerged in Collins County during regular local judge meetings in late 2003 and early 2004 as a few judges, including Judge Harrington, the current MHC judge, engaged in general conversation about future ideas for courts. At the time, they did not believe that they had the manpower or the support of the bar association to proceed. But collectively, they noted how often they were seeing the same defendants known to have mental health issues, who often also had substance
abuse issues, repeatedly in their courtrooms, a core group of about 25 to 30 defendants according to the Judge Harrington. The process in Collins County differed from other counties in that a drug court had been discussed by judges in 2001 and briefly initiated, but was discontinued within months as neither unified resources nor financial stability were in place to sustain the drug court program. But the MHC program received more broad-based support in its initial stages after the idea of beginning a MHC gained momentum when the State's Attorney and a county board which provided funding for mental health services formed a task force which included judges, several county board members, and the sheriff and representatives from his department, including corrections, office personnel, and a deputy. Soon court services, social service agencies, representatives from the National Alliance for the Mentally Ill (NAMI), the local mental health board, and the county health department were also involved in discussion groups about beginning a MHC, and the idea came to fruition in 2007 when the Collins MHC program accepted its first participant. The task force continued to meet during the first few months of program operations to ensure that, unlike the previous drug court attempt, the MHC had enough resources in place to sustain itself.¹

Judge Harrington conducts hearings twice a month Collins County MHC. Other members of the Collins MHC staff include Felix, the program coordinator; Liz, the probation officer; Nathan, an assistant state's attorney (ASA); Martin, a public defender; and two mental health workers from the primary community mental health agency in the

¹ Court and county officials in Collins County have since made a second attempt at a drug court program which began operations in late 2011.
county. One of these mental health workers is Bridget, a nurse who focuses on medication and health monitoring of program participants, while the other is Teresa, a clinical social worker providing direct services to some participants and also serving as a treatment liaison between the MHC and her mental health agency. Felix, the program coordinator, has a previous mental health background as a social worker, and is an employee of the court administrator's office who serves an important administrative role for the MHC program: organizing referrals and preparing staff meeting agendas, meeting personally with referrals as part of the screening process, organizing and attending staff meetings and providing input on referrals and participants, and contacting other criminal justice workers and workers at outside agencies as needed.

Referrals to the Collins County MHC come from a variety of sources, mostly public defenders, but also private defense attorneys, family members, police officers, or jail workers. Judge Harrington is also responsible for initial hearings for all newly arrested defendants, which occur every morning. If he believes one of the defendants at initial hearings suffers from mental illness, he will refer the case to Felix, and alerts both the State's Attorney's office and the defense attorney, often a public defender, that the defendant may be a candidate for mental health court. Felix conducts a pre-screen of all new referrals, which includes a personal appointment and an initial mental health assessment with each, to determine if they meet program eligibility requirements.

Once a referral has been prescreened by the program coordinator, he refers those cases judged possibly appropriate for the MHC to Teresa, the social worker, who conducts further mental health and service assessments; these assessments are often done
while the referred defendant is still in jail. The MHC professionals consider a referral to be appropriate for the MHC program if, during the assessment process, the defendant displays willingness to comply with program parameters, and a desire to learn social skills and life skills. After assessments are completed, and screening of criminal charges has been completed by Nathan, the assistant state's attorney, the MHC professionals discuss the results of the assessments and specifics of the case to determine whether or not the referral is appropriate for the mental health court. Such discussions occur during regularly held staff meetings, during which progress with other active cases is also discussed. After the staff collectively decides that a referral is appropriate, they schedule the referral's case for appearance in front of Judge Harrington during the regular MHC call in order to formally enter the individual into the program. The Collins County MHC accepts about one-fourth of all referrals.

Felix has the goal of sending either an acceptance or a denial notice to the defense attorney within thirty days of the initial referral, believing that the faster an appropriate referral is able to enter the MHC program, the more likely the program will be effective and the defendant will successfully complete it. A concern he expressed during interview is that defendants who linger in jail for some time may "decompensate," or have their mental condition worsen, thus rendering them unfit to enter the program. On the other hand, a significant number of referrals have already returned to their homes after meeting bond, and being released from jail, before subsequently being referred to the MHC by their defense attorneys. For those referred individuals who are in custody and homeless, after mental health workers have visited the referral in jail and conducted assessments, if
the individual is accepted she or he is transferred directly from jail to a group home or rehabilitation facility on entering the program. Occasionally some participants living at home with family may be referred to residential services if the MHC staff determines that residential treatment would be beneficial.

The Collins MHC program accepts defendants with only Axis I diagnoses as defined by the American Psychiatric Association (2000); although participants with co-occurring disorders are accepted into the program, the MHC professionals exclude those who have a primary substance abuse disorder. Felix or Teresa set up diagnoses by psychiatrists if needed, and determine through consideration of available mental health documentation and criminal history of the offender-as-case whether or not a mental disorder is the primary issue and substance abuse is a secondary issue. The Collins program accepts both misdemeanors and felonies, including some violent felonies if the charge is not specifically proscribed by Midwestern law regarding MHC programs. At the time of the survey five participants had misdemeanor cases and fourteen had felony cases. Participants in the Collins MHC enter the program on a post-plea, pre-sentence basis by pleading guilty to their offense and having their sentences deferred. Terms of participation in the Collins County MHC are standard with individualized items routinely added. The program utilizes a formal, standard contract. Participants sign an initial release of information form on entering the program, allowing the court and mental health staff to communicate, while subsequent releases of information for other purposes may be utilized.

The program is structured in phases, which are documented by Judge Harrington
and Felix and referred to by the other staff, with phase one the initial stage, requiring the most frequent contact with probation and the court: weekly visits with Liz, the probation officer, and court appearances twice a month. There are three more stages of progress to the highest, phase four, during which participants near graduation and may come to court on a monthly, or even for those doing "really well" a bi-monthly, basis, while also seeing the probation officer monthly. However, even in phase four most participants are having regular contact, sometimes weekly and often over the telephone, with the nurse and mental health clinician. Standard criteria for completion of the fourth phase and graduation from the program include a specified period of time of treatment adherence, and employment or other involvement in structured activities. The average length of participation in the program is one to two years, with twelve months being the minimum period of time allowed in the program and twenty-four months the maximum.

The Collins County MHC utilizes a variety of sanctions for noncompliant participants, including verbal reprimands, essay assignments, research assignments, community service, curfews, increased frequency of court appearances, and jail. Felix reported that over the previous year six people had been terminated for noncompliance or had opted out and entered a new plea, while a total of thirty-five people had participated in the MHC. Participants who are unsuccessful in the program may have their cases returned to the court of original jurisdiction for sentencing. Although Judge Harrington may hold a formal discharge hearing to determine whether a participant is going to be discharged or not, participants who do not adhere to MHC program requirements more commonly voluntarily leave the program. Or there may be a plea negotiation with the
public defender or private attorney and the ASA. If a participant facing termination has been in the program for over a year and has a misdemeanor case, the ASA will accept a plea to the charge and close the case. Almost all participants who successfully graduate have their charges dismissed, while charges are reduced for others who finish successfully. The minimum length of time for participation in the Collins MHC is twelve months, and the maximum length twenty-four months.

Bridget, the nurse, Teresa, the mental health clinician, and Liz, the probation officer, maintain regular contact with each other in monitoring and coordinating participants' activities and services. They describe taking a team approach to providing case management and meeting participant needs, working together to pursue services for participants, solve problems, and deal with any issues that may arise. In addition, the three workers attend staff meetings held every two weeks (occasionally more often) with other members of the team to discuss participant progress and issues. At these meetings Felix, Judge Harrington, or Martin, the public defender, may also contribute to case management by providing information about possible resources, and generally contributing to discussion about how best to meet participant needs. Nathan, the assistant state's attorney, does not engage in personal interaction with participants, but is involved in discussions in staff meetings, contributing opinions about participants, and agreeing to communicate with local law enforcement officers as needed.

Liz, Teresa, and Bridget described overlap between their respective roles of probation officer, clinician, and nurse, in terms of monitoring and providing support for participants. For example if needed Liz may help with a mental-health related task such
as contacting a physician, or Teresa may help the probation officer with a monitoring issue. However, they also described their roles as being specifically defined, which they revealed in describing their initial contact with new participants. The three workers meet together with an individual participant on entering the program and discuss the individual's treatment needs and participation goals. Bridget, the nurse, works with the participant to identify a psychiatrist for the participant, or to consider the treatment recommendations from a psychiatrist already providing treatment. She also focuses on treatment and medications for other health conditions, and discusses these with the participant. Teresa discusses clinical treatment needs with the participant, determining from which providers the participant would prefer to receive mental health services and developing a plan for accessing these services regularly. Such treatment is often provided directly by Teresa or the community mental health center where she works. Liz discusses the participant's court order, including specifics of program compliance, and requirements and goals regarding public service work, random urine screens, residential arrangements, home visits, and employment. Collectively the three staff members engage the participant to set up a workable plan that fits the participant's needs and preferences and meets the requirements of the program.

**Ferry County Mental Health Court**

The Ferry Mental Health Court program was the largest MHC studied, with 102 active participants in the spring of 2010, forty-eight women and fifty-four men. Eighty-four participants were white, nine were black, and six were Asian. Eight participants were of Hispanic/Latino ethnicity. Roughly eighty percent of the Ferry County
population was white, five percent was black, and ten percent was Asian, while about fifteen percent of Ferry County was Hispanic or Latino of any race. All of the Ferry County MHC professional staff was white, except for one of three probation officers. Ferry County, like Collins County, is relatively affluent compared to other Midwestern counties, with median annual household income more than $20,000 above the state median. The county contains a number of small cities.

The Ferry County MHC was the first MHC established in Midwestern state, beginning operations in early 2004. As early as 1998 local advocates from the National Alliance for the Mentally Ill (NAMI), after hearing about the new type of court at a NAMI convention, began talking with officials at the Ferry County health department suggesting the need for a program. In addition to NAMI, the State's Attorney in Ferry County played a key role in locating resources, planning the program, and beginning the MHC, a process which took six years. Although a drug court had been established earlier in the jurisdiction, the MHC professionals explained during the focus group that their MHC program was not modeled on the drug court, which operates with different adjudication structures and personnel as an entirely separate program.

The Ferry County MHC team consists of Judge Vandiver; Christina, an assistant state's attorney (ASA); Peggy, a public defender; Patricia, a clinical social worker from the county health department; Megan, Carla, and Art, all probation officers; Rhonda, a probation supervisor; and Paul, a program coordinator out of the Court Administrator's office. Paul did not engage in personal interaction with referrals or participants, and did not stay throughout staff meetings as offenders-as-cases were discussed, working instead
as a manager of the program: keeping program records, managing funding, and finding resources. Unlike most other Midwestern MHCs, where service providers from outside of government are members of the MHC staff who regularly attend meetings, the Ferry County MHC team is made up entirely of government employees, who attend staff meetings held once a week before MHC calls. Some participants have private attorneys who occasionally attend parts of staff meetings, but service providers from various social service agencies do not. Instead, the probation officers contact providers regularly via telephone and visits to get updates on participants’ progress. Some of these providers may be outside Ferry County, as the MHC accepts some referrals who reside outside the county. Participants who are local and must rely on public services do so through the Ferry County health department. Patricia, the social worker, serves as their case manager for treatment and services.

When the Ferry County MHC began public defenders were the primary referral source, and NAMI also made a number of referrals. As the program grew and became more well-known locally referrals began to come from a variety of sources, including various police departments, the health department, the local community mental health center, private attorneys, and family members. A referral is made via the filing of an application order by a defendant, which continues the case for three to four weeks so that Patricia, the ASA, can screen the defendant for MHC. She discovers the criminal history of the offender-as-case, learns specifics of the current charge, considers whether or not a pattern of behavior recognizable in the offender-as-case is a public safety concern, and talks with victims and police officers about the offense to see if they object to the
defendant's participation in MHC.

The program accepts both misdemeanor and felony defendants, and at the time of the study among participants, misdemeanors slightly outnumbered the felonies. Once Christina, the ASA, deems a case appropriate for MHC, the case is continued another four to six weeks while the Patricia, the social worker, conducts an intake assessment with the referral to determine the validity of mental illness, its primacy relative to substance abuse issues, and whether or not a connection can be established between the offender's mental illness if valid and the criminal charge of the offender-as-case. During this time one of the probation officers conducts LSI-R testing, a risk-needs assessment for offender treatment planning. If Patricia determines validity and primacy of the mental illness of a referral and that there is a connection between the mental illness and the crime, she communicates this to other professionals at the staff meeting. They determine who are appropriate to begin the program. Those referrals deemed appropriate have their cases continued another two to three weeks until an acceptance order is prepared by the Christina and a formal acknowledgment of willingness to participate is entered in court.

The Ferry County MHC accepts participants with Axis I or Axis II mental health diagnoses, and the primary diagnosis for those with illicit drug issues must be mental illness rather than substance abuse disorder. Forty-four percent of MHC referrals eventually enter the program.

The Ferry County MHC is a pre-plea program in which a participant's criminal charges are held in abeyance and then dismissed or reduced upon successful program completion. The minimum participation period in MHC is twelve months, while the
maximum is thirty months. For those who do not successfully complete the program, participants may accept a plea agreement or have their cases returned to the court of original jurisdiction for adjudication.

The Ferry County MHC professionals explained in interview that because the program is pre-plea, Patricia, the probation officers, and Peggy, the public defender, limit sharing information regarding participants with Judge Vandiver and Christina, the ASA, as this would make processing the case problematic if it was moved back to regular court. In the other MHCs information about participants was much more freely shared. In the Ferry County MHC, participants do not sign one overall release allowing the sharing of information among all staff, as in other Midwestern MHCs, although they may sign releases of information when needed. The limiting of information about participants was displayed during court observations, and led to an adversarial approach to work activities by Peggy, the public defender.

As in other Midwestern MHCs, Patricia, the social worker and probation officers Megan and Carla spoke of working together to case manage and monitor participants, rather than working in clearly separated roles. Peggy, the public defender communicates with these team members regularly, and motivates participants through personal interaction to follow their treatment plan and program guidelines when problematic situations arise. But specifics of these contacts may not be shared with Judge Vandiver and Christina, the ASA, as the case may be adjudicated at a later time if the participant leaves the program. Peggy described in interview how she works to ensure that information on participant progress is limited by discussing each case with Patricia and
the relevant probation officer and then determining what progress information is shared with Judge Vandiver, filtering out information that may prove harmful to the participant if shared. However, Peggy presented case progress to Judge Vandiver during staff meetings that at times included negative aspects of participants' performance, suggesting that Peggy's editing of negative report information is selective. ASAs in most Midwestern MHCs describe playing the role of gatekeeper for entry into the program, while Peggy described playing the role of gatekeeper of information during program participation. The Ferry County MHC organization affecting work activities of these professional roles will be analyzed further in Chapter Four.

All Midwestern MHCs had at least some mentally ill participants who had substance abuse issues, many of whom entered the MHC because of illicit drug charges. These participants were required to submit to drug testing through their probation officers. But the Ferry County MHC had a unique program called "colors" by which new participants with drug issues were assigned a color (i.e. blue, red, green, or yellow) and were required to make a weekly telephone call to find out which color had been randomly selected for the week; if it was the color assigned to a participant, then she had to visit the probation office and submit to a urinalysis. If illicit drugs were discovered, then a probation officer informed Judge Vandiver during the staff meeting and the participant faced sanctions at the hearing.

In some cases the process of deciding on appropriate sanctions for noncompliant participants in the Ferry County MHC differs from most other Midwestern MHCs. Judge Vandiver utilizes a variety of sanctions with MHC participants, including increased
frequency of meetings or groups, hours of participation in county work programs, added electronic monitoring, and time in jail. Decisions on such sanctions as serving hours in the county work program or spending time in jail may be arrived at in an adversarial process during the staff meeting, with Christina, the ASA, arguing for sanctioning, Peggy, the public defender, arguing for no or less sanctioning and Judge Vandiver making a determination afterward. The only other public defender engaging in an adversarial process in a Midwestern MHC was in Lynne County, described below. This adversarial process described during interview was observed in only a few cases discussed during a staff meeting, while with other cases of sanctioning Judge Vandiver and Peggy worked cooperatively to make a decision.

**Gabriel County Mental Health Court**

Gabriel County contains a number of small cities. At the time of the survey, the Gabriel County MHC had nine active participants, eight males and one female. Four participants were white, three were black, and one was Asian. In 2010 roughly eighty-five percent of the overall Gabriel County population was white, five percent was black, and five percent was Asian, while about 30 percent was Hispanic or Latino of any race. All of the MHC professionals in Gabriel County were white. The county is fairly affluent, with median household income about $12,000 more than the Midwestern median, but not as affluent as Collins or Ferry Counties.

The idea for beginning a MHC program was first promoted by the Chief Judge Hampton in Gabriel County, who spoke about starting a MHC program with Judge Albinson, now the MHC Judge, and Dr. Peete, a supervising court psychologist who
oversees a county department providing all psychology services to the court and the sheriff’s department. Dr. Peete called on the services of another mental health professional who had past experience in establishing specialty courts. Together they conducted a mental health needs assessment for the jurisdiction, and found that there was a need among the jail population for treatment and medication for Axis I diagnoses. They also relied upon the Essential Elements of specialty courts, promoted by the Council of State Governments (2008) and funded by the federal government, in designing the mental health court program. Judge Albinson set up personnel by adding Andrea, an Assistant State's Attorney (ASA), and Kevin, a public defender, who both agreed to work regularly with the MHC. Several of these staff attended a GAINS \(^2\) conference in California, and, after returning with a basic understanding of how mental health courts operate, Judge Albinson hired a program coordinator, Tina, who began working in a position which would serve as both probation officer for all MHC participants and administrator for the program. Chief Judge Hampton, working with a congressional representative from the area, obtained a federal earmark to finance the court. A task force was organized, including the MHC staff and representatives from local service providers who were invited, and the group began meeting and planning to begin the MHC program. Judge Albinson and other staff paid a visit to Lynne County to watch a court call of the MHC program there as an example. After months of planning, the Chief

\(^2\)“GAINS” is an acronym for "Gathering information, Assessing what works, Interpreting and integrating the facts, Networking, and Stimulating Change," and is the name of a center run by Policy Research Associates, Inc. in Delmar, New York for the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services (http://gainscenter.samhsa.gov/).
Judge held a press conference to announce the new MHC, and the first participant entered in 2006. In addition to Dr. Peete, other mental health workers on the MHC staff include a few social workers employed by local mental health agencies, and a monitor at the county jail.

Referrals to the Gabriel County MHC may come from jail staff, probation officers, judges, the drug court, and defense attorneys, and come most commonly from defense attorneys. After a referral is made, Tina, the program coordinator, does an initial screening, meeting with potential participants to determine eligibility issues, such as residency status, and conformity of the criminal charge to Midwestern statute for mental health courts. A referral is then passed to the State's Attorney's office, and Andrea, the ASA, considers the referral's criminal history to determine acceptability. If Andrea determines that the referral is acceptable, a court psychologist conducts a psychological evaluation, even for those referrals with a documented diagnosis. After this is accomplished, the team discusses the case and determines whether or not the referral can begin the program. If accepted, then Tina refers the prospective participant to an appropriate mental health agency in the community for service and treatment planning. She reported that out of 184 referrals since the MHC began, 31 had become participants, about 17 percent.

The Gabriel County MHC accepts defendants with a primary Axis I diagnosis; although participants with co-occurring disorders are accepted into the program, it excludes those who have a primary substance abuse disorder, who may be referred to the Gabriel County drug court. Court psychologists determine the primary disorder after
assessing the referral as described above, and results of assessments are added to the texts representing the offender-as-case. Dr. Peete explained that such determinations can be difficult to make, and that a getting-to-know process of personal interaction occurs with a participant over time that may lead to revision of the initial determination, with substance abuse disorder found to be the primary mental health problem. This situation can result in a transfer of the participant to the drug court.

The Gabriel County MHC program accepts both defendants charged with misdemeanors and those charged with nonviolent felonies, although at the time of the survey all nine participants were felony offenders. All participants enter the program on a "post-plea, pre-sentence" basis, meaning defendants plead guilty to their offense and have their sentences deferred. Participants' charges may be dismissed or reduced upon successful program completion. Depending on the specifics of the case, participants who are unsuccessful in the program may serve a deferred sentence, or have their case returned to the court of original jurisdiction for sentencing.

The Gabriel County MHC is designed in phases, and as a two-tiered program: misdemeanor participants are supervised for approximately a year, while felony participants are supervised for approximately two years. Felony participants go through a three-phase program, while misdemeanor participants go through a two-phase program. The phases represent different levels of intensity of supervision. Felony participants start out in phase one seeing the MHC judge and program coordinator every week, and gradually progress to phase two (bi-weekly appearances) and then to phase three (monthly appearances). Misdemeanor participants start out in phase one (weekly
appearances) and then gradually progress to phase two (bi-weekly appearances). All participants must sign a formal, standard contract of terms of participation, although the judge routinely adds individualized terms after staff meeting discussion.

Along with weekly visits with the judge and program coordinator, Gabriel MHC program participants see a service provider throughout the week, in many cases on a daily basis. There are a number of service providers in the jurisdiction, including transitional housing programs, homeless shelters, domestic violence shelters, and several mental health agencies. The MHC program has a residency requirement - participants must reside in the jurisdiction, and often this eligibility requirement is met through Tina or other mental health staff on the MHC finding a residential program for the participant which is in Gabriel County. There are three mental health agencies providing much of the case management and treatment planning services for MHC participants. One provider specializes in substance abuse treatment, including inpatient treatment. Case management is provided by the mental health agencies, but Tina does some case management work as well working in the role of probation officer, and maintains regular contact with the treatment providers. She was hired because of her mental health background as a social worker, and provides reports on participants' treatment progress to Judge Albinson and the rest of the professionals at weekly staff meetings, held before MHC calls. Mental health workers from outside agencies attend staff meetings as needed.

In contrast to the MHC professionals in Ferry County, when asked about information sharing Gabriel County MHC professionals responded that "everybody gets
everything," explaining that when participants enter the program they are required to sign releases of information allowing the professionals to freely share information even though the case has not been fully adjudicated. In addition, participants are required to sign other releases regarding information sharing with service and treatment agencies, and Tina maintains communication with these agencies to ensure that the MHC program and its releases are working in conjunction with information releases which agencies utilize. Dr. Peete, Tina, and Judge Albinson expressed awareness of the issue of *ex parte* communication, and acknowledged that there have been ethical issues involving attorneys disclosing information about new criminal charges.³ For those situations, they explained that they ask for consultation from the Center of Court Innovation⁴ in New York to help work through ethical dilemmas and professional issues regarding information sharing.

As the Gabriel County MHC program is structured in phases, Judge Albinson, at times after consulting with the other professionals in the staff meeting, may sanction a noncompliant participant by moving her or him down from a phase nearing graduation to one requiring more frequent appearances. Judge Albinson also uses writing assignments

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³ Improper *ex parte* communications occur when one side of a legal case is able to influence the judge's decision-making, thereby receiving an advantage (Flowers, 2000). The issue is an example of how the adversarial structure of criminal courts can affect mental health court programs even when workers in them are trying to act as non-adversarial teams.

⁴ The Center for Court Innovation is described at its website (http://www.courtinnovation.org/who-we-are accessed 2013) as the New York court system's "independent research and development arm creating demonstration projects that test new ideas." The Center is supported by state and federal funding, and is a social movement organization that is part of the nationwide socio-legal movement of judges and other legal scholars touting the use of problem-solving courts and often basing them on the philosophy of "therapeutic jurisprudence" (see Berman, 2005).
for participants as sanctions; for instance, the professionals decided during staff meeting and the judge required during hearing that a participant write an essay about the negative effects of cocaine use after relapsing. Sanctions also include assignment of additional meetings or group appointments, community service hours and, for repeated or serious program violations, jail time.

**Gilmour County Mental Health Court**

The Gilmour County MHC began in 2007. Of the nine MHC programs, the program in Gilmour County was the smallest, with only five participants at the time of the survey, including four men and one woman. Four of the participants were white, while one was black. None were of Hispanic/Latino ethnicity. During the study, the number of participants fluctuated, increasing to ten and then falling to seven by the end of the study. About ninety percent of the population of Gilmour County is white, eight percent is black, and one percent is Asian, while only about 3 percent of the county was Hispanic or Latino of any race. All of the Gilmour County MHC professionals were white except for Kevin, a black man who was one of the two probation officers monitoring MHC participants. The county is a mixture of several relatively small cities and rural areas. The median household income of Gilmour County was a few thousand dollars below the Midwestern state median.

A drug court program had been established in Gilmour County much earlier, in 1996. Eventually, a member of the local mental health board in Gilmour County contacted Carmen, the director of the probation department, and suggested there may be a need for a mental health court in the county due to people being incarcerated in the
county jail who were in need of mental health treatment. The mental health board was able to provide money to help pay for costs of the MHC, including a caseworker from each of two community mental health agencies serving the catchment areas of the jurisdiction. Carmen explained that at the time the Gilmour MHC began the probation department was able to provide a position to oversee and work exclusively with the MHC program, but since that time Gilmour County and its criminal justice system experienced budget cuts, from local government and from Midwestern state, and the position was eliminated, along with a number of probation officer positions. Currently, Amber is the Gilmour County MHC program coordinator employed by the probation department. The MHC is supervised by Amber as one of three alternative courts in Gilmour County all operating under the same guidelines for participation. Professionals operating the Gilmour MHC include Judge Rosati, who presides over the MHC, Jackie and Connie, two social workers from two different mental health agencies, Terry and Kevin, the two probation officers, and Mary, an assistant state's attorney (ASA). These staff members regularly attend court hearings, held twice a month. A public defender may attend court hearings, but only as needed for changes in a defendant's legal status.

Referrals to the Gilmour County MHC can come from a number of sources, including police, jail staff, judges, the drug court, ASAs, and family members, but the most common referral source is defense attorneys. After Amber receives a referral, she sends it to Mary, the ASA, who reviews it for approval. Amber also meets personally with individual referrals at an appointment during which an intake assessment form is completed. During the referral process, public defenders or private defense attorneys,
who may have made the referral, explain the program and the legal options to the potential participant. If the ASA, defense attorney and defendant agree to proceed with the referral, a formal motion to assess is signed by Judge Rosati or another available judge and filed with the court. Amber reports that about 80 percent of referrals eventually enter the MHC, a much higher acceptance rate than most of the other Midwestern MHCs. Connie, the social worker from one of the mental health providers, is then responsible for conducting a mental health assessment. She conducts the assessment and discusses the program with the referral to determine appropriateness of the program and the new referral's desire to participate. Next, Connie, the probation officers, Judge Rosati, and Mary discuss the referral, and if all agree to proceed, the referral formally enters the MHC program during a hearing. Connie also works as a case manager for MHC participants who live in her agency's geographic area, while Jackie works as a case manager for participants who live in her agency's area adjacent to that of Connie's agency. One of the social workers schedules an appointment to meet with the new participant and begin the process of linking them with services if the new participant has not already been receiving mental health services in the area of residence.

To be accepted into the MHC, a referral to the MHC must have an Axis I diagnosis which can be considered serious mental illness according to officially stated criteria. The Gilmour County MHC accepts participants with misdemeanor charges, but most participants are felony offenders as the substantial participation requirements and time commitment of the program may outweigh the benefit of lessening misdemeanor charges for that level of offenders. The court uses a formal, standard written contract,
although terms of participation are individualized based on the clinical diagnosis.

Generally, the initial agreement is to participate in treatment for one year, with the minimum period for the MHC is six months. Judge Rosati may extend participation time if a participant is noncompliant or needs time to achieve significant progress in treatment. The standard criterion for graduation from the MHC is treatment adherence during a period of time specified by the court. A participant signs a release of information allowing criminal justice and mental health professionals to communicate about her case.

Most of the services provided to a participant are from the community mental health agency that serves the part of the county where they live, but there are a few other mental health agencies providing services. The relevant social worker for a participant develops a recovery plan which outlines treatment modalities. This plan may include community support services, individual substance abuse counseling, psychiatric services, group and individual psychotherapy, and other services. If a participant has a private psychiatrist, then the social worker will monitor whether or not they are actually following up with psychiatrist visits and taking their medications. Connie and Jackie report progress of their respective participants to Judge Rosati at hearings, every two weeks for felony participants and once a month for misdemeanor participants.

Participants in the Gilmour County alternative courts will follow one of two tracks, depending on their criminal background and plea status. Track one participants, generally first time felony offenders with little or no criminal background, enter the program on a pre-plea basis, signing a contract to voluntarily participate in court-mandated treatment. On successful completion of treatment requirements of the MHC,
Judge Rosati dismisses pending charges against track one participants, and no conviction is added to their record. Track two participants enter an alternative court program after pleading guilty and are sentenced to a term of probation with court-mandated treatment. Judge Rosati may lessen the length of the term for MHC participants who show substantial progress in treatment. On completing the program successfully, the track two participant is released from probation but has the conviction on her or his criminal record. Although both tracks are possible, Amber explained in interview that the Gilmour MHC program is currently geared for track one participation, referred to as "diversion." The Gilmour County MHC initially was aimed at lower level offenders, but after operating more than a year there were few appropriate misdemeanor defendants who wanted to opt for the MHC rather than regular adjudication. Carmen communicated the issue with the State’s Attorney’s office, and an agreement was made that appropriate defendants with more serious felony charges could participate in the Gilmour County MHC, although Mary, the ASA, would closely monitor referrals and participants to protect public safety and ensure cases were not likely to become problematic. An equal number of misdemeanor and felony participants were active in the past year.

The Gilmour County MHC is the only one of the nine programs that did not use jail as a sanction for participants. Judge Rosati will sanction noncompliant participants with verbal warnings, increased frequency of required appearances to the MHC, or community service hours. However, he explained that most participants are fairly compliant and sanctioning is relatively rare.

The Gilmour County MHC operates hearings on a less formal basis then other
Midwestern MHCs. Gilmour MHC hearings do not have a stenographer or court secretary, and have no regular bailiff or deputy in the small courtroom where they are held. No jailed referrals or participants are brought before the judge as in other Midwestern MHCs. When the judge enters the room there is no formal announcement for all to rise, although the judge wears robes and is seated on a bench, a heavy wooden desk area elevated above the floor. Because the program has a low number of participants relative to the other programs, the dockets are small, between three and seven persons on observation. Rather than having staff meetings separated from court calls, Gilmour County MHC professionals meet in the small courtroom with no audience during the hearing. Participants wait on seats in a hallway just outside the courtroom, sometimes with family, friends, or counselors, waiting for a probation officer to call each inside one-by-one. Before calling a participant into the courtroom, the relevant social worker will report to Judge Rosati on the participant’s current treatment adherence and progress, while the assigned probation officer will add input regarding criminal justice supervision of that participant, typically required telephone calls or personal visits between hearings. The judge listens, comments on the participant’s progress, and then discusses how the participant should be dealt with during the appearance, with the social worker making recommendations and the probation officer adding input. After this discussion they decide on how to work with the participant, who is then called in to appear before Judge Rosati.

As in other Midwestern MHCs, Judge Rosati engages in personal interaction with participants. He offers encouragement and directives to each participant, praise for
following program guidelines or sanctioning for misbehavior, with commentary from the social worker and probation officer involved. After the personal interaction between Judge Rosati and a participant, the participant leaves, and the professionals begin discussing the next case. The same dynamic of personal relationship between the judge and individual participant exists as in other Midwestern MHCs, but the difference is there is no audience other than the few MHC professionals, including no other participants. The exception to this occurs when a participant graduates at a hearing, as other participants are called in to witness the event and celebrate.

Professionals may also discuss other participants not scheduled to appear during the MHC hearing, as there is no regular staff meeting as in other MHCs outside of the hearing. Mary, the ASA, regularly attends the MHC hearings, and may comment on a case during the discussion before the participant is called into the room, but during the hearing is generally quiet, occasionally providing legal documents and opinions about a case to the judge. A public defender or other defense attorney is not regularly present, unless one is needed due to a change in a participant's legal and program status, at which time Carmen, Amber, or one of the probation officers will contact the relevant public defender or private attorney and ask that defense attend the hearing.

Hackett County MHC Program

The Hackett County MHC program had twenty-eight participants, a large number relative to the population of Hackett County, the smallest of the eight counties at roughly 150,000 persons spread over a number of small cities and rural areas. Hackett County also had the lowest median annual household income of the counties at almost $10,000
below the state median. Twenty-one MHC participants were white and seven were black; none of the participants were Hispanic. At the time of the study roughly eighty percent of Hackett County was white and ten percent was black, while Hispanics of any race were about twelve percent of the population. Thus, blacks were overrepresented and Hispanics underrepresented in the Hackett County MHC relative to the county population, phenomena found at several other Midwestern MHCs. All of the Hackett County MHC professionals are white.

The Hackett County MHC was created after Judge Potter, an older white male who now serves as the MHC judge, recognized a need for the jurisdiction to deal differently with specific mentally ill individuals from the community who were repeatedly arrested. He was concerned that they decompensate in jail by not being moved into treatment. He contacted other local criminal justice and mental health professionals and began discussing a MHC, and then visited the MHC program in Lynne County. Soon the judge and representatives from the State's Attorney's Office, Public Defender's office, court services, and two local mental health agencies began meeting and planning a MHC that Judge Potter would hear. The Hackett MHC accepted its first participant in 2007.

Other professionals in the Hackett MHC program include Ben, the program coordinator, Seth, a public defender, Jill, an assistant state's attorney, two probation officers, and several mental health workers from two mental health agencies. Both agencies provide a number of mental health services to program participants, but a few other agencies may also provide services depending on specific needs. Ben, the program
coordinator, works out of the probation department, and is also involved in the drug court.

Referrals may come from a number of sources. One important way appropriate persons may be identified is via a list of persons incarcerated in the jail faxed to Hale Mental Health, the largest mental health agency, every weekday, where Alan, a social worker with the MHC program, scans it to see if any persons who receive services have become incarcerated. Similarly, workers at Oak Leaf Services, another local mental health agency, will contact someone at the MHC program if one of their mental health workers discovers that one of their participants has been arrested. Interviewees discussed how some referrals come from local police officers who have received Crisis Intervention Training. Other referrals may come from a judge who notes a defendant acting strangely, a probation officer with past experience with a mentally ill defendant or his or her family, a public defender, an ASA, private attorneys, or family members.

After a referral to the program, Ben, the program coordinator, conducts a criminal history check, both local and nationwide. He advises the MHC team of the referral-as-case including offense description, criminal history background, known mental health diagnosis, and status of court proceedings. Jill, the assistant state's attorney, can veto a referral if she believes the criminal history or specifics of the case are unacceptable. Ben and a mental health worker screen each referral independently. Once both screenings are accomplished the professionals discuss the case and decide whether or not to accept the referral into the MHC program. The Hackett County MHC accepts a third of all referrals.

The Hackett MHC accepts participants with a primary Axis I diagnosis. Although
participants with co-occurring disorders are accepted into the program, the MHC excludes those who have a primary substance abuse disorder. The MHC program accepts both misdemeanors and felonies, excluding sex offenses and others according to state law. Nine of the 28 participants in 2010 were misdemeanor offenders, while the remaining 19 were felony offenders. Generally participants enter the MHC program on a pre-plea basis, but there are some participants who have pled guilty. For pre-plea participants, charges are held in abeyance and then dismissed upon successful program completion, while other participants enter a plea of guilty to their charges and are sentenced to MHC program participation for a minimum of 12 months. Some participants are probationers who have violated probation, and are sentenced to participate in the MHC program for the violation. If pre-plea participants are unsuccessful in the MHC program, their cases are returned to the court of original jurisdiction for adjudication. Post-plea participants who are unsuccessful may have their cases returned to the court of original jurisdiction for sentencing, or Judge Potter may determine that enough time has been served and no more probation is warranted.

On entering the Hackett MHC program, new participants agree to a standard contract that mandates the treatment plan prepared by a social worker from one of the mental health agencies. New participants also sign a release of information allowing court and mental health staff to communicate, and may be asked to sign subsequent releases if needed for other reasons. The minimum length of time for participation in the program is twelve months, while there is no established maximum. The MHC is a three-phase program, with each phase representing a different level of intensity of supervision.
Generally, phase one participants are required to visit the program coordinator and attend MHC hearing every week, then gradually progress to phase two with bi-weekly appearances, and eventually to phase three, nearing graduation with monthly appearances.

Participants receive most services from one of two mental health agencies in the county. A social worker employed as a case manager from one of these two agencies will work with a new participant by setting up a mental health assessment and eventually developing a treatment and service plan. Service plans typically include medication management and monitoring, group and individual therapy, and psychiatric treatment. Case managers also utilize other agencies providing services such as housing or drug rehabilitation.

As in other Midwestern MHCs, a combination of probation officer and mental health worker is responsible for monitoring of each participant between MHC court hearings. Probation officers may have participants come to the department for office visits, they may visit participants at their homes, or they may see participants at one of the two mental health treatment facilities. Regardless, probation officers frequently communicate with the assigned case manager between hearings to discuss a participant's needs, recent progress, and problematic issues. Both probation officer and case worker see the participant once a week or more during phase one of the program. They meet with other members of the MHC team during staff meetings held once a week before hearings to discuss each participant's progress and issues.

When interviewed, Judge Potter, Ben, and Scott, one of the probation officers,
explained that the program may have organization and structure, but that the needs of the individual participant are more important than following specific protocol in program operation. For these staff, the idea of putting the participant first means allowing the program to be flexible so that it can be tailored for individual need. Flexibility is stressed not just for program design, but also for the performance of work roles. Hackett MHC staff explained that work roles are fluid, for example at times probation officers may perform case management work tasks, and case managers may perform probation work tasks, all part of a collective effort aimed at meeting the individual needs of the participant.

The other Midwestern MHCs reward participants for good behavior by praising their efforts during hearings, lessening the frequency of court appearances and, in some programs, formally moving them closer to graduation. Workers in the Hackett MHC reward participants in these ways, but also utilize a 'draw' system during MHC hearings which serves as incentive for participants to adhere to treatment and maintain good behavior. At every Hackett MHC hearing each participant who has performed in the program satisfactorily is allowed to draw a paper slip out of a multi-colored bowl, called the 'fish bowl', which Ben brings to court hearings. Each of the paper slips have a reward written on them such as chips, candy, $5, $10, or $25 gift cards for department stores, movie tickets, and other small items. Judge Potter may reward a MHC participant that has done exceedingly well since the last hearing with extra draws, or may sanction a participant for missing treatment appointments or other misbehavior by taking away the draw. Hackett MHC professionals report this system works well to motivate some of the
participants, but not all.

The Hackett MHC staff utilizes a variety of sanctions for participants who do not follow program requirements. Sanctions utilized include verbal admonishments by Judge Potter, increased frequency of court appearance, no draws from the fishbowl, community service hours, and jail for the most serious violations. Judge Potter explained that each participant responds to different types of rewards and punishments, so getting to know each participant is important.

**Lynne County Mental Health Court**

Criminal justice officials in Lynne County began discussing the possibility of beginning a mental health court (MHC) program in 2003 after the county conducted a study of its jail that noted overrepresentation of persons with serious mental illness in the jail population. The Chief Judge supported the jail study, and after looking over the results contacted another interested judge to discuss the benefits of beginning a MHC. The judges contacted the director of the local community mental health agency, Riverside Mental Health Center, which was located a block away from the courthouse, and they began discussing how to develop a MHC. The director formed a coordinating council, including professionals and advocates in the county, who spent eighteen months planning and developing resources for the MHC program. The Lynne County MHC staff includes Judge Sentzsky, the MHC judge but not one of those mentioned above who founded the program; Earnest, an assistant state's attorney (ASA); Joanie, a public defender; Sara, the program coordinator; and probation officers Gene and Loretta. Also, a number of mental health workers from the community mental health center are regular members of the
MHC team, including a psychologist who conducts assessments, a nurse, two therapists, two case workers, and three other mental health workers who work at the county jail.

In early 2005 the Lynne County MHC accepted its first participant. By the spring of 2010 the MHC had sixty-two active participants, thirty-two men and thirty women. Thirty-seven of the participants were white, and twenty-five were black. In addition, one of the participants was of Hispanic/Latino ethnicity. Roughly eighty percent of Lynne County residents are white, twelve percent are black, and three percent are Asian, while about ten percent of the residents are Hispanic of any race. Thus the Lynne County MHC was another in which blacks were overrepresented while Hispanics were underrepresented relative to county population. All of the MHC professionals were white except for Gene, a middle-aged black man who is one of the probation officers, and Shawna, a young black woman who is one of the case workers. Lynne County is made up of a medium-sized city surrounded by several small suburban towns. The median household income for the county is more than $8,000 below the state median, making it the second least wealthy of the MHC counties.

Referrals may come from a variety of sources: a family member, a probation officer, a public defender, or state’s attorney's office. The main referral source is the public defender’s office, and the second is the state’s attorney’s office. These sources fill out a referral form which is sent to Sara, the program coordinator, who records the information of the offender-as-case and sends it on to Samantha, the psychologist who performs mental health assessments. Sara also informs Earnest, the ASA, who screens the referral's criminal charge to determine if it is acceptable. Samantha meets in person
with the referred defendant to conduct a full mental health assessment and come up with a diagnosis. She also has the defendant sign releases of information and gathers information from a variety of sources, including medical history, substance abuse issues, and criminal background, and then makes a determination on whether the diagnosis is related to the defendant's criminal history. After the assessment is completed, it is sent to the other members of the MHC team for discussion at staff meeting to determine whether or not to accept the case. If the referral is deemed appropriate for MHC, the ASA will contact the law enforcement agents involved with bringing charges and, in some cases, victims to gain their approval of the offender participating in the program. About 21% of referrals are accepted into the MHC program.

The Lynne County MHC accepts defendants with a primary Axis I diagnosis, including those with co-occurring disorders. The MHC has both pre-disposition and post-plea participants, and accepts both misdemeanor and felony cases. About 58 percent of participants in the program have been misdemeanor cases, and 42 percent felony. With pre-disposition cases, after a defendant signs a consent form, she or he is brought into the court to formally enter the MHC. Judge Sentzsky will continue the case rather than determining a disposition, and upon successful completion of MHC, dismiss the charge. If a pre-disposition participant is not successful in the program, the case may be returned to the court of original jurisdiction for adjudication. For post-plea cases, the court will formally accept a guilty plea once a defendant has met all of the requirements for entry into the MHC. For those participants who have pled guilty but decide not to complete the program, they can voluntarily withdraw, face a sanction of serving state jail
time, and then transfer to standard probation. For other participants who are not meeting requirements of the program, the state will file a petition to vacate probation, and have a disposition hearing to determine sentencing.

The Lynne County MHC is designed as a three-phase program. Participants start out in phase one with intensive support and supervision, seeing Judge Sentzsky and a probation officer every week, and gradually progress to phase two with reduced support and supervision, and then to phase three with minimum support and supervision leading to graduation. Terms of participation are individualized based on need, although the MHC utilizes a standard formal written contract. Participants also sign a release of information on entering the program allowing court and mental health staff to communicate. There are no established minimum or maximum time periods of participation in the MHC. Generally, participants spend from one to two years in the program. The professionals hold MHC staff meetings and court hearings on a weekly basis.

Monitoring of participants between MHC hearings is accomplished by probation officers and mental health workers from Riverside Mental Health Center. Each participant meets with an assigned probation officer on a regular basis, at least weekly at the beginning of the program, and also meets regularly with a mental health worker, generally a case manager from the mental health agency. A few participants have private mental health care providers that report to the probation officer rather than attending staff meetings. But most participants have regular contact with a case manager and other mental health workers from the agency, such as the nurse, trauma therapist, dual
diagnosis therapist, and others, depending on the specific treatment plan developed. These mental health workers maintain regular contact with the probation officers regarding activities of participants. Riverside Mental Health Center is heavily involved with operating the MHC because it is the only community outpatient mental health provider in Lynne County. Some participants may receive services from other mental health agencies, such as housing, assisted living, and inpatient drug rehabilitation, but the majority of the services are provided by Riverside mental health workers on the MHC team. Beth is the nurse, a recently-created role via specialized funding; she focuses on medication management and other health issues of participants. Additionally, three mental health workers at the jail are liaisons between the jail and the agency so that incarcerated individuals served by the agency continue to receive mental health treatment. These liaisons occasionally attend MHC staff meetings, at times making referrals and other times reporting on MHC participants who have been incarcerated for sanctioning or new arrests.

Professionals in the Lynne County MHC spoke of a willingness to be flexible in the performance of work roles. Sara, Gene, Loretta, and several mental health workers spoke of working together as a team to best suit the needs of participants. They explained that work tasks to assist participants are not rigidly defined by roles, but rather are shared by the different workers, each of whom will perform tasks when needed that may not typically be part of their role.

A variety of sanctions are utilized by the Lynne County MHC for participants who are non-compliant, including verbal reprimand, public service hours, writing
assignments, and jail for the worst violations. Another sanction utilized is having violators called to the front at the beginning of a MHC court call and sit in the jury box while the rest of the hearing takes place. This provides a visual display which participants who violate rules may find embarrassing, as others clearly see they have misbehaved. This is also a temporal punishment, as participants are made to wait and are not allowed to leave until the hearing is over. During the staff meetings held prior to court calls, sanctions are thoroughly discussed before being applied. Joanie, the public defender, is a decades-long veteran of the Lynne County court system. She is sometimes adversarial during staff meetings, arguing for no or less sanctioning of a participant. However, she does not withhold information as in Ferry County. The Riverside mental health workers withhold specifics about therapy sessions, but share general accounts of participants. Much information is freely shared among the MHC professionals at staff meetings.

**Manzanera County Mental Health Court**

Manzanera County contains a number of small cities, a few of which have very affluent residential areas. The county is the wealthiest of the eight with annual median household income well over $20,000 above the state median. In the spring of 2010 the Manzanera County MHC had sixteen active participants, seven men and nine women. Ten participants were white and six were black, and one was listed as Hispanic on the survey. The population of Manzanera County was roughly eighty percent white, seven percent black, and seven percent Asian, while about twenty percent was Hispanic or Latino of any race. As in most other Midwestern MHCs, blacks were overrepresented
and Hispanics were underrepresented in the Manzanera County MHC relative to county population. All of the MHC professionals observed in Manzanera County were white, except for one black man who was a social worker from the county health department. A probation officer and a pre-trial services worker were Hispanic women.

Professionals operate the Manzanera County mental health court as a separate program, but it was initiated during the process of starting a drug court. The MHC was created after court and county personnel, including a judge and representatives from the State's Attorney's office, Public Defender's office, and the Manzanera County Health Department, began meeting to plan a drug court program. The group determined that another separate court was needed for persons whose criminality was the result of mental illness rather than addiction. The drug court began first, and after it was established and had been running for several months, the new mental health court program was begun, with some participants in the drug court program transferred over to the MHC. The MHC professionals include Judge Bradford, who presides over the mental health court docket; Alex, the probation director; Val, a probation officer who also works as program coordinator; Cassandra, a pretrial services officer; two assistant state's attorneys (ASAs), two public defenders, and county health department workers, including a supervisor and two case managers with clinical social work backgrounds.

Professionals in the Manzanera County MHC program accept defendants with Axis I or Axis II diagnoses, including some with co-occurring disorders. But they exclude those referrals with a primary substance abuse disorder, who may be referred to the drug court. The professionals accept defendants with misdemeanors or nonviolent
felonies, on either a post-plea and pre-plea basis. At the time of observations five of the participants faced felony charges, while eleven faced misdemeanors. Post-plea participants plead guilty and receive a probation sentence to comply with the treatment requirements of the MHC program during probation. Some participants were serving a regular probation sentence and were referred for probation violations. Judge Bradford places participants who enter the program on a pre-plea basis on bond conditions that compel them to follow treatment requirements of the MHC program, and if they are successful in completion of the program the charges are generally dropped.

Referrals can come from a number of places, including defense attorneys, judges, law enforcement officers, jail staff, mental health providers, family members, pre-trial services, and probation officers. Sixty-four percent of referrals eventually enter the MHC program, a high acceptance percentage relative to the other Midwestern MHCS save Gilmour County. Workers in the pretrial division in Manzanera County often identify somebody that has a mental illness in bond reports, which can lead to a referral of a pre-plea case. If the referral comes from the probation department, this is a post-plea case in which the probation officer has determined a mental illness may be present in the probationer, making her or him appropriate for the MHC program. Generally, pre-plea cases are going to involve persons considered to be a lesser risk, because they do not have much or any criminal history, and the offenses are typically less serious than post-plea cases. The participation time requirement for pre-plea cases is generally between one and two years. Post-plea cases are often felony probation sentences of more than two years, which may be lessened to 18 to 24 months depending on a participant's progress.
There are no established minimum or maximum time periods for participation in MHC.

New referrals must sign a petition to enter the MHC program, and a waiver of confidentiality allowing the professionals to share information. Jamie, a woman who is one of the ASAs, reviews each referral and acts as a "gatekeeper", rejecting some referrals, which go no further, but accepting others, which are then sent to county social workers for further consideration. One of the social workers will complete a formal mental health assessment for each referral, including historical and diagnostic information. A social worker will also gather information from previous reports from other treatment providers, and from family members. This information is used to verify diagnoses and determine how needs can be met by the MHC program. Occasionally people are referred who have never been diagnosed with mental illness before. For these the social worker may ask for a psychological evaluation from probation services, or have the participant receive a psychiatric assessment. After information has been gathered and a diagnosis is confirmed or determined, the relevant social worker develops a primary treatment plan for the referral to follow on coming into the court program. Val, the program coordinator, works as an employee of the probation department, and places all referrals under the pending section of the twice weekly staff meeting agenda for discussion. After the assessment is done the MHC professionals discuss the referral and vote yes or no as to whether or not the referral can be placed in the program.

Most services for participants in the MHC program are provided through the social workers for the Manzanera County Health Department, who act as case managers and can internally refer participants to psychiatric care and therapy. The case managers
also determine financial sources to pay for participant’s services. Val has regular contact with participants when they visit probation offices, and during staff meetings she may suggest participant needs which the MHC team can discuss. On getting the preliminary treatment plans from the county case managers, Val may refer participants to outside agencies, because not all resources are available through the county health department. For example, a number of participants need residential dual diagnosis treatment, which is typically obtained from a mental health agency through the probation department, and funded by the probation department. But the Manzanera County Health Department itself is the main provider of services, and there are only a few other agencies providing services to participants. Because of this, Val and the county social workers usually work together in case management of post-plea participants. In a similar way, Cassandra, the officer for pretrial services, also works closely with the case managers for pre-plea participants. Also, the public defenders, Bruce, a young man, and Jen, a young woman, were observed during staff meetings working to assist with case management by agreeing to provide rides for participants to service agencies and assist with completing forms.

During interview the Manzanera MHC professionals explained that monitoring is similar for pre-trial versus post-trial participants regarding frequency of contacts, although pre-trial services workers typically make home visits whereas the program coordinator dedicated to MHC participants typically schedules participant visits to the probation department offices. Judge Bradford hears the MHC docket weekly. He explained that sometimes as a sanction he may require a participant to visit the probation department, or even his office, more than once a week, even every weekday. Other
sanctions include formal verbal admonishment by the judge during the hearing, and for the most serious violations of program requirements, days in jail.

Judge Bradford may drop charges (pre-plea) or reduce or end the probation sentence (post-plea) for participants who successfully complete the program. Participants who are not successful by failing to comply with the requirements of the MHC may face one of several possible outcomes. If the unsuccessful participant entered the program on a post-plea basis and the charge was relatively serious, such as felony level, then one of the ASAs will file a petition to revoke their probation and negotiate a jail sentence with the failed participant. Although entitled to a hearing on the petition for revocation, these participants usually come to an agreement on the jail sentence without asking for a hearing. Judge Bradford may sentence other post-plea participants with felony cases to a prison term after revoking their probation. For participants who are noncompliant and unable to finish satisfactorily but have relatively minor offenses, an ASA and Judge Bradford may agree to terminate them from the program without further jail sentence or sanction. When pre-plea cases are terminated from the program, the relevant ASA pursues charges, and if the former participant is convicted, this results in a jail or prison sentence, or standard probation sentence, and a criminal record.

**Waters County - Bevan City Mental Health Court**

The Bevan City Mental Health Court began in 2004 and serves a large city in Midwestern state. The idea for the program formed when professional workers operating the drug court in Waters County discovered a need for mentally ill substance abuse (MISA) treatment among many participants. Some Waters County criminal justice
officials, including the drug court judges, had learned about MHCs being developed elsewhere through attending conferences and reading judicial literature. Professionals working for the federally established drug treatment agency (FDTA) present in Bevan City and already helping operate the drug court were a "driving force" behind planning and strategy meetings for the MHC, and obtained a federal grant to begin the program.

The survey in 2010 found that the men's MHC program had 30 participants participating while the women's program had 25. Among the 55 program participants, 48 (88%) were black, while 7 (12%) were white, while there were none of Hispanic/Latino ethnicity. The low number of white participants, high number of black participants and non-existence of Asian or Hispanic/Latino participants can be contrasted with the respective numbers for the 2010 population of Waters County, where roughly sixty-five percent were white, twenty-five percent were black, and five percent were Asian, while about twenty-five percent were Hispanic of any race. Waters County is ranked in the middle relative to the other MHCs in terms of affluence; in 2010 the median household income for the large, urban county was about one thousand below the median income for Midwestern state.

Unlike any other court researched in this study, the Bevan City MHC program is divided by gender, so that a judge for the women's program holds court hearings on Tuesdays, and another judge for the men's program holds hearings on Thursdays. This separation was put in place following the model previously established by the drug court program, after drug court staff determined that some women drug court participants were being negatively affected by men in the drug court with whom they had relationships.
The men's and women's MHC programs involve most of the same staff. In general, the same overall process and rules are in place for both programs, and hearings for both are held in the same courthouse in Bevan City, albeit in different courtrooms on different floors. For the purposes of this study, the Bevan City MHC is considered one overall program that can be compared to the other eight MHC programs of the study which do not separate hearings by gender.

The Bevan City MHC professionals include two judges, Judge Allen who hears the men's MHC, and Judge Jamison, who hears the women's program. Both are older white males. Jennifer, a white woman, serves as assistant state's attorney (ASA). Her role involves formal filing of charges and violations on behalf of the state during court hearings, but she does not work as gatekeeper for the MHC as in other Midwestern sites. The gatekeeper responsibility falls to Phil, an older white man who is employed as program coordinator by the State's Attorney's office. Phil has a mental health background, and he organizes meetings, pursues resources, and screens all referrals for acceptability in terms of criminal history and compliance with Midwestern state law. The Waters County staff also includes Brian and Shelly, both white and working as public defenders; Kim, a young black female probation officer who works with all mentally ill probationers; Deborah, Collette, and Janice, three black women employed as social workers by FDTA; and their supervisor Harry, an older white male. These persons regularly attend staff meetings held before the MHC court calls, with the men's and women's calls each held once a week. Mental health workers from various other service providers may attend staff meetings on occasion as needed, as do county jail mental
health workers. Interns from local graduate psychology programs are utilized to conduct psychological assessments, and occasionally attend staff meetings.

Referrals to the Bevan City MHC program can come from a number of sources, but most referrals come from the Waters County jail. Several staff stressed the importance of a newly developed data linkage system connecting data from the Midwestern state mental health department with county jail data on detainees. This system allows jail employees working with the Bevan City MHC to identify detainees who have previously received state services due to a mental health condition. Detainees identified through the data linkage system are then screened to determine if they have been diagnosed with a mental illness and are being held for a non-violent felony, and those judged to be appropriate are then referred to the MHC staff and approached about possible participation in the program. A detainee’s defense attorney will also be contacted and included in the process, typically a public defender. If the detainee expresses interest, one of the FDTA mental health workers and a public defender will meet with the detainee in the jail to explain the program more fully. For jail detainees referred this way, as well as all other referrals, Phil runs a criminal background check to ensure that the criminal history of a referral will not prevent approval. In addition, all screened referrals are discussed by the MHC professionals in staff meetings, held once a week just before hearings. They collectively decide whether or not to accept a referral into the program. About 55 percent of referrals eventually begin the Bevan City MHC program.

The program only accepts defendants who have formal documented diagnosis by
a psychiatrist of a primary Axis I mental disorder, as stated in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-R), and charged with non-violent and non-sexual felony offenses or probation violations of sentences for such offenses. As Phil explained, the Bevan City MHC is a felony program because it was established in the main courthouse in Waters County, which only hears felony cases, and is where the drug court is located. Misdemeanor cases are heard in various other court locations in Bevan City and suburbs. He also explained that the 24-month intensive probation requirement is a lengthy probationary sentence compared to what misdemeanor defendants in Waters County may otherwise face.

Participants enter the Bevan City MHC by pleading guilty to their charge and then being sentenced by the judge to two years of MHC probation. For some participants, the judge may reduce the time requirement slightly, while for others the judge may extend if they gain a new charge. New participants sign a formal, standard written contract, which routinely has individualized terms added, as well as a release of information allowing the court staff, FDTA mental health workers, and outside service agency workers to communicate. The contract and formal sentence documents from the Bevan City MHC are presented in Appendix B. The criteria for graduation from the program are adhering to treatment and remaining illicit drug and alcohol free for a time period specified by the judge.

Kim, the probation officer, meets with participants up to once a week. Social workers from FDTA meet with new participants once a week or more, and provide case management services. After initial appointments with a prospective participant, a FDTA
social worker assigned to the case develops a treatment plan with input from other MHC professionals, and then refers the participant to other mental health and social service programs. Bevan City has a number of service providers which FDTA social workers utilize. Participants are referred to other agencies for case management, individual and group therapy, inpatient treatment, outpatient treatment, residential programs, substance abuse treatment, and psycho-social rehabilitation. As Deborah, one of the MHC social workers explains, FDTA provides case management for criminal justice purposes, and functions as a "broker" of service provision, depending on participant need and program status, from a myriad of options available in Bevan City.

The judge will apply some type of various sanctioning methods when participants are noncompliant. In the staff meeting before each MHC hearing, the professionals discuss each participant on the day's docket, as well as others and new referrals, via an agenda prepared by Phil. They debate referrals after considering textual documents representing the offender-as-case. The social workers and probation officers provide verbal and textual reports to the judge on each participant's performance in treatment and living. Collectively the MHC professionals make decisions regarding the need for sanctions - whether or not to sanction and, if warranted, what kind. Such decisions are noted by the judge for use in the hearing.

Judges for both the men's and women's program engage participants through face-to-face personal interaction during hearings, as in other Midwestern MHCs. The judges offer praise for those participants who have been following program requirements, while admonishing those who fail to follow treatment plans or violate program or residential
rules. Judges made the strongest verbal admonishments to those participants who repeatedly violated plans and rules. The judges sometimes threatened, and at times initiated, removal from the MHC program and incarceration through formally documented processes and assistance from county law enforcement workers.

As in other Midwestern MHCs, another basic sanction determined during staff meetings involved changes or continuances of the length of time between scheduled court hearings. If a participant has displayed strong adherence to the program for a significant length of time, then the professionals may decide to reduce the frequency of court appearances, and the judge will often present the change in schedule to the participant during the hearing and comment on its meaning as a sign of progress. If the participant has not displayed significant progress, then the professionals may decide on a reduction in the length of times between hearings, or continuance of weekly appearances and, along with verbal admonishment, during the hearing the judge may present the frequent appearance schedule as required due to a lack of progress. Participants also face sanctions if a social worker or the probation officer detects that they have been using illicit drugs or alcohol. Monitoring professionals verify and document drug use of participants via urinalysis tests. The judge may require participants identified as abusing substances to receive inpatient treatment in the county jail health facility for a period of time, at the end of which they are released into treatment in another inpatient facility while continuing in the MHC program.

If participants are seriously noncompliant, such as with repeated drug use or refusal to participate in treatment over time, Jennifer, the assistant state's attorney, files a
violation of probation, and the participant is taken into custody by county jail officers at the court hearing. Alternatively, if the participant fails to appear she may be arrested by law enforcement officers outside of the court. The judge may have the participant placed in an inpatient bed in the county jail health facility for mental health treatment.

Eventually, if the judge determines that the participant's violation warrants removal from the MHC, the violator may attend the MHC hearing, in jail scrubs, be removed from the program via probation revocation, and be re-sentenced on the guilty plea, which can result in a multi-year prison term. However, in some cases the judge, in consultation with the rest of the professionals, will decide that a noncompliant participant does not need further prison sentence or probation monitoring, and the participant will be "PTUd" or terminated from probation unsatisfactorily with no further sentence. Such a case generally involves a participant who, although unable to successfully complete the MHC program, has served a significant amount of time on probation.

**Waters County - Tandy Mental Health Court**

The Waters County MHC in the suburb of Tandy serves several suburbs bordering Bevan City. The Tandy MHC began at the Tandy Courthouse in 2008. Of the nine MHC programs, the program in Tandy was the second smallest, with only six participants at the time of the survey, including three males and three females. Four of the participants were white, one was black, and one was Asian. None were of Hispanic/Latino ethnicity.

An official of township government in the area was instrumental in beginning the Tandy MHC. The director of the township's mental health commission obtained a federal
grant and contacted workers at the MHC in Bevan City, including FDTA workers, explaining the need to set up a MHC in Tandy. The director also contacted judges at the Tandy courthouse who assisted in scheduling regular mental health court time and having one of them assigned to hear cases. Additional funding was obtained from his township and another nearby township, although officials working there were reluctant at first to commit funds to a new MHC.

The Tandy MHC is modeled on the one in Bevan City, having the same basic requirements for participation. These include only accepting non-violent, non-sex offense felony offenders and probation violators with an Axis I diagnosis. The program in Tandy also utilizes a number of Bevan City staff persons, including Deborah, one of the social workers from the federally established drug treatment agency (FDTA), Harry, the FDTA supervisor, and Phil, the program coordinator out of the State's Attorney's office. During the study Kim, the probation officer from the Bevan City program, also began to work at the Tandy site in addition to the city location. Other workers are from Tandy, including MHC Judge Cameron, an older white male, Janet, a white woman who works as assistant state's attorney, and Charles, a white man who works as public defender. Three mental health agencies - a local hospital, a drug rehabilitation facility, and a housing service - have workers who regularly attend staff meetings, which are held twice monthly before MHC hearings. Interns from local psychology graduate programs assist the program as needed.

Referrals can come from a number of sources, including Waters County jail, judges who note odd behavior of defendants, and defense lawyers. Deborah explained
that the majority of referrals come from the medical facility at the jail. As at the Bevan City location, the data system linking the state mental health department with the Waters County jail is utilized. A jail worker compares the daily jail census with state records of mental health service provision. An arrest in Tandy or in one of a number of nearby towns will go through the Tandy courthouse, and referrals are made among those cases.

The assignment of cases to a court in Waters County depends on where the case originated: where the offense occurred and subsequent charges are filed. However, in interview Deborah explained that a case has been accepted from a neighboring municipal district that had no MHC program. She also noted that a participant was allowed to transfer MHC programs and report to probation at the courthouse in Bevan City, as this was closer to the participant's residence.

Phil runs a background check for the State's Attorney's office to screen all referrals. Approved participants enter the program by pleading guilty and receiving a two year sentence of MHC probation. The program accepts non-violent felony offenders, but no misdemeanors, as in the Bevan City program. Deborah and other FDTA social workers follow the same assessment and service planning procedures in Tandy as they do in Bevan City. A referral must have a diagnosis completed prior to involvement, and then the social workers conduct an assessment and develop a service plan. Deborah explained that during this process they rely heavily on information from "collaterals," other service providers in the community. Monitoring during the program is accomplished by Kim and by social workers from FDTA.

The members of the Tandy MHC staff who also work with the Bevan City
program noted an important difference between the programs. The Bevan City Police Department has a trained Crisis Intervention Team (CIT) which can be called on the scene of incidents involving an offender thought by other officers or citizens to have mental illness. These are police officers especially trained to defuse crisis situations in which a person has become psychotic. In the area of the Tandy MHC there are a number of different police departments, but no specific CITs among them. Deborah and Kim explained that officers from several suburban police departments and the sheriff's department have worked with them in dealing with participants, but they also described issues with some officers and departments where there was a lack of training and a lack of cooperation with the program and with mental health agencies.

As in the Waters County program in Bevan City, and the other MHCs, basic sanctions in the Tandy MHC program include verbal praise or admonishments from Judge Cameron regarding recent program participation, or continued, increased, or decreased periods of time between scheduled court hearings. In discussing sanctioning, the Tandy staff explained that jail incarceration is used as a last resort for a pattern of noncompliance. Kim explained that often sanctioning with jail occurs because of the participant's repeated positive drug screens. She also explained that the reason the MHC staff decide that a violation of probation is warranted may be to get the participant back into treatment at the jail. When participants are incarcerated for a violation of probation terms, Judge Cameron has them sent to the large county jail health facility in the city. Even when Janet files violations of probation with Judge Cameron and participants are incarcerated, Deborah explained that they work hard to "keep folks in the program" rather
than having them terminated from the MHC and re-sentenced.

**Conclusion**

Above detailed description of each of the nine Midwestern mental health court programs was presented. The next chapter explains how the programs were established, and describes each of the professional roles found at the programs, including similarities and differences found when roles were compared among sites.
CHAPTER FOUR
THE ESTABLISHMENT OF MIDWESTERN MENTAL HEALTH COURTS AND
ORGANIZATION OF PROFESSIONAL ROLES

This chapter will consider the establishment of MHC programs in Midwestern, including the organization of various professional roles and how they compare and contrast across sites. The analysis presented here includes ideas from institutional ethnography and research on social movements, as well as from previous scholarship in the sociology of professions, the broader topic area of sociology of work and occupations, and the sociology of organizations and institutions. As explained above, data collection and analysis in this study focused on work activities of professionals as they operate MHCs, while also investigating their understandings of those activities. Professionals who operated the MHCs organized their work roles at each of the sites, and engaged in a workplace culture that is the product of practices and vocabulary of two institutions, criminal justice and mental health, being blended as they engaged in action and interaction in processing mentally ill offenders. The specific research questions this chapter attempts to answer include: How were mental health courts in Midwestern initially established? How are professional roles organized and enacted at each of the sites?, How do professionals understand their roles in the MHC program, including their work activities, the activities of co-workers in professional roles, and the way these work activities affect participants in the programs?, and What commonalities and differences
become apparent regarding program structures and professional roles when comparing sites? Attempts to answer these questions must recognize aspects of power present in professional work activity performed in MHCs, specifically the power that professionals exercise when working with offenders identified as mentally ill.

**The Establishment of MHC Programs in Midwestern**

The first MHC in Midwestern was established in Ferry County in 2004, and by 2009 MHCs had spread to the seven other counties. In this section I consider how past sociological work can explain the establishment of MHCs. Past research on social movements may be used to explain how professionals collectively established new court programs, but this is problematic. As discussed in Chapter One, drug courts and mental health courts were initiated and largely influenced by the efforts of judicial officials who, informed by scholarship promoting the philosophy of therapeutic jurisprudence, had formed a nationwide social movement within criminal justice systems. But sociological scholarship has often viewed social movements as groups of persons who collectively attempt institutional change by challenging authority from outside of institutional channels (Snow, Soule, and Kriesi, 2004), while the problem-solving court movement is a *sociolegal* movement (Miller and Johnson, 2009) of professionals in positions of authority within criminal justice and governance institutions. Theories of social movements are problematic for explaining this movement of professional actors within state institutions.

Judges working in courts and other criminal justice officials make up the bulk of the national problem-solving courts movement (Berman and Feinblatt, 2005). As argued
in Chapter One, they *are* the state, at least part of the state as it exists in courts and political governing bodies. Political process theory conceives effective social movements as arising at particular times when groups of people with collective grievances can take advantage of structural weaknesses within the state, engage in contentious collective action against state leaders, and through such action exert political pressure on authorities to change institutions (Tarrow, 1998). The so-called "war on drugs" may have created structural weaknesses within the state in the form of courts, jails, and prisons being overwhelmed with drug offenders (Kappeler and Potter, 2004), but judges who collectively developed an ideology of problem-solving courts, formed a movement gaining support of key politicians, and began organizing specialty courts at the local level cannot be described as outsiders engaged in contentious action. New social movement theories do not apply either, as they consider how individual members of an oppressed social group develop collective identity, eventually confronting the state and demanding change (Taylor and Whittier, 1992).

Resource mobilization theory describes rational actors who take advantage of opportunities to create formal organizations that engage in a variety of strategic tasks, dependent on available resources, and develop links with business and government to affect institutional change (Zald and McCarthy, 1987; Aveni, 1978). As representatives of the state, judges and other criminal justice officials exercised power and obtained resources, either within or outside local government, to begin specialty court programs. They also formed professional organizations aimed at promoting specific change in the form of specialty courts, as in Midwestern where criminal justice and mental health
officials formed an organization promoting the use of mental health courts. But many of these professionals also represent the state, thus the problem of developing linkages with local government does not apply. Further, resource mobilization theory explains the difficulties of social movement actors finding resources to organize and promote interests, while criminal justice professionals in the problem-solving courts movement are often well-positioned to obtain resources from the state in order to implement specialty court programs.

A more general theory of organization from DiMaggio and Powell (1983) does not include conceptualization of a social movement but can help explain how nine similarly-structured mental health court programs emerged in Midwestern over a five-year period. There were variations found among the programs, some of which are described below, but the MHCs were also very similar from site to site. There are a number of specific professional work roles that were found at each of the MHCs, including judge, assistant state's attorney, public defender, probation officer, social worker, and program coordinator. The basic organization of every MHC program was similar, built around having each participant attend periodic court hearings before a judge to review progress in mental health treatment and other court-mandated activities, as well as stability or changes in criminal status. Generally an assistant state's attorney and a public defender attend each court hearing. Between hearings professionals such as probation officers and social workers are involved in monitoring participants, and often obtain or provide them with services. Each court program also conducted a referral progress to select new participants among applicants to the program, and a graduation
process for those participants who had performed successfully for a required length of time.

DiMaggio and Powell (1983) studied organizations within what they refer to as an "organizational field," a set of organizations that make up a recognized aggregate within a larger institution, such as an aggregate of new specialty court programs within a state's criminal justice systems. They argued that similarity occurs among organizations because as a field emerges powerful forces make the organizations homogenous bureaucratically and in other ways. Judges in Midwestern described reading professional literature and attending conferences in becoming aware of the establishment of new MHCs. After Ferry County established an MHC, other counties sought funding and began opening MHC programs. Often the establishment of new programs in Midwestern involved more than conferences and literature, as some professionals visited the MHC in Ferry County or at one of the other early Midwestern MHCs - Bevan City and Lynne County - before designing a program in their respective counties. A few individual professionals in each county, usually judges assisted by mental health leaders, exerted effort to begin their own programs while constrained by the county's specific resource availability, but DiMaggio and Powel describe how professionals and the state - the "great rationalizers" - will often deal with constraints in ways that are very similar in the aggregate in terms of culture, structure, and output.

Citing Hawley (1968), DiMaggio and Powell refer to this homogenization process as isomorphism, a constraining process causing one unit in a population to resemble another unit that faces a similar set of environmental conditions. They describe three
kinds of institutional isomorphism: coercive, mimetic, and normative. A number of professionals in Midwestern described establishing the MHCs through learning processes of attending conferences, reading literature, and visiting established programs; mimetic and normative isomorphism seem to be most relevant in explaining similarity among Midwestern MHC programs. Professionals engaged in mimetic processes when modeling programs after what was described in literature, discussed at conferences, or witnessed at newly established programs. They also engage in normative processes within their own professions. Judges discussed the problem of persons with mental illness repeatedly appearing in their courtrooms, and began sharing with each other the idea of MHCs to help such persons. Several judges reported learning about the programs from other judges, and recognizing that they could introduce the programs to target certain individuals in their own jurisdictions. At several sites, Chief Judges were instrumental in introducing programs and organizing the participation of other judges, as well as the participation of public or private agencies to provide services. Mental health professionals of those agencies described communicating with those in other counties regarding how they could play a role in the new court programs to provide services to criminalized persons with mental illness.

Program designs were similar, but there was also differentiation among the Midwestern MHC program structures. Some MHCs largely relied on local government workers - county health department workers and court mental health workers - to regularly attend staff meetings and organize or provide mental health services to MHC participants. Other MHC programs relied on outside agencies, such as community
mental health agencies, local hospitals, and residential providers, to provide workers who regularly attend MHC staff meetings and court calls, help monitor participants, organize their mental health treatment, and, in some cases, provide it directly. This differentiation varied by county affluence. The wealthiest counties, Ferry County and Manzanera County, had large programs staffed by multiple government workers doing monitoring and mental health case management. Programs in the least affluent sites - Gilmour County, Lynne County, and Hackett County - developed close relationships with one or two local community mental health agencies that provided regular staff. Collins County and Gabriel County were relatively affluent, but the population and the programs in the two counties were smaller than in the wealthiest counties. The Collins and Gabriel MHCs had workers from community mental health agencies, but also had government workers with mental health backgrounds working as program coordinators, and in Gabriel County several forensic psychologists who worked for the court jurisdiction were part of MHC staff. Waters County had the largest population and was not affluent relative to the four wealthiest counties. The Waters County MHCs relied on workers from a federally established drug treatment agency to organize mental health service provision, which was obtained from a wide variety of local agencies.

Resource dependency theory (Pfeffer and Salancik, 1978) is applicable to the differentiation of Midwestern MHCs, as it explains how the acquisition and maintenance of human, financial, and other resources is essential for organizational survival, and thus

1 As in Chapter Two, county affluence is measured and ranked by comparing each county's mean annual household income to the state mean using data from the 2010 U.S. Census.
shapes the structure of organizations. In the least affluent counties new MHC programs had obtained funding during a time of Midwestern state-enforced budget cuts overall for funding of services. In this environment, the less-affluent counties had fewer government workers to operate the new programs, but found community mental health agencies willing to commit workers to the MHC, as this represented needed funding for their mental health services, albeit through criminal courts. Although MHCs in more affluent counties also developed relationships with non-government mental health agencies, these MHCs were not as dependent on outside agencies because, in spite of state budget cuts, their courts and local health departments were better staffed with probation officers and mental health workers that could operate the new programs.

Institutional ethnography (Smith, 2005) was the basis for data collection on this study, and also provides another way to consider how MHC programs began in Midwestern by starting with the standpoint of worker. Using the institutional ethnographic method, one discovers the everyday lived actualities of workers, who become a source of knowledge, and maps everyday local relations, working through and outwards from a local site, discovering trans-local connections, and tracing upwards hierarchically in terms of power to the "ruling relations." Here I present a brief institutional map starting from the standpoint of Tina, the program coordinator at the Gabriel County Mental Health Court.

2 Resource dependency theory (Pfeffer and Salancik, 1978) shares similarities in name and some concepts with resource mobilization theory (Zald and McCarthy, 1987; Aveni, 1978), but the former is drawn from broader and more general organizational theory, while the latter is drawn from social movement theory explaining groups of people with some type of demand for institutional change, stressing the importance of resource development for such groups.
Following Smith (2005), Tina is not an object of inquiry; rather, she serves as an informant providing description and display of everyday work knowledge and activities. Using institutional ethnography, I discover how she accomplishes work, and then use this as a starting point to explore how her work is coordinated translocally beyond the local site where it is actually accomplished. The object of inquiry is made up of aspects of the criminal justice, mental health, and political institutions relevant to her experience.

Tina works in a position serving as both probation officer for all MHC participants and administrator for the program. She was hired by Judge Albinson because of her mental health background as a psychologist and counselor. She accepts paperwork for referrals to the Gabriel County MHC, and does some of her own paperwork, keeping track and organizing them. Tina does an initial screening for referrals by meeting with the potential participants to determine eligibility issues, such as residency status, conformity of the criminal charge to Midwestern statute for mental health courts, and overall acceptability to the program. She sends the information to the assistant state's attorney (ASA) for further screening of the criminal charge. If the ASA determines that the referral is acceptable, this is communicated to Tina, who then sets up an appointment with a court psychologist who conducts a psychological evaluation of the referral. After this is accomplished, Tina and the rest of the team discuss the case and determine whether or not the referral can begin the program. If the team collectively decides to accept the referral, Tina fills out paperwork to refer the prospective participant to an appropriate mental health agency in the community for service and treatment planning.
Tina meets regularly with each participant in her office, where she keeps track of their progress but also attempts to help them in a variety of ways, such as counseling, advising, and motivating them. Each week, she organizes and writes a staff meeting agenda, which structures the order of conversation among professionals, and provides important details and briefly summarizes progress for each referral and participant. An example of a staff meeting agenda is presented in Appendix B. She also provides verbal reports on the participants' treatment progress to Judge Albinson and the rest of the professionals at staff meetings. Occasionally in staff meetings Tina acts as advocate for participants who are facing sanctioning for bad behavior. As a result of getting to know each participant in private appointments, she argues to the other professionals for tolerance and understanding of a participant's bad behavior, and tries instead to highlight good behavior.

An important institutional aspect that coordinates the work of Tina and other professionals in Gabriel County is how selective the programs are. Midwestern state law allows for MHCs but prohibits persons facing certain kinds of criminal charges from participating. Further selection occurs as Tina indirectly through a court psychologist verifies whether or not a referral has a documented mental disorder diagnosis per DSM categories. Additional filtering occurs as Tina discusses with other professionals whether or not the referral will be an appropriate participant for the MHC program, one who is severely mentally ill and would benefit from treatment, rather than simply criminal. Still more filtering occurs when referrals or participants are determined through diagnoses and the getting-to-know process to be primarily substance abusers, and more appropriate for
the drug court. As mentioned in Chapter 3, Tina reported that out of 184 referrals since the MHC began, 31 had become participants, about 17 percent. Since she has worked there, her case load has fluctuated from 7 to 18 individuals, but is generally around 10 to 12 people.

The selective parameters of the Gabriel County MHC program are set up extralocally by state law, and locally by judges and other court officials who organized the program. The Chief Judge and other founders of the program were constrained by the availability of local resources, but were also informed by the extralocal sociolegal movement establishing problem-solving courts in Midwestern and nationwide, of which the founders were a part. The problem-solving court movement influenced the establishment of drug courts before mental health courts in most Midwestern jurisdictions of this study, including in Gabriel County.

The design of the Gabriel County MHC mirrored the local drug court, the basic design of which was established as early as 1989 by Janet Reno in Broward County, Florida (Goldkamp and Irons-Guynn, 2000) and spread throughout the country over the next two decades as the result of the efforts of a national movement of judges and other officials (Nolan, 2001). In 1994 Congress authorized the Attorney General to make grants for the establishment of drug courts across the country (Berman and Feinblatt, 2001). Key federal politicians supported the movement, such as Joe Biden and William Bennett, who wanted to fight the efforts of those who supported legalization and ending the war on drugs (Nolan, 2001). At the time there were many who began to criticize the war on drugs' "collateral damage," which included prisons and jails full of nonviolent
offenders, minorities imprisoned at rates that far exceed their proportion of the population, and women serving long sentences away from their children (Kappeler and Potter, 2005). Drug courts became a way for state actors to avoid the dramatic change of drug legalization by keeping the social control of drugs within the criminal justice system while also addressing the growing criticism of drug criminalization. In establishing drug courts, judges could now align their practices with the burgeoning therapeutic culture in the United States which included public recognition of illicit drug use as disease requiring treatment (Nolan, 2001). Important legal scholars who had gained financial support from the state and were often experienced as judges promoted the therapeutic practices of the new specialty court solution in academic and professional discourses (Berman and Feinblatt, 2005; Winick and Wexler, 2003). Drug courts helped institutional actors - judges, criminal justice officials, and politicians - maintain legitimacy of the state in fighting a war on drugs by providing a seemingly humane way to address its worst effects. Eventually judges and politicians recognized mental health courts as a way for the state to address the problem of large numbers of persons with mental illness becoming incarcerated in the wake of deinstitutionalization (Goldkamp and Irons-Guynn, 2000).

Tina's work as program coordinator in Gabriel County has been shaped by these historical processes. Recall from chapter one that Smith (2005) describes ruling relations as "textually mediated" connecting people across time and space and thus organizing everyday life - "the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them" (page 10).
Like other mental health courts in Midwestern, the Gabriel County mental health court in which Tina works has been largely shaped extralocally by a movement of judges, criminal justice officials, and politicians who promote a therapeutic ethos within criminal courts as a way to deal with overwhelming numbers of drug offenders and mentally ill individuals. Using Smith's (2005) schema, the sociolegal movement of judges and legal scholars who promoted the new courts, and the politicians who provided funding and passed legislation enabling the programs, are the extralocal ruling relations which coordinate the work activities in the locale of Gabriel County.

From Tina's standpoint as worker she is limited in how she can help the offenders whom she encounters. She must sift through the referrals to find individuals who fit the parameters of the program as delineated by county officials and state law, and who will be able to do a number of mandated activities over time so that they can eventually graduate and serve as examples of the effectiveness of the program. Interestingly, Tina remains within the limits of the program and works hard to help the participants, but also recognizes that the court programs are not an effective solution to the problem of mentally ill individuals being caught up in the criminal justice system. She and other Gabriel County MHC professionals expressed in interviews and during observations that the real problem is a lack of mental health services in their community. Yet, as the ruling relations dictate, Tina and the other professionals can only work at the MHC within their roles to help the relatively small number of individuals who fit the parameters of the criminal court program. Smith's (2005; 1990) conceptualization of extralocal ruling relations coordinating everyday work activities is quite useful in explaining how mental
health courts were established in Midwestern as a particular form of organization. In the next section, I present how the professional roles were organized among the sites.

**Professional Roles in Midwestern MHCs**

I observed various professional roles during ethnographic field work at the nine mental health courts (MHCs) in Midwestern state, and explored them in interviews. My data collection and analysis focused on work activities of professionals as they operate MHCs, while also investigating their understandings of those activities. As will be demonstrated below, in researching these activities and understandings one must recognize aspects of power present in professional work activity performed in MHCs, specifically the power that professionals exercise when working with offenders identified as mentally ill.

The term "professional" in this work is used to describe each of the essential work occupations present in MHC programs, including judges, attorneys, probation officers, social workers, psychologists, and program administrators. The sociology of professions was once largely an area of structural-functional analysis in which professions were viewed as representing the values of a society (MacDonald, 1995). The trait approach to professions was developed within the functional perspective and defined occupations of doctor, judge and attorney as professions distinct from other occupations. This approach refers to a number of basic characteristics or traits present in occupations that make them professions, including a specialized knowledge base ground in well-established theories and conceptual schemes, lengthy university-based training, a high value placed on the specific services provided by the occupation, ethical standards for both client service and
professional interaction, and a high degree of autonomy and self-governance (Volti, 2008). As the influence of functionalism waned in American sociology, a shift in theoretical orientation in studies of professions occurred as many researchers began using a 'power' approach (MacDonald, 1995). Friedson (1970) showed how doctors were more focused on the benefits of monopolistic control over the medical marketplace rather than on the ethics of serving the public good. Larson (1977) described the 'professional project' by which an occupational group maintains control over a body of abstract knowledge and engages in collective social mobility, with implicit support from educational systems in structures of inequality. These power approaches were critical of occupations of medicine and law rather than celebrating them as moral stalwarts of society as functionalist approaches had done.

Occupations such as nurse, social worker, and probation officer have been referred to in academic literature as 'semi-professions' having some professional traits such as specialized knowledge but lacking others such as the autonomy enjoyed by doctors and lawyers (Volti, 2008). Such conceptions of professions display how they are overlaid with their society’s patriarchal structures and gender norms. Women were initially able to become professionals only through work occupations involving health, caring, and childbirth - work identified culturally with women (MacDonald, 2005). Professions of law and doctoral medicine have traditionally been occupations for men, while women who wanted to work were relegated to caring ‘semi-professions’ such as nursing and social work (Abbott and Wallace, 1990).

Recognizing the connection between gender and work roles, Abbott and Wallace
(1990) refer to nursing, social work, probation, and youth work as 'caring professions' which are similar in that: they originated in nineteenth century philanthropy and expanded into professions as the welfare state was established; they more or less focus on the 'human qualities' of clients; they are created and sustained through the identification of a specific social problem and treatment developed for it; and they rely on bases of knowledge drawn from social sciences. Rather than debating whether or not occupations such as social work and probation should be considered professions, Abbott and Wallace (1990) contend that a better approach is to examine how occupational groups make claims to be professions and the extent to which they are successful, as well as recognizing a key quality of these occupations: their power over clients. Abbott and Wallace explain:

The caring professions are powerful because they aim to not only change and control behavior, but also help to structure the context of social and cultural life in a more general sense - through their power to command definitions of reality by which the lives of their clients are shaped. In other words, they create both the object of their intervention – the neglectful mother, the wayward teenager, the bad patient – and at the same time make these the targets of their intervention. (P. 6)

Professionals who work in MHCs, not just social workers and probation officers but also judges and attorneys, share specific ideas regarding who are appropriate targets for the interventions of the MHC program and how such interventions should be applied. In MHCs, the work understandings of caring professions – social workers and other mental health professionals - have become part of the work understandings of criminal justice legal professions (judges and lawyers), and both groups share these understandings as they collectively attempt to socially control the participants in MHC
programs. Probation officers are considered caring professionals by Abbot and Wallace (1990) but are employed as part of the criminal justice system, revealing that probation as a category of punishment is often cast as rehabilitative rather than punitive, and displaying blending of criminal justice and caring roles. As both types of professionals have organized MHCs in Midwestern and engaged in interaction among themselves and with offenders identified as mentally ill, they have developed a specific workplace culture (Volti, 2008) resulting from the blending of mental health and criminal justice professional practices and ideas. The ethnographic observations and interviews conducted for this study enable exploration of how the caring and legal professions in MHCs share understandings of clients, and how such understandings are put into action in attempting to shape their lives. The power over referrals and participants held by judges, attorneys, probation officers, social workers, nurses, and psychologists is fundamental to how MHCs operate, and is a focus of analysis of professional roles presented below.

*The Organization of Professional Work Roles and Modes of Interaction*

Although there is much similarity in program structure among the nine MHCs, the specific professional work roles vary within sites in a few important ways. Roles involved with monitoring offenders between court hearings - social workers, probation officers, and even public defenders at some sites - often share work activities, whereas others are more narrowly construed in terms of which activities accomplish the work of the court for specific purposes. The professional work roles in MHCs also varied in terms of how they interact with offenders whom they are processing, some of whom are
referrals to the MHC program, while others have gone through a referral stage and become participants in the MHC. There are two modes of professional interaction with each referral or participant of the mental health court program: personal and textual. Personal interaction refers to professionals engaging in direct, shared communication with the referral/participant, primarily face-to-face conversation. Textual interaction refers to professionals reading, relying upon, and adding to bureaucratic documents that are each tied to an individual referral/participant, such as court filings and case files, through which professionals from both criminal justice and mental health perspectives share understandings about referrals and participants and accomplish their processing. The two modes of interaction are intertwined for the professionals, such that they understand each individual offender through both forms of interaction, and do not display recognition of differentiation between the two.

Professional roles vary in terms of the amount of personal interaction with participants and referrals and the amount of textual interaction with the offenders-as-cases. Variations in terms of the sharing of work and the interaction with referrals and participants will be discussed below for each role. In the next section I describe professional role differentiation by race, gender, and age, followed by a section in which I present comparison and analysis of the work activities of each professional role found among the sites.

Professional Role Differentiation by Race, Gender, and Age

I discovered that professional role differentiation existed in terms of race, gender, and age. As Abbott and Wallace (1990) would predict, caring professional roles in
Midwestern MHCs were largely held by women. Most of the social workers observed at the various sites were women. In Bevan City the social workers were black women, some middle-aged and some younger, while their supervisor was an older white man. (The Tandy MHC served a suburb of Bevan City, and had the same social workers and probation officer as the larger urban Bevan City MHC.) The mental health workers at other sites were most often white, more often women than men, and varied in age.

Probation officers were mostly younger or middle-aged white women, although a few probation officers were middle-aged white males. The probation officer for the Bevan City and Tandy MHCs was a middle-aged black woman, and one of the probation officers for the Lynne County MHC was a middle-aged black man. In Manzanera County, two of the probation officers were Hispanic women. The program coordinators were white, including three women and five men, and were younger or middle-aged.

Assistant state’s attorneys and public defenders were white at all of the sites. The assistant state’s attorneys were all middle-aged women except for the Lynne County ASA, a middle-aged man. Most of the public defenders were middle-aged men, while two were middle-aged women. All but three of the mental health court judges were older white males. The MHC judges in Ferry and Lynne counties were middle-aged white women. One of the judges for the Gilmour County MHC was a middle-aged white woman, the other judge being an older white male.

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3 I estimated ages of professionals rather than surveying them about their ages. These estimates were based on a schema of “younger” being under age 35, “middle-aged” being 35 to 55, and “older” being above age 55. Race and gender were also observed rather than surveyed but seemed readily apparent. Although technically Hispanic ethnicity is considered separate from race, in this chapter I differentiate between Hispanic, white, or black as race, and confirmed the Hispanic category by asking relevant professionals.
The Role of the MHC Judge

Judge roles were consistent from site to site in terms of work activities performed, and work tasks, including interactions with participants, were rigidly defined around representing legal authority. The judges in each of the nine mental health court programs played the same important key role. All of the programs held participant hearings before the judge which structured the program around continuous monitoring and evaluation of a participant's mental health treatment and abidance of probation terms. These hearings were an accounting of each participant's treatment adherence and progress in the mental health court program. The MHC judge's work role was narrowly construed, as he must process cases during organized hearings in an official capacity for the state, and has the ability to exercise power by changing the legal status of each participant and referral through conviction, probation, or the dropping of charges. Although important decisions were made at staff meetings held before the participants appeared in front of the judge, in every program observed the hearing itself involved a judge, seated in a robe at her or his bench, who went over progress with the participant, and communicated which past participation efforts were praiseworthy, as well as which past behaviors were not acceptable. Probation officers, social workers, and public defenders would stand just behind a participant when she or he appeared before the judge, and these MHC staff would be involved in reporting the participant's progress. The judge would then provide praise, encouragement, or admonishment, depending on whether the reports were generally positive or negative. This communication by the judge to the participant was done in a way that relied on the power of legal enforcement which could, potentially in
any given hearing, create a change in the program participant's legal status.

The judge textually interacts with referrals and participants in processing documents, and personally interacts with each called referral and participant on a face-to-face and personal basis. These two types of interaction were a common part of judges' work activities in all of the MHCs. At staff meetings, judges often looked over documents gathered or prepared by other MHC workers to get to know each referral- or participant-as-case. In court, documents were shared, signed, officially entered into the record, or displayed for the judge as he heard each case, and sometimes changed the legal status of referrals and participants. The judge's work with documents enables institutional actors beyond the realm of the MHC to affect the individual offender as textually communicated.

Each of the judges also engages in personal face-to-face interaction with every referral and participant who appears at the MHC hearing, each of whom is called to appear before the judge individually as scheduled on the day's hearing docket. Although each judge played the role of enforcing the state's legal power, each also did so in a way that involved personally getting to know each program participant in order to provide moral support and encouragement aimed at influencing the participant to continue efforts toward treating her or his mental illness and abiding by probation conditions. Nolan (2001) found that judges in drug courts utilize an ethic of emotivism drawn from the wider therapeutic culture in working with individual participants, and acted much like therapists or social workers when interacting with drug court participants. The same was true in Midwestern mental health courts. They varied in terms of the depth of the
personal relationship or intensity of emotional motivation, but all judges observed at Midwestern MHCs engaged in some type of personal, one-on-one, face-to-face interaction with each referral or participant. Each of the judges looked at each referral or participant, addressed her or him directly and by name, and made declarations regarding being accepted into the program for referrals, or concerning recent progress in the MHC program for participants. Through such declarations, a MHC judge makes a personal relationship with a participant, or soon-to-be-participant if a referral, in order to motivate performance in the program.

The MHC judges did not engage in any personal contact with participants or referrals outside of court hearings, unlike some of the other role players. This served to make the participant appearing before the judge an important moment in programming. The emotional support of judges combined with their power of legal enforcement on display at hearings was a foundational and organizational component of each mental health court program studied.

The judges observed in this study did display different styles in working with MHC staff in operating the program. All of the judges regularly deferred to the judgment of clinicians and probation officers in determining how best to deal with a participant during the hearing. Judges would rely on these workers to help them decide if and how participants should be praised, rewarded, scolded, or sanctioned during hearings. However, judges at some MHCs took more charge in leading staff meetings and court calls than others. For instance, staff meetings in the urban Waters County Bevan City MHC, which has a men's and women's court call, are led by judges who take initiative
and quickly run meetings that involve less discussion time relative to some other MHCs. Judge Jamison of the women's MHC is especially quick to take initiative; he quickly leads a staff discussion of the MHC court call just in front of his bench right before the court call begins. Participants seated in the audience are unable to hear this discussion, as an acrylic glass wall separates audience from court area, but they are able to view the professionals as they meet before the hearing. MHC judges in the Bevan City courthouse hold MHC hearings between regular dockets that are relatively large compared to what was observed at other courts. By contrast, Judge Rosati in the Gilmour County MHC is much more relaxed in discussion of participants with other MHC staff. The discussion and process of the hearing in Gilmour County is led more by the social work case managers rather than the judge, with input from probation officers. The Gilmour County MHC judge works in a courthouse that is much smaller and has relatively few cases, allowing for a more leisurely pace during the hearing. But such variation did not preclude Judge Rosati from playing the role of legal authority and interacting on a personal level with participants during hearings, just as in all other Midwestern MHCs.

The Role of the MHC Assistant State's Attorney

Like judge roles, assistant state's attorney's (ASA) roles were very consistent across Midwestern MHC programs. Each Midwestern MHC had an assigned ASA who kept files for each referral and participant, and, as needed, formally brought criminal charges during the hearing on behalf of the state through textual documents provided to the judge and entered into the official record. At all but the two MHCs in Waters County the role of the assistant state's attorney also included acting as gatekeeper of referrals'
entry into the program. For each referral to the MHC, the ASAs who acted as
gatekeepers would get referral documents, gather criminal background information, and
look over the referral's current criminal charges, which were contained in a charge sheet
document that included details of the criminal event written by a police officer. The ASA
makes a determination of whether or not the referral is acceptable for the MHC program
based on the current criminal charges, as Midwestern state law prohibits persons charged
with certain offenses, such as sexual assault, to participate in the MHC, whereas the
current offenses of other referrals may be acceptable but their criminal background
suggests they may be a future public safety risk and thus not acceptable from point of
view of the ASA. Generally, violent offenses are prohibitive, although the ASA may
have some leeway in accepting the referral if the violent charges are relatively minor.
ASAs can also lessen charges of some offenders, a form of plea bargaining, and this may
occur as referrals are accepted or as participants are being terminated, depending on the
adjudication structure of the MHC. If a referral's acceptability into the program is
debatable, the ASA will contact the relevant police officers involved in the arrest to
gauge their level of approval for letting the offender into the MHC program. If there are
any victims of the offense, the ASA may also contact them to see if they approve of the
offender being allowed into the MHC. Generally, an ASA will not go against the wishes
of the police or victims regarding a referral being allowed into the MHC, although at
times the ASA may try to convince officers or victims that the program is suitable if they
are hesitant to approve. The ASA can reject a referral application, or, if found to be
acceptable, allow the rest of the MHC team to make the decision collectively on whether
or not to accept the referral into the program.

As a rule, assistant state's attorneys only engage in textual interaction with referrals- and participants-as-cases, and do not engage in any personal interaction with the embodied offender. At several MHCs, ASAs explained in interview that because of their role as representative of the state bringing criminal charges against offenders, it is inappropriate to engage in personal interaction with referrals or with participants. ASAs learn much about a referral or participant during staff meetings as they personally interact with other professionals, but do not engage participants on a personal level except to occasionally contribute with other professionals to brief verbal praise of a good performer during hearings. Because of these restrictions in terms of interaction, the ASA role was the one that was most narrowly construed, and there is little variability to be found when comparing the role among MHC programs. The only notable variability in the ASA role was found in the two Waters County MHCs, in which the Phil, the program coordinator, who was employed by a state's attorney's office rather than through court administration as with other coordinators, did the gatekeeper work instead of the ASA. In the two Waters County MHCs the ASA role was restricted only to filing charges at hearings and participating in staff meeting conversations with other professionals.

Assistant state's attorneys were involved during court calls in the processing of cases, enabling defendants to begin the MHC program, and in other situations in which participants had violated terms of probation or been arrested for another crime. When a defendant is initially brought into the MHC program, during the mental health court call, (in all but one pre-plea MHC program in Ferry County), the ASA reads charges and
details of the state's case against the defendant into the record. This is followed by the judge explaining all rights being waived to the defendant, asking if she or he understands what rights are being waived, and describing the basics of the MHC program before officially entering the defendant into the program. If a participant were to get arrested or violate probation after entering the MHC program, the ASA may bring further charges or violations of probation during the mental health court call, which might lead to the participant being terminated from the program, and jail or prison time, additional probation, or probation time considered served during the MHC program. ASAs also functioned to monitor the participants and their progress during the MHC program from the state's perspective, which involved keeping track of specifics about the participants' cases during staff meetings and court calls. Although they monitored participants, they did so indirectly through the reports of others.

**Monitoring Roles: Varying Compositions of Probation Officers and Mental Health Workers**

There are variations in staff composition recognizable when comparing the programs, but in all nine MHCs at least one probation officer and one mental health worker work together and share responsibility for between-hearing monitoring of participants, resulting in much personal interaction which may be weekly or even daily with a participant. I refer to probation officers and mental health workers as the *monitoring dyad* of Midwestern MHCs. The probation officers focused their work on meeting criminal justice monitoring objectives, while mental health workers such as social workers and psychologists focused on service and treatment provision and regular
personal contact with participants.

The number and type of mental health workers varied when comparing the sites, much more so than probation officers. In several of the programs, one or two community mental health agencies worked with the MHC enough that their employees were regular members of the MHC team, attending all staff meetings and court calls. These were most often social workers, and they spent much of their work time for their agency with MHC participants. Other mental health workers in some of the MHCs were employees of the court or county government, such as Dr. Peete, the court psychologist in Gabriel County, or Patricia, the clinical social worker employed by the Ferry County Health Department. In the Waters County MHC programs, there was one probation officer, Kim, and a number of social workers from the federally established drug treatment agency, as well as Harry, a social work supervisor from the agency. In Ferry County, there were multiple probation officers on the mental health court team, and Patricia, the clinical social worker. In the Gabriel County MHC, Tina worked as probation officer dedicated to the program and also served as program coordinator, fulfilling an organizational as well as a criminal justice monitoring role. Two of the programs, Lynne County and Collins County, had a nurse dedicated to the MHC team to work specifically with participants and their medication needs. These nurses were employed by community mental health agencies.

Despite some variations in staff composition, all nine MHCs had at least one probation representative and one or more mental health workers (social workers, psychologists, nurses) who work together and share responsibility for regular monitoring
of participants. The probation officers focused their work on meeting criminal justice monitoring objectives, while social workers and psychologists focused on service and treatment provision. But probation and mental health workers in the MHC programs in Ferry, Collins, Hackett, and Lynne Counties described a sharing of responsibilities and teamwork between them in order to meet participants' service, treatment, and monitoring needs. In the following interview exchange, Patricia, the clinical social worker from the county health department, and Carla, a probation officer, describe their sharing of responsibilities in working with Ferry County MHC participants:

Carla: It's very much a merged thing. In fact sometimes there's even, I would say that case management, the social worker's doing, any of these guys can do the same thing except for certain things only [Clinical Social Worker] can do. But you know what I mean? There's sometimes whoever's available to do something is the one who does it. It doesn't matter which role they have, you know, some might call that role confusion but...

Patricia: There's very much, you know, you may have heard the term "boundary spanning."

Carla: That's it, yeah exactly.

Patricia: Yeah, they do what I do, I do a little of what they do, it's all, it works nicely. It works really nicely.

The program coordinator for Lynne County, Sara, describes the same type of role sharing on the Lynne County MHC team:

Sara: And sometimes there're different functions, I think, in traditional [organization] where, well this role does this, like maybe transport to inpatient treatment or something like that. But that’s not how this team works. It’s who has the available time at 9:00 on Monday to take somebody, and it's whoever is available to do it… it’s very fluid and working together about what can be in the best interest of the participants.

The sharing of work roles in the four Midwestern MHCs is part of an organizational
ethos of program flexibility in meeting participants' needs which will be discussed further in Chapter Five.

*The Role of Program Coordinator*

Each Midwestern MHC had a professional worker who served an administrative and organizational role on the MHC team, organizing staff meetings by preparing a weekly agenda of referrals and participants to be discussed, and keeping records of these individual cases, as well as records of overall program numbers and funding. There were several variations in job title such as "Program Director" or "Specialty Courts Administrator" but all of the programs had some type of this role which I will refer to as "program coordinator." At some sites this was a full time position working solely for the MHC, whereas at others those who served this role also worked in other capacities, usually involving the local drug court. At four of the sites this position was a part of the probation department, at three of the sites it was a part of the court administration office, and at two of the sites, those in the in the largest urban county, Waters County, one person served this role for the local state's attorney's office. Generally these were blended organizational work roles, as they served a criminal justice administrative role but were often filled by workers with a mental health background. Most program coordinators engaged in both personal interaction with referrals and participants and in textual interaction with their cases. The exceptions are the Waters County and Ferry County program coordinators, who do not engage in personal interaction with referrals or participants, and focus rather on textual interaction with offenders-as-cases.

Before MHCs were introduced in the United States, Steadman (1992) utilized the
concept of *boundary spanners* drawn from the literature on organizations to describe important role players who work in diversion programs at the intersection of criminal justice and mental health systems. I found that boundary spanners existed in the administrative roles of Midwestern MHCs, although not all the administrative role players could be described as boundary spanners. This is because there is variety in the administrative roles among the MHCs in terms of their professional background, their place in the structure of the criminal justice system, and their work role performance.

In the Waters County the program coordinator, Phil, works for drug courts and mental health courts at several locations, including two of the MHCs observed for this study: the MHC in Bevan City, and the Tandy MHC. Phil is employed within a Midwestern state's attorney's office, and performs a number of administrative functions for the specialty courts, including screening the criminal background of referrals on behalf of the state's attorney. Although placed in the criminal justice system, he has a mental health background and thus fits the role of boundary spanner, as detailed below:

*Phil: My background is clinical. I worked in behavioral health care for my entire career before coming here a little over seven years ago. So when the position that I'm in now came open then the idea was to have somebody fill that position with a clinical background so that the state’s attorney’s office would have more of a clinical input into some of these alternative programs. I started out with primarily drug cases. Drug diversion was the first thing that I was involved in from the beginning. I had some involvement with the, I still have some involvement with the drug court system in the county…uh, and then when the mental health court was in the process of being implemented, the thought was that given my clinical mental health background that it would make sense for me to have the position as coordinator.*

But despite having a mental health background, the Waters County program coordinator evaluates referrals-as-cases rather than engaging in personal interaction with them. Such
personal interactions in Waters County are left to the probation officer, judge, and social workers.

Administrative roles in the other MHCs were not positioned in a state's attorney's office. In a few of the MHC programs studied, an employee of the court administrator's office was a program coordinator who was a regular MHC team member, attending all staff meetings and court calls, and providing input on participant cases, while also serving an administrative function, such as organizing staff meetings, or finding funds for program operations, among a number of other tasks. In Lynne County the program coordinator, Sara, serves an important administrative role for both the MHC and drug court programs, while also attending staff meetings and providing input on participant cases, assisting in making contacts with various governmental agencies for funding and participant needs, as well as setting up functions with criminal justice workers as needed. But Sara has a background as a prosecutor, not in mental health, and so does not meet the definition of boundary spanner. In the Collins County MHC the program coordinator, Felix, is an employee of the court administrator's office and plays a very similar role to the one in Lynne County. However, Felix can be called a boundary spanner because of previous years spent working as a social worker. Both the Lynne County and Collins County program coordinators engage in discussions during their respective staff meetings about how best to work with participants, but Felix does so from a mental health background. Additionally, Sara focuses on textual interaction with offenders-as-cases, while Felix often engages in personal interaction with referrals and participants, conducting assessments, reiterating program goals, and making other personal contacts.
In Gabriel County, Tina works as the probation officer for MHC program participants, as part of the case management team along with psychologists and community service providers, and as the program manager of MHC by being responsible for tasks such as organizing staff meetings. The position is within the probation department in Gabriel County, but was specifically created for the MHC. Tina engages in both textual and personal interaction with referrals and participants, and is a good example of a boundary spanner, performing both criminal justice and mental health work tasks within the probation department using a clinical professional background from having worked as a licensed professional counselor.

In Ferry County, managerial and organizational tasks for the MHC are accomplished by Paul, a program coordinator who is also an employee of the county. Paul usually does not engage in personal interaction with participants, having only brief direct contact with referrals at the initiation of the process of applying to be in the program. He manages the Ferry County drug court program in addition to MHC, and both are relatively large programs. The role is purely administrative and does not involve boundary spanning. Paul does not place emphasis on having input on how cases are handled in MHC after a participant begins, unlike other program coordinators. Rather, he places emphasis on acquiring resources for the MHC and drug court programs, and on administrative functions such as organizing the referral and application process. He explains the role of the position:

Paul: I would normally be at the staff meeting, but again as an administrative position what I want to make sure is that the people that are [working on the MHC team] have the resources to do the job that they need to do. And so if that means we need to fund, you know, electronic
monitoring to keep someone from going to jail as a sanction then we'll do that. You know, because again, if someone is on a med, if we cannot put them in county jail and mess up their medication schedule, then we can do something like that. So, I just handle the day to day business part of it, but being in the meeting helps get perspective as to what do the programs need to run effectively. So, day to day decisions, [the MHC clinical social worker and probation officers] are the day to day experts; that's not my role and function. So, I just deal with the treatment providers, the billing, you know, billing to the health departments and any of the other treatment centers that are out there, program development as far as grants, [and] expansion of services.

Public Defenders: Variation in Use of Adversarial and Non-adversarial Roles

Public defenders are essential personnel in all nine MHC programs studied. They engage referrals and participants through personal interaction representing their legal interests, while also being highly involved in textual interaction with the offenders-as-cases in considering criminal and mental health records. However, there was variation observed among the programs in the public defenders' performances of their role. In the research literature on specialty court programs they have been described as taking a non-adversarial approach (see for example Miller and Johnson, 2009; and Nolan, 2001), which differs from the traditional, adversarial approach in criminal courts. In the adversarial approach a state's attorney brings charges against a defendant, while a defense attorney, representing the defendant's interest, argues against the state's case and for the rights of the defendant. Because specialty courts such as drug courts and MHCs emphasize the therapeutic jurisprudence approach to the defendant in terms of mental health, and the case against a program participant is generally held in abeyance during time spent in the program, ASAs and public defenders in specialty court programs have been described in the research literature as setting aside their traditional adversarial roles.
in order to work together as members of the program team and pursue the interests of the participant's mental health. Although the non-adversarial characterization is generally true for the nine programs observed, it was only partially true for a couple of the MHCs. During court observations, a couple of public defenders displayed a somewhat adversarial approach during staff meetings as decisions were made by the team regarding how to sanction participants who had not fully followed program rules.

The public defender for the Lynne County MHC, Joanie, is a decades-long veteran of the criminal justice system and supervises the other public defenders in the county, but serves the MHC participants as a regular member of the staff. In the staff meetings, when a participant's case was being discussed, several times Joanie was observed arguing against a solution being considered by the judge, clinicians, administrator, and state's attorney, sometimes successfully so that a less severe punishment for a rule violation was meted out. Joanie played the adversarial role of contrarian in several discussions during staff meetings regarding how to sanction program participants, always on the side of a less punitive resolution. In addition, she limited the amount of information being shared with the judge and ASA during a situation involving several participants who had possibly committed a criminal offense.

The public defender in Ferry County, Peggy, reported during interviewing also taking an adversarial approach, displaying a high level of concern about keeping some information considered harmful to participants from the judge and ASA. The Ferry MHC is a pre-plea program, which is generally not true of the other MHC programs studied. (Lynne County reported working with some participants who have not yet entered a plea,
but most of the participants have entered a plea and participation in MHC is their 
probation.) Because the state has not formally dealt with charges in a pre-plea program, 
there is concern that negative information might eventually affect adjudication of a 
participant's case. Therefore, in Ferry County, Peggy works to limit such negative 
information from being shared, especially information about new applicants to the MHC. 
This is described in the interview excerpt below:

Peggy: I am very particular about [information sharing]. If we're all in 
staffing and it's all open communication I have, it's fine, but [MHC Judge] 
is not included on our emails and shouldn't be. We've developed a system 
where [others on the MHC team] got the evaluations. They can't go to her 
until someone's is going to be accepted into the program. She should not 
have that information ever, until someone's accepted into the program.

Interviewer: So a lot of your role is to control information it sounds like.

Peggy: I'm an anal retentive gate-keeper of information. Of how it gets 
controlled, because there's certain that should not be given without all 
parties present and that's just, legally it shouldn't be there, whether it's a 
wellness court or not there's [sic] due process rights involved.

Later in the interview, Peggy describes the adversarial approach taken while working on 
the MHC team:

Peggy: Make no mistake, what I say to the judge is not what I'm telling 
my client in the room. You know, I may be giving the judge the whole big 
spiel, like well, you know, their due process rights, and this that and the 
other, in finding out a sanction, you know, I don't think my client should 
be going to jail. When I'm in the side room going "you know what, your 
butt should be sitting in jail for a weekend because you did this, this and 
this and I think you should be there," while I'm in front of the judge saying 
"my client shouldn't be going to jail because of all these reasons why, you 
know." It's that dual role, but my client very well knows I think they 
should be going to jail or they should be getting the public service or they 
should be going to SWAP or whatever else. I have that dual role, which I, 
you know, will tell my client you screwed up and you deserve everything 
you're going to get, but I'm going to go in front of the judge and explain to 
the judge why you shouldn't be getting it.
Public defenders were also observed playing a role in case management for the participant in several of the MHCs observed, working with the mental health workers and probation officers on the MHC team in order to get things accomplished for participants, such as helping a participant obtain supportive services, while not necessarily focusing on legal concerns. In such situations, public defenders joined the monitoring workers in helping participants as they went through their day-to-day activities. However, in the two Waters County MHCs neither an adversarial nor a monitoring assistance role was taken by public defenders observed. Like the ASAs, the Waters County public defenders did very little in terms of input at staff meetings or action during court hearings, letting the probation officer and social workers from the federal drug treatment agency do the work with participants and make decisions with the judge about how to sanction.

**Conclusion**

This chapter has described how the mental health courts in Midwestern were established as similar organizational forms, and explored the shape of the various MHC professional roles, while also considering how these forms and roles differ across the nine sites. The idea of specific workplace culture existing in the MHCs was briefly mentioned at the beginning of the chapter, and some professional work understandings as related to roles were presented. In the next two chapters I explore the workplace culture of Midwestern MHCs in depth. Chapter 5 presents ethnographic data on work activities and understandings of MHC professionals, while Chapter 6 details the primary work understanding of performance, the organizing principle of Midwestern mental health courts.
CHAPTER FIVE

WORK ACTIVITIES AND UNDERSTANDINGS OF
MENTAL HEALTH COURT PROFESSIONALS

As I have indicated earlier, in this dissertation I approach the study of Midwestern
mental health courts from the theoretical perspective of symbolic interactionism, which
studies how human actors construct and respond to their worlds on the basis of meanings
about phenomena that they develop through shared symbols, such as language, in
interactional processes (Rudy, 1986). Weber (1977), in explicating the fundamentals of
sociology, explained that researchers engaging in the study of human action should
recognize it is usually directed toward other people and things on the basis of how they
are understood by the actors. Blumer (1969), in explicating the symbolic interactionist
approach, stated that the interactionist study of human action works from three basic
premises: humans act toward things on the basis of meanings ascribed to them, these
meanings are derived from social interaction one has with others, and the meanings are
handled and modified through an interpretive process one uses when dealing with things
encountered.

My dissertation study is focused on explaining the actions of professionals of the
MHC program by detailing their work activities, which involve personal and textual
interaction, and discovering the meaning of their work for the professionals - how they
understand their work activities and the criminal offenders with mental illness whom they
encounter. In this chapter I present results from focused coding (Emerson, Fritz, and Shaw, 1995) of field note and interview data to describe important work activities and how MHC professionals understand these activities. Midwestern MHC professionals expressed the meaning of action when explaining their work in interviews, and they displayed such meanings during personal interactions in which their utterances were part of their work activities. The displayed actions and shared understandings through utterances that I analyze in this chapter are of the everyday work settings of embodied professionals engaged in personal interaction with each other and with participants and referrals, rather than work understandings of professional discourse contained in institutional texts.

MHC professionals sometimes spoke with each other during staff meetings, court calls, and in-between times using the language of professional legal and mental health discourses, but they also shared understandings of how to process offenders in the everyday of doing work activities, what Smith (2005) refers to as "work knowledge." For example, how do the professionals determine the appropriateness of a referral? How do they accomplish having a misbehaving participant arrested and placed into the mental health facility at the jail? These types of questions go beyond professional discourse to reveal the professionals' work knowledge of the specific actions that they must take in the everyday setting to accomplish institutional tasks affecting offenders.

Generally, an aim of ethnography is to see the field setting through the eyes of the people engaged in social action there (Hammersley and Atkinson, 1995), so my aim was to understand the activities of mental health courts from the perspective of people who
organized and engaged in them. Both legal and mental health professionals have an understanding of participants that shapes their everyday work activities. At their work sites they interact with each other and participants and engage in the specific workplace culture (Volti, 2008) of their MHC program. The workplace cultures present in organizations of criminal justice and mental health institutions become in the mental health court a culture of what I will refer to as a “blended organization,” a model of organization attempting to solve a social problem thru linkages between multiple institutions, and thus sharing ideas from the culture of those institutions. I use the word "blended" to describe how there was little tension observed between criminal justice and mental health professionals in terms of how they understood and conducted work with offenders with mental illness; rather both types of professionals displayed similar understandings. Work knowledge in the MHC necessarily includes the professionals' use of a blended institutional vocabulary, shared understandings of work and offenders which the criminal justice and mental health professionals displayed during interaction with each other and with offenders, and which they expressed during interviews. The presence of recently organized mental health court programs throughout Midwestern state offered a unique opportunity to explore professionals from two institutional backgrounds sharing a newly developed workplace culture at a variety of sites, and centered on understandings of mentally ill criminal offenders.

The reader may notice overlap between the categories presented below, which are important work understandings, and in the next chapter, which details performance understandings. Professional work understandings include their views toward individual
clients with whom they work, and in the MHC these views include those of participant and referral performance. The categories below and in the next chapter are not presented as mutually exclusive, but instead as a move of analytical focus from general professional MHC work understandings to the specific work of performance judgments.

Professional Work Activities and Understandings in Mental Health Courts

Being Flexible: Two Ways

Flexibility is an aspect of problem-solving courts celebrated in academic literature (see for example Miller and Johnson, 2009), and shared among professionals at Midwestern MHCs, as described in several of the presentations of programs above. It is conceptualized by professionals and academics in two related ways. First, they state that specialty-court programs, or more specifically professionals working in specialized courts, should be flexible in processing offenders, recognizing that the specialized needs of the individual may require a unique set of program requirements and a personalized approach. Professionals at a number of sites made claims during interviews and observations that their programs were flexible and individualized in approach, and that they worked together as a team to meet the individual's needs. In the following interview excerpt, Ben, a probation officer from the Hackett County MHC, and Seth, the public defender, describe how the program is flexible to best meet the individual needs of the participant, and how the professional roles work together in the interest of the individual participant:

Ben: The one thing about this team that I know or see is that it’s completely driven by the individual. It’s not driven by rules or guidelines or anything like that - it’s driven by the individual’s needs. Which, to me, is what really makes this so unique and work so well is that it’s all about
the individual and what their needs are. And this team, their whole purpose is to meet the needs of that person.

Seth: And that starts from the beginning when someone gets identified as a potential participant. That can come from police officers in the field that have participated in crisis intervention training. That can come from the probation officer who has worked with this person in the past, um, or has some other knowledge from working with family members throughout the community. It can come from a judge at first appearances when they are first brought to answer to the charges. It’s recognition from the public defender’s office, the state’s attorney’s office, or any other member of the team that brings them into this and from there, then like you saw today, we discuss this person, uh, and those attributes that are unique to them. And then the case plan is developed and we all decide if this person is appropriate and what we can do for this individual, and then my role is making sure that the person’s rights are protected throughout that process. But it is a collaborative effort even with the police officers that arrested the person.

A second way that flexibility was presented by professionals during interviews and displayed during work activities is some professional roles themselves are flexible, although other roles, such as Assistant State's Attorney (ASA), were recognized by informants as necessarily inflexible. At most of the sites probation officers and clinical social workers, and additionally at some sites public defenders and nurses, spoke about being flexible in doing the work of the court by being willing to share duties and do specific work activities outside of one's specific work role. These professionals spoke of doing "whatever is needed" to best work with participants, which might include monitoring, counseling, case management, and transportation regardless of whether one's role is drawn within criminal justice or mental health institutions. Professionals also spoke of "teamwork" as a concept that requires they be flexible in role in doing work activities. Below Sara, the program coordinator in Lynne County describes MHC staff being flexible in sharing work activities, and Gene, a probation officer follows up with an
example of teamwork:

Sara: And sometimes there are different functions I think in traditional programs where, well, this role does *this* - like maybe transport to inpatient treatment or something like that. But that’s not how this team works. It’s who has the available time at 9:00 on Monday to take somebody and it’s whoever is available to do it. So [probation officer] may do it, staff from [community mental health agency] may do it. It’s very fluid and working together about what can be in the best interest of the clients.

Gene: Just as an example of how the different components seem to work together at times. We had an individual last week who we had talked about at staffing that we were looking for a treatment facility. And our dual diagnosis person, she contacted the treatment center and she sent an email to the team stating that we needed a court order to allow the agency to go into the jail. Immediately the PD, [public defender], she contacted the team asking to do the [creation of document releasing the individual from jail]. She made contact with the state’s attorney that the judge emailed her back that he would sign off. So it’s kind of a team effort in many areas throughout the day that we don’t even think about. It’s kind of automatic now.

In the following example, Ben, the program coordinator from the Hackett County MHC who also works as probation officer for some participants, describes how professional workers share roles in their program:

Ben: I think the one thing that may kind of make this court stand apart from a lot of the others is that there is such a close teamwork aspect to this that there aren’t necessarily some really specifically defined roles. I mean, the probation officers actively help case managers. They share a lot of the duties. They share… [looks over at another probation officer and a social worker seated together] …you guys are working together all the time. [The two others nod.] Uh, so it’s… there’s a lot of crossover. You know, we leave a lot of the mental health stuff obviously to the mental health professionals but the probation officers… the probation department is a huge part.

The concept of "boundary spanners" (Steadman, 1992) in academic literature conceptualizes the professional role of one who connects the work of persons in criminal
justice organizations with that of workers in mental health. Below Patricia, the lead clinical social worker for the Ferry County MHC, and Megan, a probation officer, refer to boundary spanning during interview, justifying their need to be flexible in work roles and displaying their knowledge of applied academic literature for their respective professions:

Researcher: Ok, yeah that's what, that was kind of what I was getting into with the case management question - who does the social work type job?

Megan: It's very much a merged thing. In fact sometimes there's even, I would say that casework the social worker's doing, any of these guys can do the same thing except for certain things only Patricia can do. But you know what I mean, there's sometimes whoever's available to do something is the one who does it. It doesn't matter which role they have, you know, some might call that role confusion but...

Patricia: There's very much, you know, you may have heard the term "boundary spanning?"

Megan: That's it, yeah, exactly.

Patricia: Yeah, they do what I do. I do a little of what they do. It's all… it works nicely. It works really nicely.

As introduced in Chapter Two above, probation officers and social workers at all of the MHCs form a monitoring dyad, engaging in regular contact with participants between MHC hearings throughout program participation. Workers in the two professional roles described doing much the same work as needed, such as counseling participants, filling out forms to help them access services and housing, contacting police officers to discuss a participant in the community, transporting participants to psychiatrist appointments, and others. The two roles, which may include two to four or more professionals depending on the site, regularly contact each other throughout the week via e-mail, telephone, or face-to-face interaction to discuss participants and what specific
work activities need to be done for them. Additionally, at several sites public defenders described sharing duties with probation officers and social workers to do "whatever is needed" to best serve participants, and displayed such work activity, making a monitoring triad. Below Peggy, the public defender from the Ferry County MHC, explains in interview how she works with "clients" (participants) to assist with their behavior modification, and the probation officer (Megan) and lead county social worker (Patricia) concur:

Peggy: Yes. I've been told I'm not a probation officer by someone. She looks at Megan and they both chuckle. Yes, you know I've got to… my job is to a) make sure my clients get through the program, and b) my job is to make sure my clients listen to [Megan and Patricia]. You know I don't… my job is to not do their job, but my job is to help them do their job and to make sure my clients listen, especially some of the more difficult ones. Most of my clients are a dream! They're phenomenal. They do what they need to do. They don't act up and, like, lose their minds. There's… you know for the most part they're very, you know they follow the program, they do what they need to do, they do what [Megan and Patricia] ask them to do. There are those [participants] that just have had mental health flair ups where they can't basically get themselves together. There are some that will always be difficult because of their mental health issues. There's some that are just difficult people to begin with having nothing to do with their mental illness. They're just a pain.

Patricia: Or more personality disorders.

Peggy: Yeah, or just their personalities in general. So it's my job to kind of get them whether it's to toe the line or do what they need to do, or to just help them figure it out sometimes. You know I'm notorious for giving lectures. I'm notorious for pulling them in the side rooms [of the courthouse] and yelling if need be.

Megan: Therapeutically of course. She smiles.

Peggy: Yes.

Researcher: Well basically [you lecture them] to follow requirements that they've been given by the court?
Peggy: Not even, yes, or just to follow… like, to be a normal human being. Like don't sit there and be a jerk. Don't treat other people rude. Like, [it's] just normal things. It's not even just the judge's rules. It's just...

Daniel (another county social worker): Socialization.

Peggy: Socialization and to do things like that. Like don't be… there's someone that's going to get a very nice lecture tomorrow. She smiles and looks knowingly around the table at the other professionals. Like, don't be a jerk where you're staying. Like, no one wants you to be a jerk.

Patricia: Just really things that are in their best interest. And I can say that the public defender and, in terms of the clinical piece, [Patricia, Megan, and Daniel] do work together in helping the clients see that we are doing things in their best interest and helping them kind of follow along on what's been recommended because there's a good, kind of pay-off for them, not only with good mental health but, you know, their case may get dismissed. So [there are] a lot of nice carrots at the end.

Peggy: Right, and make no mistake, what I say to the judge is not what I'm telling my client in the room. You know, I may be giving the judge the whole big spiel, like well, you know, their due process rights, and this that and the other, in finding out a sanction. You know [I'm saying to the judge] "I don't think my client should be going to jail" when I'm in the side room [saying to the participant] "You know what? Your butt should be sitting in jail for a weekend because you did this, this and this and I think you should be there!" While I'm in front of the judge saying my client shouldn't be going to jail because of all these reasons why. You know, it's that dual role, but my client very well knows I think they should be going to jail or they should be getting [community service] or whatever else. I have that dual role, which I, you know, will tell my client you screwed up and you deserve everything you're going to get, but I'm going to go in front of the judge and explain to the judge why you shouldn't be getting it.

In the following narrative example from observation Peggy does work activity at a court hearing in which she engages in personal interaction with a participant and represents her as an attorney, which includes Peggy describing her work of mental health case management with the participant to the judge:

While everyone is waiting for the Ferry County MHC hearing to begin a young woman comes into the courtroom. She is white, thin, medium
height, and has shoulder-length brown hair pulled back by two clips. She appears to be in her early 20s and is casually dressed in well-worn blue jeans, light blue tennis shoes, and a white t-shirt with a colorful graphic design on front. As she moves through the room among professionals and other participants, Peggy, the public defender, a tall white middle-aged woman with dark brown hair pulled back in a bun and dressed in blue women's suit of skirt and jacket, walks up and moves the young woman to the side of the room by gently grabbing her arm. They begin talking quietly, and from a small brown purse the young woman has strapped around her shoulder she pulls a folded-up piece of paper, unfolds it, and hands it to Peggy, who looks it over carefully. They continue their conversation for a few more minutes. Later, during the MHC court hearing the young woman's name is called out by the ASA to stand before the judge after a number of other participants have already appeared. The young woman, whose first name is Caitlin, and Judge Vandiver, who is a white, middle aged woman with graying hair seated in black robe behind an elevated bench, exchange friendly greetings. But then the judge's facial expression changes and becomes stern as she looks down at Caitlin and says "You've had a couple of misses? What's going on?" The young woman looks up to Judge Vandiver and quietly explains that she missed her appointments with her probation officer and mental health clinician because she was having menstrual cramps and did not feel well. In addition, she explains that she overslept on one occasion. Caitlin also acknowledges missing a urinalysis test but taking one recently by saying "I know I also missed a color on Monday, but I did a drop this morning." Judge Vandiver asks for clarification about the urinalysis from Peggy, who has been standing behind Caitlin's right, and Peggy says "Negative, your honor." Judge Vandiver then looks at Caitlin and asks "Did you call the hotline Monday?" This refers to the telephone system by which Ferry County court workers communicate to participants whether or not their assigned color has been selected for urinalysis testing that week. Caitlin looks down, shakes her head and answers "no" quietly. Judge Vandiver then shakes her head, makes a facial expression of frustration, and begins writing on paper on her bench. She then says tersely "Next week you have to see Carla. I'm scheduling your court call for one week." Carla is Caitlin's probation officer. The young woman looks up and agrees, "I will see Carla next week." Peggy steps closer to the judge's bench. She expresses concern that the young woman has not been taking her "meds." Peggy tells Judge Vandiver that she explained to Caitlin that she must follow her doctor's prescription, and cannot change medications without seeing the psychiatrist. Peggy says "Caitlin promised me she will fill her prescriptions and start taking her medications today." The young woman looks up at Judge Vandiver, nods her head, and says "I will. I promise." Judge Vandiver sternly tells Caitlin that she cannot miss any more
appointments or she will face sanctions, then reiterates that Caitlin must see Carla next week and is scheduled to appear at next week’s MHC hearing. Caitlin says "Thank you judge," looks at Peggy and nods, then turns and swiftly walks out of the courtroom.

In the narrative above Peggy displays how her work goes beyond that of legal representation of a client as an attorney and into work activities of a social work clinician attempting to teach medication management to a person with mental illness. None of the other Midwestern public defenders were as active in monitoring participants as Peggy, and in some MHCs they engaged in relatively little personal interaction with participants compared to the probation officers and social workers in their respective organizations. But all of the public defenders engaged in some type of motivation of participants through personal interaction aimed at assisting other professionals and improving participants' performances in the MHC.

Informants at a couple of sites describing the need to be flexible also included a nurse as one of the roles working with other professional roles in a flexible way to help in whatever way might be needed on a given day. Nurses described helping participants with their medical issues but also assisting in motivating and counseling them to perform. Only the work roles formally exercising state power through enforcement of criminal laws - the judge, whose work with participants and referrals is limited to MHC staff meetings and hearings, and the ASA, who refrains from personal interaction with participants and referrals - were strictly limited in sharing of work activities among MHC professionals.

*The Getting-to-know Process*

Some referrals to an MHC are already known by several of the professionals of
the program, as the referrals are long residents of the county and have already received services from the local mental health agency, or were already known by the judge or other criminal justice workers for prior offenses. But many of the professionals engage in a getting-to-know process with participants they have not encountered before through personal interaction over time. During counseling sessions, group sessions, case management and probation appointments, service assistance, and, for the judge especially, court hearings, the various professionals get to know the individual participant on a personal level that goes beyond professional discourse and textual interaction with the offender-as-case. Whether known beforehand or through referral and participation in the program, if a professional has gotten to know the individual participant and recognizes her or him as a unique individual living in a specific context, this may aid professional understanding of problematic behavior, and mitigate decisions on sanctioning or possible termination. In the following narrative example, professionals in the Gabriel County MHC debate how to address a participant in an upcoming hearing for problematic behavior. Tina, the program coordinator, has gotten to know this problematic individual on a personal level, and defends him as they debate how to sanction him:

Tina, a petite white woman in her 30s, looks down at the staff meeting agenda and names the next participant to discuss. His first name is Nasir, and after naming him she begins explaining that he recently dropped by her office without an appointment. Tina has a mental health background and is program coordinator, but she also serves as probation officer for the MHC participants. Nasir went to her office to admit that he had forged the signature of a counselor to fake verification that he had attended a group therapy session. Dr. Peete, an older, white man, the head court psychologist dressed in a grey suit and tie, says "Boy, that is popular" about participants forging signatures to try to verify meetings and
appointments to the court. Tina explained that she already knew about the forgery, and that Nasir had also missed another group because, as he explained, he took too many Tylenol PMs the night before. Tina relates to the professionals gathered around the conference table that she explained to Nasir that forging a signature is a criminal offense, and they would have to sanction him in some way. Tina says "Every time he does something bad he reverts back to using his mental illness as an excuse. He kept saying 'I was going crazy.' He says that whenever he is engaging in negative behavior. 'I was going crazy. I was going crazy.'" A clinical social worker with a doctorate, Dr. Hammond, has been hired by the Gabriel County court to evaluate the MHC program, and has been recently attending staff meetings, offering input as to how best to work with participants. He is an older white man dressed in a navy blue sport coat and tie, and he advocates that Nasir "lose a level," meaning he be moved down a level in the MHC program, which would increase his time in the program and move him further from graduation. Dr. Hammond explains that an important function of the MHC is to sanction bad behavior in order to encourage change in participants. Tina counters that lesser sanctions have worked well with "clients" in the past. When Nasir was sanctioned before he understood that the MHC staff were trying to prove a point but "he still reverts back." Judge Albinson, a tall, older, grey-haired white man wearing a crisp white dress shirt and tie but no jacket, says "I agree with Dr. Hammond. We should put him back to level two." Mike, the probation supervisor, a white, brown-haired, middle-aged man wearing glasses, asks Tina if Nasir has made any progress recently. Tina explains that Nasir recently gained employment at a convenience store. She does not think that he should be moved down a level because he will have to visit the court more frequently, and that could hurt his ability to keep the job. She says emphatically "This court isn't about limiting opportunities." And Dr. Hammond counters "But it is about honesty." Tina explains that they should take Nasir's job seriously, as he has an extensive work history. Judge Albinson says "I don't want him to lose a job opportunity. It's a bad economy, so we shouldn't keep him from getting a job if he has a chance." Dr. Hammond shakes his head and complains "I don't think we've ever reached him." Tina talks about the group and individual therapies that Nasir has been engaged in, saying he missed some meetings and appointments but has done a lot over the past few months. Dr. Peete asks "Is he still seeking drugs?" Tina smiles, and says "He told me he tried to get a 'Chinese benzo.'" She chuckles, then says she thinks he may also have been selling Ritalin recently. But then she begins defending him: "You have to understand, his sole objective is to work. It's part of his cultural background." She explains that to him even selling drugs is just a way to earn money, which he believes he should be doing as a man. She concludes "He does what we ask him to do." Dr. Peete adds "But then he
Dr. Hammond states "This court's goal is beyond just being able to work. The goal is for clients to become mentally stable." Tina argues "but basically he is being compliant." Dr. Peete counters "But he's shady. I think he's shady." After a brief lull in the conversation Judge Albinson says "Well, we need to reprimand him, but I would like to see him keep his job." He looks at Tina and asks "What would you suggest to sanction?" Tina suggests that they could tell Nasir he has to bring in his Ritalin, and then they could have someone from the mental health agency control its distribution to him. They discuss past punishments of a couple of other clients who have forged signatures. Mike asks "Should he go to jail overnight?" Judge Albinson says he could have Nasir spend a night in jail. Adam, a young white man who is a court psychologist comments "I think he [forged the signature] because he was frantic, not to manipulate." Penny, a white woman social worker from one of the local mental health agencies who does case management with Nasir, thumbs through a large notebook on the table in front of her, reads a page, and says "He's stuck on doing groups on Monday and Thursday." Dr. Peete looks at Judge Albinson and says "Warn him. Have him increase his groups but tell him he is in jeopardy of moving back a level. If work is important to him, suggest how this could harm his working." Penny adds "We need to develop a relapse plan." Tina sighs, exasperated, and complains "But now everyone has a different suggestion! We need to focus." Judge Albinson suggests as sanction Nasir goes to coming to the MHC hearing every 2 weeks rather than once a month. They settle on this. But Tina also says they need to get him to groups that are clinically appropriate for him. Penny says "I don't believe he has the criminal thinking that our other clients have." She discusses various treatment groups available at the agency. Adam suggests how the judge could set it up, "You just forged these documents, now you must go to these groups." But Judge Albinson looks at him and warns "Treatment cannot be used as punishment." After they discuss different groups, Tina and Penny settle on a drug treatment group for Nasir. Judge Albinson says "So let me crystalize this for everybody. They will refer him to the treatment group, and I will tell him he has to come every two weeks as a sanction for forging the signature." Tina makes a note in a spiral, then looks at the agenda and calls the name of the next participant to be discussed.

As the above example reveals, Tina has gotten to know Nasir to the point of excusing his misbehaviors, although she does not ignore how they represent his need for more mental health treatment. The getting-to-know process through personal interaction does not replace or prevent the continual textual interaction with the offender-as-case. Indeed, for
probation officers, case managers, and psychologists, personal interactions are noted in case files and become part of the offender's institutional image presented in texts. But for some professionals, the getting-to-know process leads to meaningful understanding of the embodied offender that affects how they judge him, how they try to work with him, and how they present him to others.

*Finding a Bed*

A person with a criminal charge and a documented diagnosis of mental illness may complete the process of the referral stage and formally enter the mental health court program while still being held in jail. This situation was common in the inner-city environment of Bevan City, but less so in MHCs in more affluent counties, where defendants with means may bond out of jail before completing the referral stage. New participants in either situation may be mandated by MHC professionals to enter inpatient treatment in a mental hospital or substance abuse facility on entering their program. Such participants may later be required to live in residential facilities for persons with mental illness, as might other participants who are not necessarily required to be hospitalized beforehand. These facilities - mental hospitals, inpatient substance abuse hospitals, and residential homes - have to provide a "bed" for a participant on entry. "Finding a bed" was a common work activity described and displayed by MHC professionals at all sites.

In Bevan City, an incarcerated new participant often attends MHC hearings while the social workers attempt to set up arrangements for release from jail. This almost always includes release to inpatient treatment in a mental hospital or substance abuse facility, but this is not an immediate, automatic process as there is not always room
available at the inpatient facilities. Although the social workers have developed relationships with a number of different facilities, often they must check around over a number of weeks until one of the facilities agrees to allow the new participant to be released into their care.

When a new participant awaiting his release from the jail into an inpatient facility attends hearings of the mental health court, the judge, serving as the highest authority representing the mental health court program, assumes a demeanor that offers promises and occasionally apologizes as MHC professionals work through the process of “finding a bed.” In the following observed exchange Judge Allen, the Bevan City men's MHC judge, asks a new participant still in jail to be patient during the process of finding a bed:

A man’s name is called, and a new mental health court participant enters from a back room between two bailiffs who are standing around the door to the back. The participant is escorted in shackles by a uniformed deputy holding on from behind to the chain wrapped around the participant's torso and holding his arms in cuffs in front. The new participant is an older, white man, perhaps in his late 50s, with short, dark grey hair, and stands about 5'9”. His face has grey stubble and a leathery, wrinkled appearance. He is wearing the tan, jail-issue scrubs and dark blue tennis shoe loafers all of the participants and referrals held in jail are wearing. He moves slowly to stand in front of Judge Allen, an older white man seated at his elevated bench in black robe and with neatly combed grey hair and glasses, and the deputy releases his hold on the participant. The judge smiles, looks down at the participant, and says “Hello, It’s good to see you. Now I apologize, I know this is taking a long time. But we’ve been working real hard on this, and now everything’s going okay. There will be a bed available for you [in a little over three weeks]. I know it’s awhile so hang in there, okay? We’ll see you back here [in three weeks].” The new defendant looks up at the judge with some effort, speaks slowly and says “Oh, okay. Thank you, judge.” He then turns as the deputy regains his hold from behind, and is escorted out the back door from which he entered. As the participant leaves, the judge writes on papers on his desk. This exchange between participant and judge is very brief.

During this exchange Judge Allen points out that he understands the participant’s
situation as he waits to be released from jail, and by apologizing the judge recognizes that professionals in the mental health program have made a promise to the participant to ensure his release that has not yet been fulfilled. Judge Allen stresses that the people who run the mental health court program have “been working real hard” and that it is just a matter of time before the promise that has been made to the participant will be fulfilled. Judge Allen works toward a definition of the situation that the program is working for the participant’s best interests, and therefore he should be patient.

In the following observation Judge Jamison, the Bevan City women's MHC judge, makes a different point of emphasis as the new participant will soon be released:

Judge Jamison, a tall, older white man with white hair and glasses and seated in black robe at his elevated bench, calls for another participant and a tall black woman with braided hair and appearing to be in her 30s emerges from the jury room door wearing blue jail scrubs and shackles, escorted by two women bailiffs. The judge smiles, looks down at the new participant, and says “Good news! We found a bed for you.” He explains that the participant will be released from jail tomorrow, to the care of [FDTA] social workers, who will transport her to a local inpatient drug rehabilitation facility. The participant smiles and thanks the judge, saying “Oh that’s good judge, I’m real happy.” The judge warns her “Now stay away from drugs. I know you have a drugging issue.” She assures the judge “Oh I will, judge, I will.” The judge schedules her for the next court session in two weeks. She thanks the judge again and exits through the same jury room door which a bailiff is holding open for her. As she leaves, he writes on papers on his desk and hands them to the secretary seated to his right.

Judge Jamison defines the situation as one of expectations now that the professional workers in the mental health court program have “found a bed” for the participant. He issues a warning to the her that she needs to live up to her end of the bargain and “stay away from drugs.” The participant displays her happiness at the news and assures the judge that she will not get involved in substance abuse, beginning the relationship of
personal interaction between MHC judge and participant that will involve continuous
evaluation of her performance for what may be the next two years, if she is not
terminated from the MHC as an unsuccessful case beforehand.

The term “finding a bed” was one that was heard regularly during court room
observations, not just in Bevan City but at all sites, but it did not always refer to releasing
a person from incarceration. Sometimes it referred to a participant who needed to be
placed in a residential facility in order to move out of her family's home, or to a
participant who was "decompensating" - exhibiting signs of deterioration of mental
health as recognized by professionals - and needed to be placed in a mental hospital.
Occasionally, the term would refer to a participant who had gotten into trouble being put
back into a county jail facility after having lived in a residential home allowing freedom
to leave during the daytime. In the following observation, a Bevan City participant who
has come up positive on a urinalysis screening faces being re-incarcerated in the jail's
hospital facility:

On the right wooden bench, the second from the front, a short Black man
is sitting wearing a suit. He is about 5'8", skinny, and his short cropped
hair is slightly graying. His black suit is well worn and ill fitting, as both
the pants and the coat sleeves are too short. He also has on a yellow shirt
and a green tie. The tie looks faded and seems to be an older, broader
style. The man is also wearing worn black tennis shoes with black socks.
If he is a mental health court participant, his appearance is odd as no other
participants have been observed wearing a suit to sessions of the court.
Almost all participants wear jeans to court sessions, and even the well-
dressed participants do not wear ties or suit jackets. … Judge Allen calls a
name, and the man in the shabby black suit gets up from the audience area
and opens the glass doors into the main court room. As he moves before
the judge, he quietly says “Hello judge, how are you?” looking up at the
judge briefly. Judge Allen looks down at him from his bench with a look
of concern and says “I’m doing fine, but I have to tell you, reports are not
good. You tested positive on a drug test and that’s a violation of
probation. You need inpatient treatment, and we found you a bed.” The judge turns to the ASA, a middle aged white woman dressed in a grey suit and standing in front of his bench to the right of the participant. They confer about the participant’s legal standing and look over documents, and then the judge says in a raised voice “The defendant is remanded to custody.” The judge bangs his gavel and looks over at a deputy, who takes the man in the shabby suit by the arm and escorts him out the door in the back of the court room. The judge writes on a document and hands it to the secretary seated to his right. Both the ASA and the public defender write notes in their respective folders.

A follow-up inquiry into this situation revealed that the participant had tested positive for cocaine, and went back into the county facility for what was likely a ninety day stint. The wearing of the suit may have been his attempt to avoid going back into the county hospital facility. Judge Allen showed concern, banged his gavel, and prepared documents along with the ASA that enabled sending the participant back into the jail facility. The non-adversarial teamwork approach of the Bevan City MHC ensured that the public defender, who stood quietly to the side during the exchange, would not debate this decision with the judge and ASA during the hearing. The decision had already been made collectively by MHC professionals in the staff meeting beforehand. During the hearing, the judge defined the gravity of the situation to the participant, and completed the criminal justice process involved. Professionals in mental health court programs enable treatment for mentally ill offenders by finding a bed, but also engage in criminal justice processes that enable the restriction of freedom for offenders who violate terms of their MHC participation.

Controlling the Residential Living Situation

Finding a bed is not the only professional work understanding involving a participant's residential situation. MHC professionals continuously monitor the behavior
of those participants who are mandated to stay in a hospital, drug rehabilitation facility, or long-term residential facility by maintaining contact with mental health workers of the facility, getting reports from them on a participant's behavior, and occasionally intervening if facility workers note a problem. If a problem with a participant's behavior is serious enough he may be discharged from the facility, so the professionals aim to prevent this by influencing the participant at times of personal interaction. In the following example from observation, the Tandy MHC judge attempts to influence a participant's behavior in a residential facility:

The Tandy MHC judge, Judge Cameron, is an older white man of thin build and balding head of short, thinning grey hair. He is seated in black robe at his elevated bench, flanked on his left side by a secretary, a middle-aged white man, seated at a desk about a foot lower than the bench, and to the left of the secretary and lower a stenographer, a middle-aged woman who appears to be of Hispanic ethnicity, seated before a grey stenotype machine. Judge Cameron calls out another name of a MHC participant to appear at the hearing. The first name of this participant is Calvin, and after it is called out a young black male appearing to be in his 20s walks from the third row of wooden benches in the audience area to stand before the judge's bench. Calvin is tall and thin, clean shaven, and wearing white tennis shoes, dark blue jeans, a bright red winter jacket, and a baseball cap of the same red color that is emblazoned with a sports team logo. Judge Cameron smiles, looks down at Calvin, and asks how he is doing. Calvin briefly greets the judge, mentions the residential facility for mentally ill persons where he lives by name, and complains that workers there are not allowing him to talk to his girlfriend on his cell phone. Judge Cameron smiles thinly, and explains that one of the rules at the housing facility is that a resident cannot engage in romantic relationships with someone living at another specialized housing facility. He says "I understand why you don't like it, but if you are kicked out of [the residential facility] it is violation of your probation." Judge Cameron tells Calvin he must follow the rule. "It's not my rule, it's their rule. But what are you gonna do?" Judge Cameron further explains to Calvin that if he is kicked out of the housing facility and has his probation revoked, he will end up being incarcerated, so he must avoid this by following all of the facility's rules. Calvin nods acknowledgement and looks down. After a pause, Judge Cameron looks at a social worker who has been standing
nearby to the side of the bench, along with the public defender and the
probation officer next to her, and an ASA across from them. The judge
asks "What else?" The social worker, a middle-aged black woman
wearing a red sweater with a floral design and blue pants, says "Calvin is
going to [a local college] for another class. He is doing well other than
this issue with a girlfriend and [the residential facility]." Judge Cameron
nods, then looks back down at Calvin and speaks calmly. "You've got a lot
hanging over your head. You've got to take care of your business. Don't
think you can deceive [the workers at the residential facility], you can't. I
hope you make the right choice. See you [in two weeks]. Any
questions?" Calvin looks up at the judge, shakes his head, and says "No.
Thanks judge." As Calvin turns to leave out the front door of the room the
social worker approaches him and they talk quietly and briefly before he
exits. Judge Cameron writes on papers on his desk, and then calls out the
name of the next participant to appear.

Judge Cameron stresses the consequences of not abiding by residential rules, which could
include revocation of probation leading to a multi-year prison sentence if Calvin is
terminated unsuccessfully from the MHC, as the Tandy program only accepts offenders
with felony charges against them.

During staff meetings and court calls, professionals at all of the MHC sites
displayed attempts to control the living situations of participants. But these attempts
were limited by the availability of beds in hospitals and residential facilities. Throughout
the study, professionals at the various sites lamented dwindling funding for state hospital
and housing services at the same time that they celebrated finding funding for their MHC
programs. They often faced waiting periods for the placement of participants as beds
were not always available, as described in above examples. As a result they tried to
cultivate valuable relationships with workers at such facilities. At the Tandy MHC
professional workers from a local drug rehabilitation facility and a local private hospital
had become regular attendees of staff meetings. At other MHCs, professional staff
regularly contacted hospital and residential workers to discuss placed participants and available beds, and occasionally asked these workers to attend their staff meetings to discuss problematic participants.

Professionals also aimed to control the living situation of those participants who were allowed to live in a private residence in the community. In the following example from observation, professionals in a staff meeting of the Ferry County MHC debate how to approach a young participant who wants to find an apartment with his friends:

Judge Vandiver looks down at the staff meeting agenda on the conference table in front of her and names another participant. Carla, one of the probation officers, reports that the participant is a young man who has just finished a summer camp counseling job. Now home living with parents, he has an appointment with his psychiatrist today after the court hearing. Peggy, the public defender, adds to the conversation by telling the judge that the young man has a "plan for his future," which includes going to college and moving out of his parent's house. "He does have issues with his mom," Peggy comments, adding "He wants to get an apartment with his buds. We need to vet the friends." Patricia, the social worker, comments "I thought he [got an apartment] already." Peggy responds "He said he was going to but hasn't. He wants to go to school and get a job. I think he could do well if there are no bad influences. We need to find out who those friends are." Carla says "We can ask him about his friends, maybe do some checking." Rhonda, the probation supervisor, looks at Carla and cautions "We can't do background checks on friends." Peggy concludes "I can talk to him and find out who they are. I can look up their criminal history on [a database]." No one adds to the public defender's comment. After a brief lull in conversation, Judge Vandiver moves on to discussion of the next participant on the agenda.

Protection from bad influences was much of the concern of professionals controlling the living situation of participants. In the following example Judge Jamison, the Bevan City women's MHC judge, tells a participant who is being discharged from a treatment facility that she will not be allowed to live in a part of the city known as the "east side" because of potential bad influences that might lead to substance abuse:
Judge Jamison moves on to the third name on the hearing docket, calling out the name of a woman, Cleona, who is seated in the audience. She is black, of medium height, middle-aged, wearing glasses, and heavy set, with short close-cropped hair, and dressed in pink warm-up pants, white tennis shoes, and a black winter coat. Earlier, Cleona had been talking in the audience area with a young white woman social worker from a local community mental health agency. Now she gets up from the second row of wooden benches in the audience area and moves to stand before Judge Jamison's bench. Judge Jamison smiles and looks at her, they exchange greetings, and then he says "I hear you've been doing real well in treatment. Now you're about to get out." He congratulates her for doing well in the inpatient program, but then he lifts some papers on his desk and explains that it is a written report from case managers at the treatment program describing Cleona's plans for what she will do once she is discharged. He then says earnestly "I know you want a place on the east side, but we can't let you do that. It's not good for you. I know you want to be near your mother, but this is where you always got into trouble. We'd be wasting our time with you if we sent you back to live on the east side." During this explanation Cleona stands quietly facing up at the judge. Judge Jamison then asks her not to fight this decision, and reminds her that she had signed a mental health court contract that requires her to follow directives of the court. Cleona looks down for a second, then back up at the judge without saying a word. Judge Jamison lowers his voice and says patiently "I told you there would be a lot of ups and downs, a lot of heavy lifting. But don't use this as a reason to backslide." Cleona nods, still looking at the judge. "Get some stability under your feet" he implores, explaining she has come too far to make a mistake now by turning to drugs. "Don't let yourself down" he concludes. Cleona nods again and says quietly "Okay. I understand judge." Judge Jamison smiles and speaks this time in a more cheerful tone. "You've been doing so well you don't have to come back again until [four weeks later]." Cleona nods and says thank you to the judge, and he says goodbye. She then turns and walks back to the audience area to sit next to the young woman social worker, who begins whispering to her. Judge Jamison writes on papers, hands them to the secretary seated to his right, looks down at other papers, and calls out the next name on the docket.

In order to control the living situation Judge Jamison gets a report on the participant's plans from a treatment agency. The sharing of information among MHC professionals and mental health workers at other organizations was a crucial element of this control made possible by a participant's signature on waivers of information and a program
contract. Judge Jamison had previously discussed the situation with the public defender, probation officer, and social workers during a staff meeting, and made the decision, which the other professionals agreed with, that Cleona would not be allowed to live on the east side. The Bevan City MHC is non-adversarial, and judges have the final say on decisions made. Judge Jamison engaged in controlling the living situation to protect Cleona's hard work and progress in the MHC by keeping her from the bad influences of the poor, drug-ridden, inner-city neighborhood where she had lived near her mother. The non-adversarial approach of this MHC ensures that the public defender will not consult with Cleona to see if she wants to fight this directive during the hearing. The deliberative democracy Mirchandani (2008) observed by which participants have a voice in the Salt Lake domestic violence court was almost non-existent at the MHC sites I studied, although at two of the sites, Ferry and Lynne Counties, the public defenders took an adversarial approach behind the scenes at times on behalf of some participants. But controlling the living situation and other directives of the judge were rarely questioned by participants in Midwestern MHCs during hearings. Very often, participants facing directives of the judge were simply passive, like Cleona.

Making Claims of MHC Program Benefit

Most of the professionals I interviewed and observed spoke very positively about their MHC programs. These professionals talked of the benefit of the MHC program for the participants with whom they worked. In the following interview excerpt, Phil, the program coordinator for the Bevan City MHC, explains how he thinks the program is beneficial to participants:
Phil: You know, when somebody asked me recently “What’s, what is it that is different about people, why is it that they get better in mental health court?” and my stance for a while now has been that when people come to the court they, it appears that they don’t have a whole lot to lose. They don’t have any family support, not much if any. They don’t have control of their finances. They don’t have a stable place to live. They don’t have job options. And so, you know, in a way, in that framework, whether somebody spends a couple weeks in custody in the jail or homeless on the street, it’s not a whole lot of difference. In some ways it’s even desirable. You know, you know where your meals are coming from. You know you have medical care if you need it. You know you have some place that’s dry and relatively warm or whatever as opposed to living on the street. But as people are with us, it’s like we’ve, kind of in a real global way, thought that like around the one year point people are starting to kind of get it. That “I do kind of have something to lose now.” You know, “I do have … I’m back seeing my family again. I have, I’m taking a job. I’m in a job training program that’s giving me clothes to wear when I go for a job interview.” Or, you know, “the medication seems to be working, I’m not, my thoughts are clearer, I’m not as agitated.” You know, so I think people then start to think, you know, “I don’t wanna do what I used to do because I’m gonna end up in jail and I’m gonna lose all this stuff.” So I think that’s, in this, the most simplistic way, I would say the people who are doing well are the ones who realize that “What I’m getting out of this program is a good thing and I want it to continue because I haven’t had this for a while.” Even finances, you know, people end up being their own payee. You know, we’ve seen people come to court like their first court date after becoming their payee and getting, with support and guidance, being able to spend some of their own money, and come to court with new shoes and a new jacket, and, you know, wanting everybody to know that “I bought this on my own, with my own money. It was … I didn’t go to some place and get a handout. I bought this myself.” And that’s a real legitimate sense of pride, that somebody is able to take control. They have their own benefits. They know they’re not having to go to jail to get treatment for a medical condition. They have a medical card that they can go on their own and get services that they’re entitled to.

Professional Dissent

Not all of professionals at the programs I studied were fully supportive of the idea of MHCs. In the following field note narrative, the head court psychologist from Gabriel County describes his dissent from the professional claims of the benefit of specialty
courts existing in academic and professional literature and at other Midwestern MHC
sites:

The MHC hearing has ended, and as I leave the courtroom with Tina, the
program coordinator, she leads me down a hallway, and we run into Dr.
Peete, the head court psychologist. He says he will show me out as he is
leaving, and after we say bye to Tina he leads me through another
hallway, through another doorway, and we walk past the security guards
and exit out the front entrance of the courthouse. We end up chatting in
the grass between two large parking lots adjacent to the court facility. Dr.
Peete is an average sized man dressed in a brown suit and tie, with neatly
combed thin greying blonde hair and a mustache. I would guess he is in
his late 50s. He is very friendly. We chat about my research and I tell
him that I am studying how MHCs developed in the state. He looks at me
with a wry smile and says "You know what happens? The Chief Judge
saw another Judge doing the program, and so he had to have it here. It
becomes like a shiny new toy, something to show he is keeping up with
the times." I am surprised by his candor, and ask him what he thinks
about whether or not MHCs are effective programs. He indicates he does
not support the programs. He tells me he is a twenty-year veteran of the
court there, working as a psychologist, and from what he has seen he does
not believe the MHC program is an efficient use of resources. "I don't
know why we don't just move [MHC participants] out of the court process.
Just divert them straight to treatment without taking up the court's time
and resources." I ask "So you don't think mental health courts are cost
effective?" He looks at me and says "No, I don't see how they can be.
You're taking up the judge's and the court's time, that's costly. You could
accomplish the same thing in a cheaper way by just diverting
[participants] out of the criminal justice system altogether." After a lull in
the conversation, I thank him for showing me out and talking to me. As
we exchange good-byes I tell him that anything he says to me is
confidential. He smiles and says "Oh, I'm not worried about that, you can
say whatever you want. I've been here more than twenty years. I'm not
worried about that now!" He chuckles, and turns to walk to the employee
parking lot. I go the opposite direction to the visitors' lot where I am
parked.

Cheerleading

The interaction in the parking lot with Dr. Peete in the preceding example
occurred during my first visit to Gabriel County. I was not sure if his opinion about the
benefits of mental health courts was shared by other Gabriel County MHC professionals. However, a number of the other Gabriel County professionals - Tina, the program coordinator; Kevin, the public defender; Penny, a social worker; Mike, the probation supervisor; and MHC Judge Albinson - made statements during interviews and observations that indicated they do not believe MHC programs are the solution to the problem of persons with mental illness being involved with the criminal justice system. But the same group of people also displayed detailed and focused work effort to help individual participants during staff meetings and court calls that belied this opinion about mental health courts. In the following interview excerpt Dr. Peete and some of the other Gabriel County professionals communicated dissent from claims of the benefits of MHCs made by advocates who view them as a solution to the problem:

Kevin: I guess you're going to talk to other people in other jurisdictions that are true believers. I don't know that we fall into that category.

Researcher: Yeah? Well, maybe not.

Mike: I think we're a little more realistic as opposed to idealistic.

Researcher: In other words you think other places there may be people that think these programs should be expanded and be the way that this population is served?

Kevin: Right, I'll take that.

Tina: I think you're going to find some cheerleaders in other jurisdictions. She laughs as she finishes the sentence.

Mike: Like it's something that should be growing. I think it’s something that should be receding, if anything.

Tina: And I am a cheerleader, don't get me wrong.

Mike: And we're working more from a different end.
Judge Albinson: I think we should go back to what used to work is having community based mental hospitals.

Dr. Peete: Yeah.

Judge Albinson: And there would be a list of people who have these problems and, you know, if they had an encounter with the justice system they would be taken to the hospital, treated, rehabilitated and then, you know, returned home. Instead, I mean, in essence that's what we're doing in the court system.

Kevin: Right.

Dr. Peete: Absolutely.

Tina: Yep, we are.

Kevin: There's a need for it, but do we want people who are mentally ill to be arrested? No.

Researcher: As an entry point to mental health care?

Dr. Peete: Exactly.

Kevin: Of course not. But that's what's happening all the time now.

The above excerpt reveals the working ambivalence of professionals at the Gabriel County MHC. On the one hand, they work hard to help the participants by finding them services and trying to influence their behavior in order to improve their lives. On the other hand, these professionals understand that MHCs do not increase the overall amount of mental health services available in the community, while many of their colleagues at other Midwestern sites are "true believers" who advocate for MHC expansion. Tina displays this ambivalence: she refers to these true believers as "cheerleaders," joining her Gabriel County colleagues in recognizing that MHCs are not a real solution to the problem of persons with mental illness winding up in jails and prisons, while also saying
she too is a cheerleader because she strives to help her clients through the operation of the program.

Working with the Mentally Ill Drug Abuser

A common part of the work of Midwestern MHC professionals was dealing with issues of substance abuse among referrals and participants. At staff meetings, drug abuse issues of referrals and participants were a common topic of conversation, as displayed in some of the examples above. At all of the sites I asked program coordinators if it would be possible to get data on program numbers and on individual cases with identifiers removed. Several of the sites were either unable or unwilling to provide such information, but a number of sites did provide datasets. These included how many MHC participants were diagnosed with substance abuse issues or how many crimes of participants were illicit drug crimes. In Hackett County, forty percent of participants in the MHC during the previous two years were diagnosed with substance abuse disorder in addition to mental illness. In Lynne County, thirty-seven percent of MHC participants of the past two years were dually-diagnosed. The Bevan City MHC provided data on the types of criminal charges that brought participants to the MHC, and sixty-two percent of these charges were for possession of a controlled substance. The total number of participants in Gilmour County was much smaller than most of the other sites, and by contrast only one of the sixteen participants of the previous two years for which records were available was dually diagnosed.

All of the sites accepted "dual-diagnosed clients," which usually meant referrals who had been diagnosed with both mental illness and substance abuse disorder, but the
Mental illness had to be the primary problem as judged by program coordinators or mental health professionals. Thus another calculation was done by some MHC professionals to determine whether or not a given referral has primarily a problem with mental illness or primarily a problem with substance abuse. During an in-between time observation waiting for a staff meeting to begin with Felix, the Collins County program coordinator, he related this determination as follows:

Felix: I had a [referral], he told me he's been sitting around smoking a lot of pot because he's depressed. See if he told me "Hey I sit around all day smoking pot because I just like it," well then he's not right for the program. But if he says he smokes pot because he's depressed, well then he's appropriate [for the MHC].

In their work with drug-abusing participants, professionals described having to expect "slips" of participants - times where they engaged in substance abuse - early on in the program, but eventually expecting improvement. In the following interview example from the Lynne County MHC, Judge Setzsky and Sara, the program coordinator, describe two cases of participants with substance abuse issues:

Judge Setzsky: Okay, we had one where he preceded my involvement in the court, which was three years ago, where he was an individual who we finally saw kind of a cycle pattern for him where he did 90 days where he was doing pretty well, and then start to miss and not show up and start getting a little antagonistic towards the team, then dropping dirty, and then we would be basically at the bottom with him. Generally speaking there would be some jail associated with that, and that happened, I don't know, two or three times in that cycle period. So we talked it through as a team and kind of hit on that, "okay now we're starting to see the same disintegration pattern that we've seen before. Let's talk to him about it and see if we can't maintain [stability] this time." And we had the conversation as a team in court, and then all around. And all of the contact was reinforcing that, and broke the cycle, and he graduated. He's stayed clean and sober for a year and he has another one of our MHC clients currently residing with he and his mother where he’s trying to, he's being a peer mentor to this other client to help him achieve recovery and…
Sara: He spoke at [a meeting of the Midwestern MHC professional organization].

Judge Sentzsky: He spoke at [the meeting], so that was a case where, really, I think we were all at our wits end and about to bomb him out and say "enough already! You’ve taken a lot of time and resources and you don’t seem invested in this." And a light went on and he worked it, and he's doing great. Then we have another one who came in and he was…One of the target populations that we all, I think, feel pretty compelled to give strong consideration are younger people. We want to see them on the front end. And they often present with some real tall challenges, and one individual who was, I think, 19 when we took him in: history of heroin abuse, history of rapid decompensation, violence, serious suicide attempts, and very, very scary.

Sara: He was into anything he could get his hands on.

Judge Sentzsky: Yeah, anything he could get his hands on he wanted, he just got…

Sara: Cough medicine, huffing.

Judge Sentzsky: Yes. And…but we took him and it was a real bumpy road in the beginning. He reoffended, he stole alcohol and drank, and he was using. And we finally ended up… he was a nursing home candidate. We had him in that kind of residential placement for a number of months.

Sara: Lots of issues there, too.

Judge Sentzsky: Lots of issues there, too, and 2hard to know the true facts. I mean some of it he would go on furloughs and use. And so, I mean, clearly that was a huge issue. Or people would smuggle stuff in to him.

Sara: Or give it to him through his window.

Judge Sentzsky: But also the [nursing home] staff, I think, also targeted him as a trouble maker and so made it more difficult for him to remain there peacefully. Long and short of it is we finally transitioned him out to his parents who I think adjusted some of their overall supervision of him. But right now we’re dealing with medication issues where one of his parents is sort of…is regulating the medications, he’s not taking it as prescribed, but as they see fit, or at least one of the parents sees fit, so that’s a huge issue. We’re trying to get past that so a crisis bed stay was our hope to kind of identify what his real presentation is.
Sara: And as of this day he was in the hospital and had seizures.

Judge Sentzsky: I mean, [it's] a rocky road with a lot of these folks.

A substance abuse diagnosis of a participant can involve alcohol rather than illicit drugs. In the following observation example from the Collins County MHC staff meeting, Judge Harrington praises the other MHC staff for work with a participant who seems to be finally accepting his alcohol addiction. Later, during the MHC hearing, Judge Harrington stresses to a participant the need to face the alcohol problem, and warns him about the possibility of prison:

The staff meeting for the MHC is held in a conference room near Felix’s office. He passes out photocopies of a staff meeting agenda listing the participants and brief notes on each to the other MHC staff gathered in the room, including Liz, the probation officer; Teresa, the social worker; Bridget, the nurse; Martin, the public defender; Nathan, the ASA; and Judge Harrington. Felix begins talking about the first person listed on the agenda, a participant named Bill, and notes a status report about his recent problems with alcohol, and his failure to pass a breathalyzer test administered by Liz. After the group looks the report over, Judge Harrington says he is glad to hear that Bill is "recommitting" to treatment. The judge says "Everybody has to reach their bottom; he's finally reached his." Then Judge Harrington and Felix discuss how the choice of an addiction counselor made by Bill is a good one, and based on their suggestion. Judge Harrington says Bill had to learn to expect monitoring at all times. The judge also says that he thinks Bill will now improve. Judge Harrington looks around the conference table at the other professionals and tells them "You've all done a great job [working with Bill]. Do you agree?" the Judge asks, looking at Martin, who nods acknowledgment. Liz then explains how Bill "used" and came up positive on a breathalyzer. He had tried to argue that the test was wrong, so Liz ran it three times to confirm. Judge Harrington says "But that's his m.o." Martin asks "Was it a PBT?" (A PBT means a preliminary breath test for alcohol.) Liz answers "Yes." Martin suggests that maybe Bill should be required to go to 12 step meetings on a daily basis. They discuss this suggestion, and Martin adds "90 meetings in 90 days." The team decides this is what they will tell Bill he needs to do, and all agree this strategy will work if he is truly committed.

Later at the MHC hearing, Judge Harrington, a tall, thin white man
with glasses and a full head of greying black hair, is seated on the bench in his robes. A white woman secretary is to his left seated a little lower, and to her left stands a white male uniformed sheriff's deputy. Felix, Liz, Teresa, and Bridget are sitting together in the jury box quietly watching the proceedings. Nathan, a young, white ASA wearing a brown suit, is standing in front of the bench holding documents. Judge Harrington talks with Nathan. They discuss how Bill, the first participant scheduled on today's docket, is present, but that the second client scheduled is not present. Martin, a middle aged, white public defender in a grey pin-striped suit, comes in with Bill, a young, white male with close-cropped hair, wearing blue jeans, brown shoes, and a white shirt, following behind. Martin asks if he can approach the bench. The judge nods and says yes and he and Martin have a brief, inaudible conversation while Bill waits about ten feet behind. Judge Harrington looks intensely up at Bill and says "I think you've learned about your issues." The judge tells Bill that he is finally beginning to understand his problems with drugs and alcohol, and that he must follow treatment as planned from now on. Looking sternly at the participant, Judge Harrington holds up his thumb and index finger and says "You're this close to prison." He praises Bill for taking a positive first-step, having come to understand that he must work with his treatment providers. Judge Harrington further explains that the court cannot do anything more for Bill and that it's now up to him to work his treatment program. Bill nods agreement. Judge then looks over at Liz seated in the jury box, and she and Martin talk briefly with Bill to schedule his next appearance in a couple of weeks. Judge Harrington reiterates Bill's responsibilities, and then dismisses the participant. He thanks the judge, says something quietly to Martin, then turns and leaves the courtroom.

Judge Harrington refers to all substance abusers eventually reaching their "bottom," and in the preceding example Judge Sentzsky refers to a participant who "worked" the program and "stayed clean and sober." These comments draw from the language of twelve-step substance abuse programs, part of an ideology first developed by the original twelve-step program, Alcoholics Anonymous (Rudy, 1986). Professionals at the various MHCs required that participants who were diagnosed with substance abuse issues attend twelve-step meetings as part of their treatment, as displayed in several examples above. Judges often spoke the language of twelve-step programs to participants during hearings.
Occasionally, a participant would introduce his twelve-step sponsor to the judge when called at a hearing. At MHC graduation ceremonies, participants who had successfully completed the program often made testimonials to the audience which used the language of twelve step programs, including religious statements that drew directly from the formally stated twelve-steps of Alcoholics Anonymous (Rudy, 1986). The language of twelve-step programs is an important part of the vocabularies of MHC performance and was used by professionals and many participants at all of the sites.

Finding Difficulty with Youth

Professionals at a number of MHCs spoke of the difficulty of working with young participants, specifically those in their late teens or early 20s. In a few instances of referral discussion at staff meetings, some professionals suggested that cases of young people should be avoided, as it was particularly difficult to get young people to be motivated to perform in the program. Other professionals, however, suggested that their MHCs should target young people, because although they can be difficult to work with, the program is most effective when it influences persons with mental illness early on in their lives in order to prevent years of involvement with the criminal justice system. In the following interview example from the Collins County MHC, Liz, the probation officer, describes the difficulty of working with youth and suggests the need to develop a different strategy for them, while Felix, the program coordinator, and Bridget, the nurse, add input:

Liz: Another factor is many of our clients, a good percentage of our clients especially most recently are very young, and that’s a tough population to work with. And one idea I was just talking to my supervisor about was just having a little different track for the young people because
they just have so many different needs and their awareness level is just so low about their disease, you know, maybe something like that to problem solve.

Researcher: Okay, so with the youth it’d be a problem with awareness?

Liz: Awareness of their disease.

Researcher: Any other issues specific to young people?

Liz: Maturity level.

Bridget: Maturity, I mean, everything that young people do at that age. I mean they’re not doing anything pretty much outside of what other, you know, [people in their] late teens early twenties are doing. You know, smoking pot, drinking, whatever they’re doing, they’re just getting caught. They can't understand.

Liz: Peer pressure.

Bridget: If mental illness enters the picture [with young people] where it does, where it crosses the line, I mean, they’re also caught up in that kind of phase of maturity.

Felix: Yeah "I’m 20. Everybody does this."

Liz: Yeah.

Felix: That mentality and not really having any insight into possible addiction or how the mental health may interplay with those kinds of things.

Bridget: So they’re not going to want to be pulled out of the party to sit and not only, you know, pay retribution or whatever for the crime they did but now they have to look into their, you know, addiction. Now it’s an addiction. They have a mental illness, and all this stuff, and I definitely don’t think that they have the wherewithal or…

Felix: …the motivation…

Bridget: …to do that.

Felix: [The motivation is] to get the charges dropped, not necessarily to be in recovery and get treatment. So, you know, as you get some older
people who’ve been around in the system, they understand they not only
want to get the charges dropped but they also want the services and a lot
of the help. So we’ve run into [the issue of participant's age] pretty often.

Liz: And that lack of insight [of young people] will also kind of prevent
success in the program.

Conclusion

This chapter has presented a number of professional work activities and
understandings found at mental health courts during interviewing and ethnographic
observation. The next chapter presents the theory of performance as the organizing
principle of Midwestern mental health courts. Performance is an important part of work
activities of MHC professionals, and the fundamental understanding they rely upon to
operate the programs.
CHAPTER SIX

PERFORMANCE AS THE ORGANIZING PRINCIPLE OF MIDWESTERN MENTAL HEALTH COURTS

This chapter details the principle of performance - which my analysis identified as the organizing principle of Midwestern mental health courts (MHCs). Performance refers to how MHC professionals primarily understand participants and referrals in terms of their ability to perform in the program. Performance understandings held by professionals are fundamental to how the programs operate, as they are centered on judgments of referrals for their potential performance, and judgments of participant performances during programming. Performance understandings are central to the everyday work activities of professionals at MHC, as they are the basis for how professional workers accomplish the processing of mentally ill offenders in the MHC program. In this chapter, I begin by explaining how language is important for institutional work, and how professionals engage in personal and textual interaction in doing their work with offenders and making performance judgments, by which professionals operate the MHC program as a filter. Then I present and discuss several important kinds of performance judgments discovered during ethnographic observation of professional work activities.

Vocabularies of MHC Performance

Smith (2005) refers to language as coordinating subjectivities, and that the forms
of coordination of people's doings that constitute institutions are in language. Language shared between speaker and hearer, or between writer and reader, creates an intersubjective realm, what she refers to as "interindividual territory," in which both speaker and hearer share common referents, whether referents are based on actual human experiences or on textual items. Performance understandings are socially constructed and shared through language among professionals and between professionals and participants, such that the work of the mental health court can be accomplished via the coordinating of professional work activities, including personal and textual interactions with referrals and participants.

Dunn (2010) refers to "vocabularies of victimization" in her study of legal advocates for women who are victims of domestic violence. The advocates work with each victim to tell elements of her story, and teach her to tell her story, in ways that best match social constructions of victimization present in the criminal justice system in order for her own behavior to not be viewed as problematic by adjudicators. Borrowing Dunn's idea, I view the understandings of professionals presented below as containing vocabularies of MHC performance which reveal how individual offenders are judged by professionals as referrals likely to perform and become successful graduates and, if accepted into the program, as participants engaged in good or bad behaviors affecting successful graduation. The vocabularies defining good or bad MHC performances are primary to the blended organizational workplace culture in which criminal justice and mental health professionals work together to judge offenders with mental illness. Professionals also communicate these vocabularies to MHC participants who, if they are
to become successful graduates of the program, must recognize the vocabularies and strive to be good performers.

According to vocabularies of MHC performance, the *good performer*:

- Accepts his or her mental health diagnosis
- Has mental illness at an acceptable level – severe enough to justify being in the program, but not so severe as to be unable to perform
- Works hard to improve his or her life
- Lives in residence set up or approved by court monitors
- Follows the treatment plan mandated by the court
- Attends psychiatrist appointments and takes medication as prescribed
- Attends all scheduled group and individual psychotherapies
- Regularly attends 12-step meetings (if she or he has substance abuse diagnosis)
- Follows all program and residential rules
- Attends all scheduled hearings and appointments with MHC professionals
- Listens to and trusts MHC professionals
- Does not argue with MHC professionals
- Makes her or himself available and accountable to MHC professionals on request
- Does not commit crime, including using illicit drugs
- Does not get arrested
According to the vocabularies of MHC performance, the *bad performer*:

- Fails to address his or her mental health diagnosis
- Has mental illness at an unacceptable level – either invalid or too severe
- Does not work hard to improve and does not seem to care
- Has trouble living in residences set up or approved by court monitors
- Does not follow the treatment plan mandated by the court
- Misses psychiatrist appointments or does not take medication as prescribed
- Misses sessions of group and individual psychotherapies
- Does not work the 12-step program (if she or he has substance abuse diagnosis)
- Breaks program and residential rules
- Misses scheduled hearings and appointments with MHC professionals
- Does not listen to or trust MHC professionals
- Argues with MHC professionals
- Is missing or unable to be located
- Commits crime, including using illicit drugs
- Gets arrested

**The Performance Filter**

Professionals utilize vocabularies of mental health court performance in operating the MHC program as a *performance filter*. Criminal justice and criminology textbooks have presented the criminal justice institution, including law enforcement, courts, and
jails and prisons, as a large funneling or filtering process by which the population of persons who enter the institution on arrest may face any number of outcomes, including plea bargaining for probation, acquittal at trial, the state's attorney dropping charges, or conviction and incarceration (see for example Conklin, 2012; Schmalleger, 2004; Allen, Simonsen, and Latessa, 2004). Conklin (2012, page 299) refers to "case attrition" by which a large number of arrestees are filtered down to a relatively small number of persons incarcerated in jail or prison after their cases are processed through the courts. In the same way, I present the mental health court as a filtering process by which a relatively large number of referrals are filtered down to a small number of select few MHC graduates.

Performance judgments are the primary mechanism by which the filter is operated by professionals. My use of the term "performance" in this work refers to face-to-face interaction between the social actors observed who were placed in different positions of hierarchical power - the professionals and the MHC referrals and participants - as well as performance by referrals and participants that occurs through textual interaction between professionals and the referral/participant-as-case. Professionals rely upon specific understandings of "mentally ill," and often "substance abusing," referrals and participants in making judgments about who might best perform among the referrals and who is actually performing among the participants in the MHC program. Performance judgments work as a filter to determine who among the criminalized mentally ill population may receive mental health services in the community, and who may have to receive such services in jail or prison. Of course, when MHC professionals and
referrals/participants engage in face-to-face interaction, the referrals and participants also make judgments about the professionals' performance of work activities. But referrals and participants are in a position of limited possibilities to exercise power (especially if they cannot afford private counsel), so their judgments of professionals do not often lead to the ability to make changes against professionals' wishes, and rarely lead to exercising the power of institutional text. Because of this, in presenting performance as an organizing principle of MHCs, I focus on the performance of referrals and participants as they are judged by the professionals who do the work of the mental health court.

The performance filter is operated by professionals who work in MHC programs in a three-stage process, including the referral stage, the program stage, and the graduation stage (see Figure 1 below). At the referral stage, professionals draw upon their knowledge and past experiences in evaluating a referral to the MHC program both during face-to-face interaction, and especially, while perusing or preparing a case represented textually. Those referrals who perform the best, both as a case represented in legal and mental health paperwork in files and during face-to-face interaction, are judged by professionals as worthy of their help, and likely to do the things necessary to succeed, or to perform, in the MHC program. A minority of referrals passes through the filter at this point and becomes participants in the program, entering the program stage, the second stage of the performance filter. Although some referrals may have other probationary options, especially those who can afford private counsel, many of the rejected are eventually incarcerated, having to receive mental health services, when available, while living within the walls of jail or prison. At the program stage, face-
Figure 1: The Mental Health Court Performance Filter
to-face interaction becomes more prominent in professionals' evaluations of participants, although textual interaction with the participant-as-case continues and accomplishes fundamentally important work, such as changing a participant's criminal status from probationer to prisoner, or changing program status from participant to graduate. As a participant engages in repeated face-to-face interactions with professionals over time during monitoring or counseling appointments or during court hearings, professionals get to know the participant as an individual and develop judgments regarding the individual's mental health and criminality. Such judgments may then be shared with other professionals and the participant in face-to-face or other personal interaction, and they may be transferred to textual interaction with other professionals and the participant-as-case by being added to the individual's case file in the form of case notes and other documents evaluating and processing the participant. Both face-to-face interaction with the participant and textual interaction with the participant-as-case inform performance judgments that impact how professionals operate further filtering of the mental health court leading to the graduation stage for some of the participants.

The graduation stage is the final stage of the performance filter occurring in the weeks just before graduation from the MHC and culminating in an official ceremony, during which participants typically make personal testimonies to an audience that often includes family members. These participants become successful graduates who are no longer involved in criminal justice supervision, and are a select few individuals relative to the overall number of referrals. Other participants are unsuccessfully-terminated from the MHC and face conviction, incarceration, or other probationary supervision, or may no
longer require criminal justice attention if the judge determines that the time spent participating in the MHC was a sufficient probationary period.

As explained in Chapter One, I rely on the thought of Goffman (1959) and of Smith (2005) to theorize the notion of performance as an organizing principle of the work activities of professionals in Midwestern mental health courts. I analyze professional understandings of participant performance emerging in personal interaction using Goffman's (1959) dramaturgical method, which relies on analogy of the theater. I analyze professional understandings of participant performance emerging from textual documents using Smith's (2005) institutional ethnography, which includes discovering how text enables the accomplishment of work in institutions and mediates power relations. Below I explain how the personal interactions of referrals and participants with professionals can be analyzed as performance, and then further explain and analyze how textual interaction occurs in the mental health court. Although the two modes of interaction are explained in separate sections, I do so to clarify how they are central to everyday MHC professional work activities, not to suggest there is clear separation between the two as professionals do their work. The two modes of interaction are intertwined and fundamental to professional work activities, and to the overall process of mental health courts.

Two Modes of Interaction and Sociological Analyses

Goffman's Dramaturgy and Personal Interaction with Embodied Offenders

In The Presentation of Self in Everyday Life Erving Goffman (1959) developed a new theoretical approach to the sociological study of human interaction, an approach
referred to as “dramaturgical” because of its use of the analogy of the theatre to describe how an individual engages in social interaction with others in a given situation via a “performance.” Goffman's performance is the way the individual as an actor conducts her activities in order to influence other participants in a given situation. The human relationships observed in the mental health court can be analyzed as a set of performances in the sense that Goffman theorized. Nolan (2001) utilized dramaturgical analysis to analyze both the drug court movement and the microinteractions occurring during drug court hearings he observed. For the later he utilized Goffman to analyze the various professional roles in the drug court and how they worked together. He analyzed how professionals in the back stage of the staff meeting plan the way they will address participants during the hearing, and how in the front stage of the courtroom they present a united front, with the judge leading the performance.

Here I focus not on the performance of professionals, but rather on the performance of participants as they are judged by professionals. During times of contact with the mental health court program, each embodied offender diagnosed with mental illness engages in personal interactions with professionals. These interactions are usually face-to-face but also occur via telephone and email. Such encounters may or may not also involve the professionals engaging in textual interaction with the offender-as-case, such as the filling out of forms or conducting of mental health assessments. Regardless, each of these personal interactions offers the professional an opportunity to get to know the embodied offender in some way, and to judge her or his behavior, condition, and appearance. These performance judgments of personal interaction are crucial to how the
embodied offender will be processed by professionals. They affect how textual documents may be completed by professionals, but they also affect the general feelings and opinions the professionals have about the offender. As explained above, my theoretical argument is that the performances of referrals and participants during personal interaction with professionals are crucial determinants of how far an offender identified as mentally ill may move through the performance filter of the MHC.

Referrals and participants engage in impression management with professionals in an assymetric relationship (Goffman, 1956). During appointments and court appearances, a referral must interact with professionals in such a way that they are persuaded that the referral could perform in the MHC program and would benefit from participation if the referral is to be accepted into the program. A participant must display hard work and a willingness to acquiesce to professional instruction in order to move further toward graduation, and to mitigate any indiscretions which might be committed. Failure to do so can lead to participant termination.

Goffman (1959) described how an individual performer in a social interaction uses a “front,” a part of the performance involved with presenting behavior of a certain appearance and in a certain manner, even utilizing a particular setting, in order to define the situation for the audience who is observing. “Personal front” refers to “items of expressive equipment” that follow the performer wherever she goes and which the audience identifies with the performer. Parts of the personal front might include age, racial characteristics, gender, posture, speech patterns, size, and clothing. In defining the personal front Goffman was describing how signs or markers of a person’s social status
are always carried around by a person. Referrals and participants varied in age, but for many their elements of personal front, including shabby clothes, hip-hop apparel, or jail scrubs, or their race, marked them both as lower-class and as offenders with mental illness. They also displayed posture and speech patterns when appearing before the judge or meeting with other professionals that communicated their level of investment with the program and acceptance of professionals’ rules. This is not to suggest that all good performers who eventually graduated from the MHC were skillful manipulators of the opinions of the judge and other professionals. Indeed, I observed some individuals who displayed problems with personal interaction, such as the disorganized speech typically associated with schizophrenia (Emery and Oltmanns, 2000), but who were still praised by the judge during the hearing for their good performance in the program. But fundamentally those who performed poorly during hearings by displaying an improper attitude or not acknowledging their own shortcomings, or who did not perform in the program by missing appointments or creating conflict with workers at residential facilities, were viewed as bad performers by MHC professionals, and were terminated from the program if they did not display improvement in performance during personal interactions over time.

I cannot conclude this section on personal interaction without discussing the work of Arlie Hochschild (1979), who is somewhat critical of the interactionist approach that Goffman (1959) took in The Presentation of Self and his other works, although she recognizes that his approach served his theoretical purposes, which accomplished “a brilliant achievement in the intellectual history of social psychology.” Her criticism is
that Goffman focused on human situational interaction without a consideration for emotional processes within the individual, or for social structural determinants of the individuals and the situations in which their interactions take place. Hochschild attempts to address these missing elements through her development of the concepts of “emotion work” and “feeling rules” from an “emotion management” perspective. Emotion work refers to “the act of trying to change in degree or quality an emotion or feeling.”

Goffman’s notion of performance, for Hochschild, refers to surface acting, whereas emotion work refers to “deep acting” within the individual as she tries to control emotion and feel the appropriate feeling for a given situation. A feeling is appropriate in a given situation based on feeling rules which are “social guidelines that direct how we want to try to feel.” For instance, a person at a funeral understands that she should feel sadness and makes an effort to feel that way (emotion work) if that feeling is not already present.

According to Hochschild (1979), feeling has been commoditized in capitalist societies, in that doing emotion work and understanding and following feeling rules is a part of some labor requirements for certain job positions. She argues that middle-class jobs more often require an element of “personality,” an ability to promote one’s self and one’s organization, than do working-class jobs, which often involve physical labor while not requiring contact with customers. This argument may now be somewhat outdated, as beginning in the 1970’s the American economy underwent a transition from an industrial economy to a service economy; now many low-paying jobs, such as in fast-food restaurants, are in the service sector and require customer contact and an element of “personality.” But still many professional jobs, including those in the mental health
court, require a skill set in conducting emotion work and in understanding feeling rules.

Judges and other mental health court professionals thus engage in emotion work, but this is also a requirement of referrals and participants if they are to conduct a good performance during personal interaction with professionals. On beginning the program during a hearing, a referral is often expected by the judge to display enthusiasm and a positive attitude toward the work to be done in participation. On being verbally sanctioned by the judge, a participant who has misbehaved must display a somber attitude in recognition of the gravity of the mistake and in acknowledgment of the need to improve. Recall that above I discussed how Nolan (2001) found that judges in drug courts utilize an ethic of emotivism in working with individual participants in which they try to motivate participants through a personal, emotional connection. To perform well in the MHC, a participant must display an appropriate emotional reaction when expected to do so by judges during MHC hearings, or by other professionals at other times of personal contact.

*Smith and the Notion of Textual Interaction with the Offender-as-case*

Smith (2005) explicates the importance of including and analyzing institutional text in her ethnographic method. I include consideration of the use of text in this study in a way similar to that suggested by Smith, considering how institutional discourse represented in texts mediates power relations among individuals. Lemert (1992) points out that Smith has developed her own theory of modernity in conceptualizing the use of texts by institutional actors in the interests of ruling relations. One can analyze professional understandings of participant performance emerging from the textual
documents that represent the individual referral/participant using Smith's (2005) conceptualization by discovering how text enables the accomplishment of work in institutions and mediates power relations. Within mental health courts these power relations occur as professionals utilize texts to exercise power over referrals/participants. Outside of mental health courts the relevant power relations involve connections between professionals operating the MHCs and the criminal justice and political figures who exercise power and enable the programs, and who are part of the sociolegal movement promoting problem-solving courts. These outer connections are also textually mediated through official policy and legislation, in official reports, and in presentations made during meetings of the professional association promoting mental health courts in Midwestern. But here I focus on textual connections within mental health courts, what I refer to as textual interaction.

Textual interaction refers to professionals reading, relying upon, and adding to bureaucratic documents that are each tied to an individual referral/participant, such as court filings and case files, through which professionals from both criminal justice and mental health perspectives share understandings about referrals and participants and accomplish their processing. An institutional image of each individual criminal offender in a court jurisdiction is constructed through textual interaction of workers in the local criminal justice organization which represents an official version of who the offender is, and what specific crime events he has enacted. In MHCs, textual interaction also includes workers in mental health agencies creating an institutional image of each person believed to have mental illness whom they encounter which represents the specific
Figure 2: Two Modes of Interaction of MHC Professionals
medical illnesses, behavioral actions, service needs, and program outcomes for each individual. As stressed above, there is a blending of criminal justice and mental health understandings in MHCs such that professional understandings of the offender-as-case are merged. Figure 2 above presents how MHC professionals of both institutions engage in interactions resulting in the construction of the offender-as-case as a shared understanding. As displayed in Figure 2, the embodied offender is always linked to her or his case through some form of identification utilized by workers in institutions, for example name, case number, fingerprints, driver's license, social security number, or birth date. One professional may communicate to the other through personal interaction with the embodied offender, for example a mental health counselor might tell the offender to tell her probation officer that an appointment was cancelled. But professionals also communicate with each other through the offender-as-case as they read, share, and add to textual representations of the offender. I diverge from Smith's (2005; 1990) conceptualization of textual mediation of power in institutions in a few ways. Smith (2005) describes texts as produced by institutional actors then remaining static across contexts over time. But I view the textual representations of the offender-as-case as being shaped over time as more documents are added, and existing ones are altered.

Smith (2005) refers to the importance of textuality for coordinating the work of institutions, but in the process, she explains, the institutional account of the individual is decoupled from her lived actualities. The particularities of individual context are erased from institutional accounts (Smith, 1990), and "meaning is detached from local contexts
of interpretation" (Smith, 1984). Smith (2005) explicates the fashioning of institutional representations as three key processes:

...one is that they transform the local and particular into the generalized forms in which they become recognizable and accountable across the local settings of institutional work; two, the objectification of institutional realities overrides individual perspectives…; three, the translation of the actual into the institutional is an essential step in making the actual actionable institutionally. (P. 186)

My argument for reworking Smith's (2005) description of this conceptualization of language, texts, and power in institutions is not that such processes did not occur or were not evident in my ethnographic research on mental health courts. Certainly, across sites the professionals spoke and wrote of groups of individuals known as "mentally ill offenders," some of whom had "schizophrenia" or "depression" or some other acceptable "mental disorder" for the program, who may be "substance abusers," and also "non-violent" or "violent offenders." On entering the mental health court program the offenders all agreed to participate in a program of mandated treatment which included regular court appearances and the same kinds of mental health services. In this sense, unique individuals were grouped together and objectified through texts to enable institutional processes. But what is missing from Smith's (2005; 1990; 1984) conceptualization is how MHC professionals as institutional workers engage in textual interaction over time, along with personal interaction, to learn a story of a unique individual who is evaluated both as a moral actor making choices of free will and as a diseased individual in need of treatment.

I refer to textual interaction because I describe an interactive process between
professionals and an offender-as-case. A personal interaction leads to an impression that one person has about another as Goffman (1959) described, and in the same way the textually-represented offender-as-case provides an impression to a professional about a particular individual. For the purposes of the mental health court, when a professional engages in a text-reader conversation with the offender-as-case it *performs* just as the embodied offender may perform in personal interaction with the judge during a court hearing, or with a mental health worker during an appointment. As part of the process of textual interaction with the offender-as-case, I stress the importance of the unique, personal story of each offender for the professionals' shared work understandings.

Nolan (2001) refers to drug court 'storytelling' as fundamentally important to how drug court participants are evaluated. In drug court, a participant must tell an acceptable story to professionals who run the program in order to be understood by them as having the right attitude and doing the right things to succeed in the program. Similarly, I found that through personal and textual interaction professionals in Midwestern MHCS learned a unique story from each referral and each participant through a getting-to-know process that allowed for the evaluation of potential or actual performance. The longer the period of time in which professionals interact with mentally ill offenders, the more in-depth the story learned. Some institutional texts include more unique details drawn from an offender's lived actuality than others, and the level of detail in texts has meaning for professionals that they share with each other and with participants in evaluating performances. This process of storytelling is similar to what Dunn (2010) describes on detailing the vocabularies of victimization utilized by attorneys representing cases of
battered women in court, as these attorneys tell the women’s stories using the vocabularies in a way that portrays them as victims. As I said above, the story of each MHC referral and participant is shared among professionals using vocabularies of performance in addition to other vocabularies drawn from medical and legal discourses.

Two examples of institutional texts I gathered during the research will serve to respectively illustrate the decoupling and objectification process Smith (2005; 1990; 1984) describes and the beginning of the getting-to-know process I include as an additional consideration of textual interaction. Figure 3 below is a copy of a blank mental health court order from Waters County. The mental health court order has been edited only for the pseudonyms used to protect confidentiality. This court order enables, mandates, and legitimates the work of the federal drug treatment agency with an offender diagnosed as mentally ill being formally considered for acceptance into the program. As a formal process during a MHC hearing, one of the Waters County MHC judges completes this form for all offenders who enter the referral stage of the performance filter. This is one more document added to the textual image of the offender-as-case.

This court order is an example of a textual representation of institutional work that objectifies individuals and makes their story fit the institutional process, as Smith describes. The document enables and legitimates the exercise of power by professionals in the court but contains only a few identifiers of the individual with no other unique detail, and no representation of the individual’s lived actuality. Institutional workers may activate the text as described by Smith (2005) with her concept of text-reader conversations, and this may be part of a recognizable sequence of text-work-text or work-
text-work. The document becomes a part of an institutional record that can be shared

**Figure 3: Waters County Mental Health Court Order**
over time among various workers in various contexts, constructing the individual as "a person in need of a full range of mental health services" and, for some, "having a substance use/abuse problem." The court order states that workers from the federal drug treatment agency in Waters County can meet with the offender in the jail and obtain jail records for the purpose of determining appropriateness to enter the MHC.

Next, consider the document presented in Figure 4, an actual document known as an intake screening form completed for a specific referral by Amber, the program coordinator in the Gilmour County mental health court. Amber blacked the identifying information out of this document per Health Insurance Portability and Accountability Act regulations before providing it to me as an example of how the referral process is conducted, and I did editing of description of the case to further protect anonymity. The intake form begins the development process of the offender-as-case as a unique story attached to the embodied offender. After the intake appointment, Amber turns the offender-as-case information over to other relevant staff so that they may begin to learn the referral's story. But she also brings her opinions about the embodied offender developed during personal interaction to a staff meeting, at which both the behavior she observed during the intake interview and the offender-as-case are discussed by the professionals, but understand as one individual. Both of these document examples include objectification processes of the work of professional actors in the MHC, but the intake screening form example reveals one way in which professionals begin to learn a specific story attached to an offender who, if accepted into the program, will become known more intensely as a unique individual to be treated, served, and taught by
GILMOUR COUNTY MENTAL HEALTH COURT

**INITIAL INTAKE SCREENING**

<table>
<thead>
<tr>
<th>Date:</th>
<th>2011</th>
<th>Date Arrested:</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Referral name</td>
<td>Age</td>
<td>30</td>
</tr>
<tr>
<td>AKA:</td>
<td></td>
<td>D.O.B.:</td>
<td>1980s</td>
</tr>
<tr>
<td>Gender:</td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Stat:</td>
<td>Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race:</td>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSN:</td>
<td>000000000</td>
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</tr>
<tr>
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<td>00000000</td>
<td>Charges</td>
<td>Forgery</td>
</tr>
<tr>
<td>Tel:</td>
<td></td>
<td>Attorneys</td>
<td></td>
</tr>
</tbody>
</table>

**RESIDENCE/FAMILY**

Present Address and Phones:
- Street Address
- Telephone number

Residence Information:
- Describes how referral moved in with parents.
- Parents

If released, will reside at/with:
- Describes how referral lost custody of children.

Marital/Dependents/Child Support:
- Refers to nearby relatives.

**EMPLOYMENT**

Employment Information:
- Describes how referral lost job due to criminal charge.

**SUBSTANCE ABUSE**

Drug(s) of Choice:
- Cocaine

Assessment Recommendation:

Urinalysis Positives and Levels:

Comments:
- Describes how referral has used drugs since teens, and how she has been diagnosed with bipolar disorder.

Signature
Gilmour County Program Coordinator

Figure 4: Gilmour County Intake Screening Form
professionals following their shared understandings of who that individual is and how she may be affected. Some aspects of the offender's lived actualities are included in the intake screening form, but they are textually constructed by the program coordinator to fit the institutional process. In the next section, I present several kinds of performance judgments that were discovered among professionals during ethnographic observation.

**Performance Understandings of Mental Health Court Professionals**

**Filtering via Performance Judgments**

The concept of performance as the organizing principle of MHCs is drawn from descriptions of participants used by professionals in the field. I was first introduced to the concept in conversation with Phil, the program coordinator for the Bevan City MHC in Waters County, during a hearing, but at the time I just noted his comments. The following narrative describes the scene from the pilot study in which performance as a concept was first suggested to me by Phil:

During the Bevan City MHC hearing, another participant is called and emerges from a door at the back of the court room wearing tan jail issue scrubs and shackles and escorted by a sheriff's deputy. Phil, the program coordinator who has been sitting next to me quietly watching the proceedings up to this point, turns toward me and explains in a whisper that this participant is going to be released from the MHC program because "he just can't keep out of trouble." Phil explains further “It’s not that he is defiant, it's just that he can’t do the program” [emphasis in original speech]. He further explains that this participant is unable to perform in the program because he is too mentally ill to improve, so “[H]e will probably be sent to a home somewhere because prison won’t do him any good.” Phil says that it is only the fifth time that this has happened in four years, the participant being released from the program in this way because he just cannot improve. As Phil is talking I see that the participant is a young white man who appears in his mid-20s, of medium height and weight, with thick black hair cut into one length just above his shoulders. He is escorted by a uniformed, large, muscular black male
sheriff’s deputy to the center of the room to stand in front of the Judge Allen’s bench. The participant smiles at the judge when he comes before the bench, says hello quietly, then looks down. Judge Allen, a short, older white male wearing black wire-framed glasses and a full head of grey hair, smiles back and greets the participant, then quietly and patiently explains that because the participant has been arrested again the MHC team is discussing whether or not to terminate him from the program. The judge further explains that he will give the participant one more week. The participant nods and turns with the deputy escort back through the door in the back of the room.

The next participant called is a middle-aged Black man of medium build, perhaps 5’11”, whose head is completely shaved. Like the previous individual called, he too is wearing tan jail issue scrubs and shackles. As he moves before the judge, escorted by a deputy holding on to the shackle chains from the rear, the ASA, a middle-aged white woman holding a clutch of documents, looks at the papers and speaks, one of the few times today I notice her talking. She explains to the judge that this man has violated the terms of his probation, and then she and the judge discuss the disposition of his case. While the judge and the prosecuting attorney are speaking Phil leans over to me and says “This guy has a felony charge. He’s leaving the program and he’ll get three years.” Phil explains that this man is being terminated because he will not work the program, even though the MHC team believes "he could work the program if he tried" [emphasis in original speech]. Phil points out that this is different than the man who will be terminated from the program who Phil had commented on before, because that man was considered incapable of working the program whereas the current participant standing before the judge is considered capable but simply does not apply himself [emphases added by author].

The ASA states that the current violation of probation involves a charge of burglary. However, Judge Allen also considers the ruling on the participant’s previous offense which had led to his being referred to the MHC program. He explains to the participant that when defendants are terminated from the MHC program, the original offense that initiated their referral becomes a consideration in sentencing for a violation of probation involving a new charge; sentencing for the new charge will thus not involve the minimum.

This participant, having failed to stay out of trouble while serving two years of “mental health probation” as stated by Judge Allen, will now receive a new sentence for the current charge if he is ready to plead guilty. The judge explains this before asking for the participant’s plea, and goes over a number of rights that the participant waives if he pleads guilty. Each time that the judge explains a right, he thumbs through documents on
his bench, and asks the participant if he understands the right being waived. Each time the participant responds “Yes.” After going through the waiving of rights the judge asks the participant how he pleads and he says “Guilty.” Judge Allen sentences the man to three years in a Midwestern state prison, with credit given for time served during the man’s recent stint in jail. The ASA and judge look at their respective calendars and discuss how to calculate the time served in jail to subtract it from the three year sentence. After the number of days is noted by the judge for the court record, he looks at the participant and comments that the MHC gave him a chance and he wishes that things had worked out differently. “You should not have gotten arrested,” the judge says, with disappointment in his voice. The man shrugs and smiles, a response that seems odd and inappropriate considering the gravity of the situation. The judge asks the man “Would you like to say anything?” The man, still smiling, says “Thanks for the chance.” The judge extends his arm over from the bench and shakes the man’s hand. The man then asks, “Hey judge, how’d you come out in the Super Bowl?” As I look around the courtroom I see several professionals shaking their heads, reacting to the inappropriateness of this question in the present circumstances. The judge looks up with a slightly startled expression, but he immediately loses this and smiles and comments softly about one of the football teams. The man makes another comment about the Super Bowl, says “Thanks judge,” and turns and walks back out to the back door, escorted by a bailiff.

Phil indicates that the Bevan City MHC professionals are able to make a differentiation between participants who are capable of working the MHC program but do not make a satisfactory attempt versus those that are incapable of working the program despite their best efforts. The important issue displayed above involves the dichotomy between expectations of individual moral responsibility versus excusal from such responsibility due to mental illness, what previous researchers have referred to as “badness” versus “sickness” (Conrad and Schneider, 1992). This is a very similar moral determination to the one of criminality versus mental disease often expressed by the professionals, except here the moral issue is defined as motivation to improve one's self rather than criminality, although lack of such motivation can be viewed as leading to
criminal behavior. This determination can result in a person being held legally responsible for his or her criminal behavior versus being excused for criminal behavior because it is seen as the result of an illness that is not under the individual’s control. If an individual’s criminal behavior is judged as the former, the individual is seen as making a willful choice to break the law. If it is judged as the latter, then the individual is understood by professionals as not desiring to break the law, but instead being unable to make a choice between good and bad behavior, unable to control the self, and unable to perform in the MHC. The determination is one that has important implications for the individual participant. For the first participant described by Phil as being incapable of completing the MHC program, the judge apparently will recommend that the participant be put in a home because “…prison won’t do him any good.” By contrast, the second participant in the narrative above is not excused for being unable to complete the MHC program, and is sentenced to three years of prison time. The point is that the performance of participants in MHCs may be judged in terms of disease and excused by professionals on occasion, but in the vocabularies of MHC performance it is primarily judged in terms of moral choices of free will for participants understood as able to become successful graduates if they apply themselves. Several months after initiation of the funded study, I began to recognize the importance of performance as an organizing principle of MHCs.

Meeting the Needs of the Individual: Qualification and Organizational Myopia

Professionals at MHC programs spoke of the need for their programs to be flexible in meeting individual needs as described above in Chapter Five, but this meeting of individual needs only begins to take shape when a referral becomes a participant. The
ideology of meeting the individual participant's needs was expressed by professionals at all of the MHCs, but they often qualified such statements by explaining that there was a necessity of responsibility placed on the individual participant to perform in the program in order to become a successful graduate. Thus, in the sharing of institutional vocabularies among MHC professionals, meeting individual needs in the professional or even clinical sense was blended with a qualification of moral value placed on a participant's own effort and motivation to perform.

The responsibility for performance placed on the individual MHC participant by professionals includes the participant's willingness to regularly perform a number of tasks over time. Participants are expected to regularly attend court hearings, probation appointments, case management appointments, psychiatric appointments, treatment sessions, and, for many, 12-step meetings, and submit to mandated living arrangements, all while displaying the proper effort and attitude. MHC professionals at a number of sites referred to their programs as requiring "hard work" of the participant. Professionals often expressed the necessity of effort to the individual offender. Probation officers, social workers, and public defenders commonly explained to participants at appointments and hearings that they needed to attend all probation and mental health appointments, 12-step meetings, and therapy sessions. Judges expressed the need for a participant to work hard in the MHC program during hearings, both to participants needing to improve their performance and to referrals being considered for acceptance into the program.

The identification of a referral's willingness to work hard in the MHC program is one of the primary professional work activities affecting the performance filter at the
referral stage. In the following interview exchange from the Collins County MHC, two representatives of the state working in the MHC, Felix, the program coordinator who has a mental health background, and Martin, the public defender, explain the focus on meeting individual needs qualified by the necessity of finding a referral with sufficient individual motivation to perform:

Felix: Yeah, you know I think [the ASA] said overall we're… this is not an exact science. I think [it's] the hardest thing for a lot of people to understand. Who you accept into the program, what they do while they’re in the program, it's not the same for everyone. So some individuals that somebody might make a referral and think they are really perfect for mental health court, now we understand that there are certain types of people that have been more successful and more compliant than others. So we want people to come into the program that are going to be successful, but then they also don’t all get the same services. We have a couple mandated groups that everyone attends, but [one] might need anger management, [one] might need family therapy. So it’s totally different, you know. So I think just the awareness and being open to what mental health treatment really is - I think that's another hard part for stake-holders that aren’t really involved in the mental health world, and never have been before - that idea that recovery is really owned by the individual in the program, and that they have to want the services if they’re going to succeed.

Martin: And each time when we bring in a person into the mental health court we really don’t know what's going to happen, I mean, it's just everyone’s so unique and so different. Everyone has a different situation, so we really don’t know, and uh… But at the end when they graduate there are definitely a couple things that are in common or a common denominator. One, they all feel like they have control of their lives, you know. It just seems like it's a common thing with each graduate. Second, they are very appreciative of the team, because it seems like no one has ever listened to them in the past, you know, no one was there for them. And it just seems like the team wraps themselves around these individuals, and I think they realize at the end how important the team was to them and their lives. So I just think that their lives are in order at the time of graduation. When we get them into the program it's not. And we don’t know what’s going to happen, and they don’t know what's going to happen, and their lives are a complete mess at that time.
The reader may note in the above exchange how the concern of the program coordinator and the public defender is focused on identifying and serving the individual participant who becomes a successful graduate - a successful performer as recognized by representatives of the state. Consistently throughout the study professionals at all of the Midwestern MHCs expressed and displayed this individualistic focus. But during interview and work observation most of these same professionals displayed little to no concern for mental health treatment of the population of mentally ill offenders in the criminal justice system who cannot perform in the MHC, or for the population of all persons with severe mental illness in their communities, whether criminalized or not. As discussed in Chapter Five in the section on professional dissent, some of the professionals in the Gabriel County MHC were a notable exception to this, as during interviews and staff meetings they questioned the efficiency of MHC programs relative to the overall distribution of mental health services in their community. But professionals at other Midwestern MHCs seemed to lack this broader perspective. I refer to this lack of perspective among MHC professionals as organizational myopia produced by the focus of their work activities on the performance of individual participants in MHCs, an issue which I discuss further in Chapter Seven.

Judging Referral Acceptability

Judging referral acceptability is the defining process of the referral stage of the performance filter. Determining a referral's willingness to work hard was an important part of the process of judging a referral's acceptability to the MHC program, in addition to the screening of the referral's criminal charge by the ASA. The level and validity of
mental illness was also part of the process of judging referral acceptability. Professionals tried to determine whether or not referrals had valid mental illnesses to justify their being accepted into the program, but did not want to accept referrals with mental illness so severe that they would not be able to perform, as occurred with the first man in the Bevan City example above who was being terminated from the program. In the following interview example from Lynne County, Judge Sentzsky describes change over time in the program's goal of finding referrals who have valid mental illnesses but are not too mentally ill to perform:

Judge Sentzsky: [W]e’re willing to take the more difficult cases because we really see the value of the court, and the whole court model, in terms of how it can help people to recovery even when they present with some really tough challenges. And we don’t measure, I think, our success quite the same way as we did on the front end. I think the front end was very conservative because you want a proven track record. Now that we, you know, we work, we function well as a team, and we know what our resources and capacity truly are, we talk it all through, and this is all part of the staffing. And if someone is going to be such a challenge that it would overwhelm, especially the case managers and probation officers, those dealing on the front line, and the therapists, too, well we don’t want people to be overwhelmed. We need to work within our capacity, but we want to take the tougher cases because they deserve, you know, this is a privilege but it’s also a resource, and we don’t want it to be such a rare resource or limited offering that people who really could benefit are excluded.

In order to determine a referral's acceptability into the MHC programs, professionals create textual documents in the form of mental health assessments. In the excerpt below from the Collins County focus group interview Felix discusses how he is trying to develop a new assessment form that focuses on measuring a referral's willingness to work in the program. Teresa, the clinical social worker, describes how the
program is more difficult than referrals may realize, and Liz, the probation officer, describes how a referral's being in jail affects the professional ability to successfully determine a referral's appropriateness for the program:

Felix: You know I thought today actually [about the problem of avoiding acceptance of referrals who are not motivated to do the program], Teresa and I were just talking about trying to do maybe more of an assessment. Include in the original assessment in some way a level of engagement, you know, a level of motivation for treatment. Does this individual really want these services, or are we just trying to stick them in services that we want for them? So more of an assessment, I think, to determine the stage of motivation for treatment.

Researcher: Would that be a very low score in terms of motivation, somebody that doesn’t seem motivated at all? Would that then be a reason not to let them enter the program if that’s a part of the assessment?

Felix: Yeah. We’ve had that before, I mean, numerous referrals that I’ll get. I’ll even get a referral from an attorney, and I’ll call the individual and explain the program, and they’ll say "I don’t wanna do that" right away, you know, so sometimes you know off the bat.

Researcher: Right, right. Ok.

Teresa: Because I think where everybody’s saying that people think that it’s a slap on the wrist; I think that's what the offender thinks. So where it's not and we try to make it real clear that it's not, I think that some of these offenders think that it is. So they’ll just skate by, and they have no motivation. It’s just a better option than, you know, [incarceration].

Liz: Along that line I was going to say that many times we assess them in the jail, so their motivation to get out of the jail is very high. She laughs. So that’s a factor that’s always a red flag. You know, you don’t really know until they get out, and they don’t really know the reality of what they’re getting into as well.

The use of mental health assessments by those professionals who have a mental health background, like Felix, are a way to use clinical means to determine a referral's appropriateness. One clinical factor affecting the professional judgment of a referral's
acceptability is whether or not the diagnosed condition is a DSM-IV-TR (2000) Axis I disorder, such as schizophrenia, bipolar disorder, or depression, or an Axis II disorder, which may be a personality disorder such as borderline personality disorder, or developmental disorder like mental retardation (although some developmental disorders are now placed on Axis I.) Five of the programs do not accept participants with Axis II diagnoses. In the following interview excerpt Dr. Peete, the head court psychologist from Gabriel County, explains why Axis II disorders are considered problematic:

Dr. Peete: What we find is most of the time those [referrals] who have a personality disorder, they are either borderline personality disorder or antisocial personality disorder and agitated. They’re not good candidates.

Researcher: They’re not good candidates, okay. Axis I and axis II are acceptable to the program, right?

Dr. Peete: Correct, but we prefer axis I.

Researcher: Okay, because you… if they’re personality disorder like you talked about, antisocial personality…

Dr. Peete: Or borderline.

Researcher: Then, or borderline…

Dr. Peete: The program was constructed… if you read you know our goals and objectives. You know, our primary goal is to achieve medical stability, and so what we’re looking for is people where you know they’re off their medicine, they commit a crime and we get them hooked up and stable again so that they can return to the community. And that’s primarily a medical kind of problem. Borderline personality disorder isn’t treated through psychotropic medication.

But not all judgments of referral acceptability made by MHC professionals are clinical ones. In the following example from the Bevan City MHC, Judge Jamison determines a referral's acceptability using a non-clinical approach:
A second name is called, and another black woman wearing blue jail scrubs and shackles is escorted from the back by deputies. Judge Jamison looks at papers on his desk briefly and then begins speaking to her, greeting her and then saying that she has been assessed and has been deemed acceptable to the MHC program. The woman, of medium build and with short-cut hair pulled to the side, flashes a look of disapproval and then asks the Judge "How long is the program?" The Judge explains it depends on how she does but two years or so. The client then says that she thinks there are "too many rules." She asks more questions about the program, and as the Judge answers these he expresses some impatience. He explains that the program is for her benefit, but if she doesn't really want to participate that she can always go back to the regular court call. Referring to the MHC program, the client asks "Well where am I going?" Judge Jamison smiles at her and explains that if the staff accepts her into the program, she will be sent to inpatient treatment for a few months, then to a residential program. The client begins explaining that she has had problems "with other homes." She explains that she doesn't want to stay in homes and doesn't want to have "all the rules." She finishes with "I don't want to spend two years incarcerated in no nursing home." Judge Jamison looks at her seriously, shrugs, and then says that in the case he is sending her back to jail and she can be put on the regular court call. The woman does not argue, and is escorted out by the deputies. Judge Jamison writes on papers, puts them to the side and looks toward the MHC staff standing nearby. He says "We have too many to worry about for her to be starting off like that."

During this court appearance, Judge Jamison determines referral acceptability based on the attitude of the woman being held in jail. The program is voluntary, but there is no attempt by him, or by other MHC staff in the courtroom, including the public defender and social workers, to explain the consequences of being sent to prison rather than being sent to a mental health treatment facility. Judge Jamison makes no acknowledgement or investigation of the possibility that the woman's attitude could be indicative of symptoms of mental health diagnoses as presented in the DSM-IV-TR,¹ and

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¹ Major depressive disorder, bipolar disorder, and schizoaffective disorder are three types in which symptoms may include a persistent negative view toward one's environment (DSM-IV-TR, 2000).
no other professional intervenes to suggest this. Nor is the complaint about living in nursing homes viewed as valid irrespective of the woman's mental health condition. Rather, the judge determines that the woman's attitude is simply too problematic to accept her into the program.

*Encouraging a Good Performance and Sanctioning a Bad Performance*

Professionals in MHCs utilize the process of court adjudication to affect change in participants by rewarding good performances and sanctioning bad ones. At staff meetings, professionals discuss each participant who will attend the hearing that day, and collectively they decide what the judge will do with the participant at the hearing. The judge has the final say on what she or he will actually do at the hearing, but usually a judge will listen to input from social workers and probation officers and follow their advice regarding how to deal with a given participant. There are various punishments and rewards given to a participant during hearings for good or bad performances throughout his or her time in the program. A participant who has followed all program guidelines will be rewarded in some way, while one who has performed badly and not followed program guidelines (i.e. missed appointments, failure to take medication) will receive some type of sanctioning from the judge. In the following interview excerpt, Ferry County MHC professionals describe various rewards and punishments given to participants:

Megan: We try to go from lighter to heavier sanctions. So if someone's done something, public service is a usual starter. We try to couple those - whatever it is, whatever we're sanctioning them for - we try to couple it with some kind of therapeutic response as well to make sure that it's, that we're also helping them along as well as punishing their bad behavior.
We're helping them not to do it again, with essays or thinking reports, for more serious things there is [community service for the local sheriff's department] where [deputies] check them in in the morning and work with a convicted offender. This is because it is monitored by the sheriff, and they're monitored all day long, and they're shuffled along with their day glow orange, and doing, you know, painting curbs or...

Patricia: …car wash.

Megan: …car wash, yeah, washing, yeah, squad cars.

Patricia: Yeah, and probation cars.

Megan: And then of course our big trump card is the jail. But in terms of sanctions, if we sanction someone with jail, we're always looking at any step, every step of the way, we're always looking for that next therapeutic response that we can address, and looking to see if there isn't something that caused them maybe to do whatever they did that we could address in some therapeutic way, so.

Researcher: Okay, is there any rewards system at all?

Megan: I think the biggest reward is less frequent court dates, you know, less restrictions is the reward. And you know rewards are "Atta boy," and maybe clapping in court occasionally but not …physical rewards are hard to get.

Patricia: Occasional reaffirmation.

Megan: Yeah "atta-boys."

Researcher: That's really your role a lot of time, right? It's to say "great job, keep it up," and then "you were coming in every two weeks, now you come every month."

Patricia: Right, right, and sometimes if they're, you know, not drinking for a couple of months and they had a [alcohol monitoring] bracelet on, that [is removed].

Peggy: Yeah, [the bracelet] can come off.

Patricia: [It] can come off.
Megan: We also give them travel passes.

Patricia: Right, right, right.

Peggy: We'll let them [travel outside the state].

Jail was utilized as a sanction at all but the Gilmour County MHC, but professionals at the other MHCs described using it sparingly, and only for the most serious misbehaviors. In the following interview excerpt, Manzanera County professionals - Jen, the public defender, Alex, the probation supervisor, Val, the program coordinator, Cindy, the county social worker, and MHC Judge Bradford - describe using jail to handle a complicated case:

Jen: Well I can think of a very sick girl who was pregnant, and she just had the girl. Her issue was she was young, and her ethnic background kind of led to her parents fighting off mental health. There was no acceptance whatsoever. She wouldn't take medication. She ended up committing many more crimes while on probation, little ones, but it's still all the stuff she was getting in trouble for, and it was directly linked to her mental illness.

Researcher: What kind of crimes?

Jen: She was throwing rocks out the windows, so it was like criminal damage to property, [and] prank calling the police department.

Val: [There was] the shopping cart.

Jen: She took a shopping cart from a store.

Alex: That’s what got her in the [MHC] program. She attacked a jail guard.

Jen: You know, she said that the judge better order a raincoat because she was going to spit on him, like, there was a lot of fear, so she came [to the hearing] with a thing over her mouth at one point. And she’s young, but we got her on injectable medication and that saved her life.
Researcher: While she was pregnant?

Cindy: No.

Val: She had already had the baby.

Cindy: That’s when we sent her down to [the state mental hospital], and they stabilized her. But she’s so good at manipulation that they didn’t think she had a mental illness, so they had to call and verify everything.

Val: And we ended up at that point also, I personally called [Midwestern children's services] when the baby was born and told them that they needed to find an alternative placement for the baby, either with its father or with its grandparents, simply because we knew she couldn’t care for the baby because she was not compliant with medication, and she was a threat to herself and to other people. She had threatened to kill the baby’s father. She had, you know, ended up in the hospital with [suicidal intent]. So what ended up happening was she started to see a doctor who gave her oral medication, until she could tolerate the shots. In collaboration between all of us she was put in the jail. When we wanted to release her, the medical director of the jail came to court with the public defender. [The director] came into the jury room and administered a shot to her. That was the first time she had used that medication and she…we were able to have a visiting nurse from another program go to her apartment every other week to administer the shot as well. Initially when she started taking the shots I would take her to another clinic every other week to have the shot administered, and then we got the nurse to administer them to her. She cleared up very well psychiatrically. She ended up going to court and getting visitation with her child, and then eventually married the child’s father. They moved out of state and she, every once in a while, will send me a card saying "I’m doing very well."

Judge Bradford: [It was] tremendous amount of effort by the way, these folks getting medication, got us the medication. He looks around the conference table at Val, Jen, and Cindy, then at the researcher. They were able to find a program with some funding available and also some pharmaceutical company's [assistance].

Cindy: The other thing too is, you know, there was a point at which we didn’t have medication to provide for her. We didn’t have the funding to pay for the medication. We were able to ask the probation department to pay for the medication for her as well.
Val: Yeah, it was expensive.

Cindy: Like $250 a shot.

Researcher: And that was a successful graduate of the program?

Alex: Yes.

Val: She ended up graduating successfully, and honestly, I don’t think anybody would have actually bet that she would. She was also a client that the chief public defender ended up coming to see me with because she refused absolutely to go see the doctor, to take the medication, or to do any of the things we asked her to do.

Researcher: Okay is there any way to avoid this problem with future clients, the idea that they’re not getting the proper medication?

Jen: It ultimately comes down to the point where a client has, in this state at least, the right to refuse to take medication, and we cannot force them to take medication, and if they refuse we can try our best to contain them, but that doesn’t mean that they’ll get better or that things will progress if they refuse.

Alex: Well, they can have it ordered as a condition of probation right? And if they don’t they can be in violation of probation, but that’s always a slippery slope to navigate.

Jen: That’s why it's important that [the other public defender] and I, or whoever’s defending [a participant], have a big open conversation with them beforehand [where the defense attorney says] "if you don’t take your medication you will end up not completing this program, whether that be jail or some other sanction, but don’t come into this program if you don’t want to take meds." Like, I have this conversation with these people beforehand, and we have a man right now who was adamantly against it before he came into the program. I begged him to do it, and now he’s on injectable meds, and he’s much better. So you just have to tell them everything up front so they know what they’re doing.

Judge Bradford: Well, it’s a standard condition [of the MHC program] that they comply with all the doctor’s recommendations and prescriptions.

The large urban jails in Midwestern have medical facilities that MHC professionals
utilize to incarcerate misbehaving participants while also providing them with mental health treatment. Like the man in the shabby suit in the 'finding a bed' example from Bevan City presented in Chapter Five, Manzanera MHC professionals had the woman described above placed in the local jail's medical wing in order to facilitate treatment, with the hope that it would eventually lead to her good performance and successful graduation from the program.

**Judging Mental Illness Versus Criminality**

Professionals may draw their judgments of criminality about a particular individual from several possible sources. Those working in criminal justice contexts were able to access the criminal background, including a record of arrests and convictions, either directly or through another institutional actor. Such records are maintained by Midwestern state on a computerized database that certain authorized institutional actors, such as judges, police officers, or state's attorney's, may access and/or alter. The offender-as-case can be represented textually on a computer monitor displaying his data or on a textual document produced from the database by institutional workers to be added to their file of the individual case, enabling further work. The content of texts displaying criminality was shared among professionals at MHCs, and was an important part of their understanding of each participant. Additionally, some of the mental health professionals were able to perform psychological tests directly, or set up such testing indirectly, in order to measure characteristics of the individual, including criminality or likelihood of future criminal behavior, as well as psychological characteristics, and the results of such testing were then added to the other textual
documents representing the offender-as-case, and shared with the other MHC professionals. Both criminal justice and mental health professionals displayed work activities involving their use of textual materials during staff meetings and court calls in considering the level of criminality of each referral or participant, and also distinguished this from the level of mental disease. In the following individual interview excerpt, Dr. Peete, the Gabriel County head court psychologist, who works in a blended organizational background of mental health and criminal justice, describes understood difference between criminality and mental illness in a specific participant. But he qualifies such judgments by describing an interaction between mental disease and criminality:

Researcher: I think you were talking with maybe the public defender or somebody, how do you distinguish the criminal from the mental illness in the behavior, you know outside of a drug offense? Now I’m just talking about in general that idea of there’s criminal behavior and there's mental illness behavior.

Dr. Peete: Okay, sometimes [whether or not the individual is a criminal] doesn’t become clear until the person is stabilized. We had a woman - she was one of our first participants - who was suffering from a major depressive disorder. She was receiving a series of ECT shock treatments when I first saw her. We started doing fitness for trial evaluations. She clearly was depressed. She had a family history of depression and she was a retail theft person, and she was a participant in our [MHC] program. She got appropriate medication. She got psychosocial rehabilitation, group treatment, and then she went on to commit more crimes. And so what I say is that she was a success because we stabilized her and got her back to work. She was really a criminal. She was a depressed criminal, but she was a criminal, and she ended up going to prison because we stabilized her [and] got her better. She went back to work, and she got caught and she went to prison.

Interviewer: And by "work" you mean actual…
Dr. Peete: Criminal.

Interviewer: …criminal activity?

Dr. Peete: Yeah. So sometimes it’s not really easy, yeah, and you know the more nonsensical kinds of things, you know, the guy who walks into the 7-11 or the retail store, goes and takes a knife from the store, opens the package and sticks it in front of the store clerk, says "you know I want one pack of cigarettes" or "a Kit-Kat candy bar." I mean those kinds of things, so sometimes it’s not really easy. And a lot of times the interaction between a mentally ill person and the socialization they obtain on the street leads to criminal thinking so there may not be much of a distinction between the pathology of the person and the criminal thinking, they may think like criminals but they may be mentally ill. So again it’s one of those things that it’s not that easy, I don’t think, to tease out. A lot of times when people become stabilized, though, you can see the criminal thinking rise to the surface.

As part of their blended organizational culture, professionals in Midwestern MHCs share understandings about the mentally ill offenders with whom they work that contain a subtle calculus in which health and moral factors are combined in making judgments. In various contexts, understandings of the mentally ill offender as diseased individual mitigate understandings of the offender as moral actor. When professionals decide how much to hold a mentally ill offender morally accountable in a given situation of problematic behavior it is usually a matter of degree, a placement on a continuum from sickness causing problematic behavior to one's own moral choices controlling one's behavior, rather than a dichotomy in which the individual is understood by the professionals as completely sick (mentally ill) or completely immoral (criminal).

However, when making decisions collectively in staff meetings, such as whether or not to sanction a participant for problematic behavior, or whether or not to accept a referral, professionals may weigh in on one side or the other on the scale. In the following
narrative example from observation of a Lynne County MHC staff meeting, professionals collectively decide not to accept a referral viewed as a criminal:

Sara, the program coordinator, a middle-aged white woman who previously worked as a criminal prosecutor, is standing at the head of the conference table. She looks down at the staff meeting agenda and names the next person to be discussed. Her first name is Nicki, and she is a referral. A psychologist is seated at the conference table with a stack of eight to ten file folders in front of her. She is a middle-aged white woman named Mary who works for the community mental health agency a block away from the courthouse, and is responsible for doing mental health assessments for all referrals to the MHC. She picks a file folder from the stack, sits it on her lap, opens it, and begins thumbing through it, describing the results of recent tests and interviews with Nicki. Mary explains that Nicki suffers from depression. One reason for this is her boyfriend has been in prison for several years. Nicki also complains of back pain. She has been charged with retail theft four times. The last incident occurred when she was hired as a waitress but stole from the restaurant just before she began her employment there. Nicki has two school-age girls. During her interview with Mary, Nicki cried several times. Sara interrupts Mary and asks "Was the crying genuine or manipulative?" and Judge Sentzsky, a middle-aged white woman seated at the other end of the conference table, asks "Yeah, are there borderline issues?" referring to borderline personality disorder, an Axis II disorder in the DSM-IV-TR. Mary looks at the judge and says "It seems possible." Several other professionals at the staff meeting begin making negative comments about Nicki's case. Seated around the conference table, which almost entirely fills the white room with faded yellow carpet near the probation department offices, are eight other professionals, including a public defender, an ASA, two probation officers, and four other mental health workers from the community mental health agency. The judge, attorneys, and program coordinator are dressed in business suits, while the rest are dressed in business casual. All of the professionals are women except for the ASA, a probation officer, and a mental health worker. All are white except for one black male probation officer. They discuss the difficulty of working with personality disorders, and specifics of Nicki's case. Sara comments that "The red flags are the way that she steals." Judge Sentzsky nods and adds "I see criminal thinking." Mary explains that Nicki's boyfriend's criminal behavior probably supported her before, so she began to engage in criminality once he was put in prison. Sara looks around the room and says "So do we take her?" They vote unanimously not to accept Nicki into the program.
Clarification and Conclusion

After discussion of performance and various categories presented above, the theory requires some clarification. First, the theory of performance is limited to Midwestern mental health courts. It is a grounded theory and does not necessarily describe practices in other specialty courts. I suspect performance judgments may be present in other mental health courts and in drug courts, but I cannot definitively make that claim because I only have studied performance in Midwestern mental health courts. Also, performance judgments do not replace the professional vocabulary, knowledge, and practices of legal and mental health workers. Rather, professionals use disciplinary knowledge and techniques to work with and understand offenders with mental illness, and in the mental health court knowledge and techniques support performance judgments. In this blended environment legal and mental health professionals use knowledge and practices of their respective disciplines, but in interacting with each other and with offenders in operating the MHC, they share the vocabulary of performance, and make performance judgments.

Finally, performance refers to how MHC referrals and participants move through the filter of the mental health court program, and does not necessarily refer to progress made by mentally ill offenders in treatment. For example, a participant may be required to undergo cognitive behavior therapy or CBT (Emery and Oltmanns, 2000); CBT may be directed to changing a participant’s ways of thinking and acting, which may seem to the reader to be identical to performance. But whether or not a therapist believes a participant is doing well in CBT need not affect performance. If the therapist does not
give a negative report textually or in personal interaction that is shared with the other MHC professionals and has consequences leading to judgments of bad performance in the MHC, then poor progress in therapy would not affect the participant’s movement through the filter toward graduation. On the other hand, if the therapist believes the participant is doing well in CBT and shares this with the rest of the MHC professionals, this would lead to good reports of performance, and would positively affect the participant’s movement through the filter. The crucial determination is whether or not the therapist communicates reports that affect performance judgments made with other MHC professionals collectively, rather than how the participant is actually progressing in treatment.

Another example of treatment progress being different from but possibly affecting performance is psychotropic medication therapy. Many of the participants observed at MHC hearings or discussed in staff meetings were taking psychotropic medications and seeing a psychiatrist as a requirement of participation in the program. Drug therapy may impact the participant positively so that she presents a better personal front interacting with professionals, and is seen as performing well in the program. But even if the drug therapy was not so impactful, the important issue for performance may not be the efficacy of medication, but instead the mental health worker reporting medication compliance to the judge, which would be viewed as a good performance on the part of the participant leading to graduation.

The reader may sense that the theory of performance in this dissertation is presented not just as the actual work of professionals, but also as criticism of the mental
health court programs. In the next concluding chapter I rely on Foucault's concepts of bio-power and governmentality to analyze the exercise of power by professional actors, and describe how their work in MHC programs can be criticized in terms of social justice. I argue that the theory of performance in Midwestern mental health courts suggests that the programs are problematic for persons with severe mental illness, including both the criminal and non-criminal groups in the population.
CHAPTER SEVEN
MENTAL HEALTH COURTS, GOVERNANCE, AND SOCIAL JUSTICE

In this concluding chapter I change the focus from analysis of the professionals' work activities and understandings to analysis of the implications of performance understandings in the specific context of Midwestern state. In doing this, I rely on conceptualizations drawn from the work of Michel Foucault. First, I review some of Foucault's work and discuss how it may be relevant for understanding how MHCs operate, referring to work of disability studies and sociology of law researchers on Foucault. Next, I use Foucault’s concept of governmentality (1991) to explore how new MHC organizations in Midwestern affect mental health services for the population of persons with severe mental illness in the state, and evaluate this effect on services in terms of social justice. I shift the level of analysis from the micro-level of interaction within each mental health court (MHC) program to a broader, state-level, macro-analysis of how these MHCs as a set of organizations affect the distribution of mental health services relative to population. Finally, I end with suggestions for change in community and criminal justice approaches to persons with severe mental illness, including the abandonment of mental health court programs in favor of more direct diversionary practices.

Foucault and Mental Health Courts

This dissertation has focused on analyzing the subjectivity of professionals who
operate the mental health court programs in Midwestern, exploring how these professionals understand the referrals and participants with whom they work, how they understand their professional roles, and how they organize and conduct work activities around their shared understandings. Foucault (1973; 1977) bracketed out individual subjectivity in exploring discourses of health, including mental illness, and disciplinary practices of institutions, including prisons, although in his later work he turned to the individual subject as he explored ethics of the self (Foucault, 1978). Despite Foucault's anti-subjectivity (Kelly, 2009), many of his conceptualizations are quite useful in problematizing (Foucault, 1996) the establishment of mental health courts in Midwestern by exploring the practical significance of what is taken to be true in mental health court settings - that good performances are evidence of efficient programs for dealing with persons with mental illness in the criminal justice system. Foucault's work is relevant to mental health courts in that he explored the domains of psychiatry and the penal system, and the mental health court innovation is a relatively recent amalgamation of the two. Foucaultian ideas can be utilized to form a conceptualization of the power relations present in mental health courts, and to develop a critique of Midwestern's governance (Foucault, 1978) of the population of persons with severe mental illness, including those persons with mental illness who become involved in the criminal justice system, and those who do not. What follows in this section is not Foucaultian analysis in the sense of archaeological exploration of discourse (Foucault, 1972) or genealogical exploration of power relations (Foucault, 1977). Rather, I review important conceptualizations introduced by Foucault, explain how these conceptualizations can be used to critique
mental health courts, and review the work of sociology of disability and sociology of law researchers who utilize and debate Foucault’s ideas.

*Power/Knowledge and Discourse*

Foucault (1977) argued that power is fundamentally entwined with knowledge. Such knowledge may be that of academic disciplines, or of government statistics on population, or of specific individual cases known to institutional workers. According to Foucault (1977) the knowledge of human science disciplines such as psychology and medicine enabled a “political technology of the body,” a mastery of the body, a “micro-physics of power.” In *Discipline and Punish*, Foucault (1977) details the relationship between power and knowledge:

> Perhaps we should abandon the belief that power makes mad and that, by the same token, the renunciation of power is one of the conditions of knowledge. We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute power relations. These ‘power-knowledge relations’ are to be analyzed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but, on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformation. (Pgs. 27-28)

The development of the human sciences enabled a subjugation of the body, turning it into an object of knowledge, an instrument that could be constrained and manipulated in order to get at the soul (Foucault, 1977). The body of the prison convict could be taught to follow time tables, forced to perform work, subjected to treatments, probed by doctors, preached to by ministers, educated by teachers, studied by psychologists, all in the name
of improving the soul while both instilling habits and developing knowledge.

Discourse is an essential element of Foucault’s concept of power/knowledge, a link in the interrelationship between power and knowledge. Foucault analyzed the relationship between disciplinary bodies of knowledge and disciplinary practices by considering how discourse spreads knowledge throughout institutions and thereby shapes disciplinary practice. In utilizing the concept of discourse in terms of knowledge Foucault is referring to the specific social, historical, and political conditions under which particular beliefs, facts, and statements of knowledge are viewed as true or false (McHoul and Grace, 1993). Discourse for Foucault is not limited to the sharing of technical know-how under specific conversational rules but also refers to the determination and spread of ‘truth’ in a social, historical, and political context.

Criminal justice and psychiatry are social and cultural fields, and discourse is an important part of how such fields operate because it is the means by which a field communicates about itself to itself (Danaher, Schirato, and Webb, 2000). At different points in history, the discourse within each field has communicated to its discipline historically varying definitions of mental illness and varying strategies of how best to manage persons designated with mental illness, mental illness being the object on which the discourse focuses its attention. In History of Madness Foucault (1969) explored this variation through the method of archaeology in which he compared discourses regarding the object mental illness in Western Europe from the fifteenth to the nineteenth centuries. Foucault had not yet explicitly defined or perfected his method of archaeology, but History of Madness was a highly influential book that contributed to the movement to
close asylums for persons with mental illness and set the pattern of his later books of exploring specific revolutionary changes at roughly the same historical juncture (Kelly, 2009).

Bio-Power, Discipline, and Governmentality

Foucault (1978) introduced the notion of ‘bio-power,’ which he contends is a type of power that first began to operate in the late 18th Century but was overlooked by traditional political philosophy. As the state and institutions began to collect statistics and develop measurements of population such as birth and death rates, a concern with securing the well-being of the population developed. Institutions of public hygiene began to centralize practices of medicine and develop a discourse of normativity, and knowledge was utilized in developing sets of prescriptive norms that could be put into place to ensure the security and safety of the population. Bio-power, then, concerned itself with intervening in the lives of individuals for the betterment of public welfare (Foucault, 1978).

Bio-power can be seen as having two poles of operation depending on whether it is operating on the individual or group level: discipline and governmentality (Tadros, 1998). Discipline is a form of bio-power that first began in the Classical Age in institutions such as schools, workshops, and prisons, but in the Modern Age began to be utilized in the family, in hospitals, and in social service agencies. Discipline operates at the individual level, on a particular individual in a particular space, collecting information about an individual and then acting based on this knowledge (Foucault, 1977). Disciplinary practices are targeted at individual bodies that are docile and thus pliable
because they are unable to truly resist subjugating disciplinary power (Foucault, 1977).

The word ‘discipline’ is used by Foucault in two senses, as he refers also to the ‘disciplines’ of the human and medical sciences, as well as to their disciplinary practices on individuals (McHoul and Grace, 1993). A discipline such as medicine or psychiatry utilizes a normalizing gaze in observing the individual and making judgments. The individual may experience regular surveillance from a normalizing discipline to the point that he begins to discipline himself in order to avoid sanctions for any observed indiscretions (Foucault, 1980).

Governmentality (Foucault, 1991) operates at the level of population through state efforts in gathering statistics, analyzing tendencies, and developing techniques that can be administered to the population to adjust its condition. Governmentality is a system of thinking about governmental practices, which have been rationalized so that these practices are understood, accepted and considered applicable by those who conduct such practices and by those upon whom such practices are conducted. In defining governmentality, Foucault (1991) contended that knowledge in the form of political economy (an understanding of multiple and varied networks of relationships between a population, a territory, and its wealth) and technical means of intervention in the form of apparatuses of security (such as a criminal justice system or a mental hospital) both became very important to the “state of government” targeting a population. Foucault (1991) used the term ‘art of government’ interchangeably with governmentality. Although the state may utilize governmentality, the art of government is not limited to the state. The word ‘government’ should be thought of in its general sense, as any mode
of calculated, considered action aiming to structure the possibilities of action for one or a
group of persons, or even for oneself. Governmentality aims to structure the possibilities
of action for an entire population, and its use would not be limited to the state but may be
employed by others, such as the psychiatric community in determining techniques for
managing the population of persons with severe mental illness, for example.

Bio-power at the pole of governmentality targets a population with the
development of new disciplinary techniques (Tadros, 1998), such as mental health courts.
In the development of such techniques, "population" may refer not simply to the
population of persons with mental illness who are arrested, but also to the population of
all persons with severe mental illness in a community, or even to the entire population of
a community who might be affected by misbehaving persons with mental illness, and
who might also be affected by the release of such individuals from jail without treatment
provision in place. Bio-power at the pole of discipline (Tadros 1998) operates on those
individuals who participate in the mental health court and agree to regular treatment
under the care of psychiatrists and counselors in a community mental health center.

In developing the notion of bio-power, Foucault (1976) stressed a new way to
consider how power is expressed. Previous conceptions of the power of state institutions
such as the criminal justice system consider their repressive nature. But when
conceptualizing techniques of the criminal justice system as an expression of bio-power,
such power is not repressive but rather productive, in that individuals are shaped to
behave a certain way, under specific normative guidelines (Hunt and Wickham, 1994).
Bio-power operates through disciplinary practices to shape individuals, who become
subjects in the process. Unlike the traditional view of power in political philosophy, which posits that power is possessed by individuals who willingly give up such power to the state and agree to live under the rule of law, Foucault viewed power as something that is exercised, rather than possessed or owned like a commodity. Violence should not be viewed as power but rather as an instrument or result of power, and modern power should not be conceived as repressive. Foucault contended that violence and repression are not essential to modern power. Power exists only in action, and modern power, or bio-power, is not repressive, but instead produces subjects. Modern power is productively constraining – it enables subjects to act in a manner that serves to constrain them (Tremain, 2005).

Regarding how bio-power affects persons considered disabled, Tremain (2005) contends that since the late 1700’s “a vast apparatus, erected to secure the well-being of the general population, has caused the contemporary disabled subject to emerge into discourse and social existence.” This apparatus consists of all the governing practices employed to classify, manage, and control persons with disability, and includes IQ tests, medical tests, rehabilitation programs, public financial support, paratransit systems, mental health courts, and many others. Bio-power puts regulations in place that organize the population around a norm, allow for some measure of variation around that norm but with limits, and then separate out the random elements of the population that surpass the normative limits in order to ensure the security of the overall population and to maximize its life-affirming conditions. Through the governing practices, persons whose measurements are considered beyond the limits of normality according to knowledge of
disciplines such as psychology, medicine, and criminology, are separated out and identified as disabled, impaired, handicapped, retarded, deaf, blind, mentally ill, etc. Once such persons are separated out, they are singled out as a case that can be understood scientifically, and they may come to view themselves in the same scientific manner. They are objectivized, understood scientifically, and then made disabled subjects.

Two meanings of the word subject are pertinent in understanding power (Foucault, 1978). To be subject can mean to be subject to another person through control and dependence, or it can mean to be tied to an identity through knowledge of self. Both forms of subjectivity are involved when modern power operates, because a person is subject to the disciplines and their knowledge, as well as to institutions and apparatuses organizing around a norm and aiming to provide security. And as a person is constituted as a subject, he or she may gain some of the knowledge generated in the exercising of disciplinary power, which may become part of his or her own understanding of self. Tremain (2005) contends that this is precisely what has happened in modern society as bio-power is exercised to govern the population of persons with disability, including persons with mental illness.

In Midwestern communities the behavior of the mentally ill may be tolerated until it violates the criminal code in a way that draws the attention of law enforcement officials, leading to arrest and incarceration. When the criminal case of a person with mental illness is selected for adjudication in a mental health court, professionals put into place a treatment plan that aims to produce a compliant, law-abiding, rehabilitating, mentally ill participant, replacing the non-treatment-compliant, mentally ill criminal that
existed before. The mentally ill defendant is allowed a measure of freedom in not being incarcerated, and is enabled to act in the community as long as action is directed toward receiving treatment for mental illness and avoiding future misbehavior - this action is what I have referred to as *performance*. If the mentally ill defendant fails in this process, he is separated out, often by returning to incarceration in order to prevent any future possible threats to the security of the community. In this process the mental health court disciplines individual mentally ill offenders, constituting them as subjects and inscribing societal norms for how mentally ill subjects should behave, norms such as attending regular counseling, taking psychotropic medications, attending to personal hygiene, participating in workshops, remaining in a group home rather than wandering and sleeping on the streets, and refraining from illicit drug use and alcohol. As mentally ill subjects begin to see themselves as the court sees them, they govern their own behavior and follow the treatment protocol. Eventually compliant participants graduate, and some of them give testimonials during graduation ceremonies which reveal how they have come to understand themselves. In Midwestern and nationwide the establishment of mental health courts represents a new rational and technical practice to govern the population of persons with mental illness by attempting to focus efforts on a select few individuals in order to create more compliant mentally ill subjects within the population.

*Law and Surveillance*

Mental health courts were established in Midwestern through state legislation authorizing their use as an option of court jurisdictions. Judges and court officials in the counties of this study then worked in local jurisdictions to initiate MHC programs. Thus
law in the form of politicians passing laws and judges hearing cases enabled practices of disciplinary power through the programs.

Hunt and Wickham (1994) explore how Foucault viewed the position of law in modern power relations, and develop sociology of law as governance based largely on Foucault’s thought. According to Hunt and Wickham, a consistent theme present in much of Foucault’s work can be referred to as ‘law versus discipline.’ Although law is not the central focus of Foucault’s thought, in several of his works produced in the 1970’s Foucault discusses law in the context of exploring the nature of power in classical and modern Western society. Hunt and Wickham point out that in these works Foucault repeatedly refers to law linked conceptually to negative, ‘juridico-discursive’ power: specific prohibitions against certain acts. Such a view considers law to be a set of rules combined with punishments enforced by the state if such rules are violated. But this is too simplistic a conception of power for Foucault, who wishes to create a new conception of power that reaches far beyond the state and the enforcement of its laws. In modernity, power is not simply possessed by the state and expressed in a ‘negative’ fashion as punishment is meted out when law is violated. Modern power (bio-power) is essentially ‘positive’ and productive, and exists in a multitude of disciplinary forms. Foucault thus presented a temporal contrast between juridical power and ‘bio-power’: in the classical age power was more visible, centralized, and represented in the command power of the monarch, whereas in the modern age power has become diffused, its location less visible because it is dispersed throughout a disciplinary network. Bio-power is not limited to the juridical realm but is spread throughout a web of control enmeshing individuals, who are
subjected to disciplinary micro-powers in all areas of living, in the workplace, in schools, in the home, in shopping centers, in recreational areas, in the streets, everywhere. Knowledge is an important dimension of the power exercised by micro-powers, knowledge developed in the discourses of the disciplines as well as knowledge gathered through the exercise of disciplinary power and its techniques of surveillance, hence Foucault referred to ‘power/knowledge’ (Foucault, 1977).

A central point of Foucault’s is that when scholars and legal theorists focus their attention on sovereignty and centralized law they fail to recognize the most distinctive feature of modernity: the importance of disciplinary power (Foucault, 1980). Foucault contends that the ‘juridical monarchy’ is a carryover from pre-modern times that is now represented by unitary constitutionalism in Western societies, but it is a form of power that is a faint echo of the past. To truly understand modern power one must consider how a wide multiplicity of disciplines engages in practices of domination in subtle, diffuse forms that are almost unrecognizable. But law-as-sovereignty (as a manifestation of the state’s supreme authority) is not simply coercive state power, for it also involves the production of truth. In modernity law and science are privileged sources of truth, and legal truth from the mid-nineteenth century on has become increasingly dependent on various sciences such as psychology, medicine, and psychiatry, as in the reliance of courts on having psychiatric experts determine the dangerousness of an individual (Hunt and Wickham, 1994).

Foucault (1977) argues that discipline and law are dual, opposing processes:

[W]hereas the juridical systems define juridical subjects according to universal norms, the disciplines characterize, classify, specialize; they
distribute along a scale, around a norm, hierarchize individuals in relation to one another, and, if necessary, disqualify and invalidate. In any case, in the space and during the time in which they exercise their control and bring into play the asymmetries of their power, they effect a suspension of the law that is never total, but is never annulled either. Regular and institutional as it may be, the discipline, in its mechanism, is a ‘counter-law.’ (P. 223)

The power of discipline engages in continuous communication with power of law, and this allows for the functioning of a carceral network consisting of the institutions where the disciplines are conducted and perfected (such as prisons, factories, and hospitals) (Foucault, 1977). In such institutions law and the disciplines have displayed a mutual dependence, but as time goes on they have become disaggregated. The disciplines have multiplied and begun to operate independently of law. But this does not mean that law will completely wither away; rather law will assume an increasingly subordinate or support role within a disciplinary society. Law itself becomes colonized by the new disciplines as it is invaded by practices of observation and training, the gaze of surveillance. Law can be referred to as the mask of real power, as it legitimizes practices of domination by the disciplines within a juridical framework (Hunt and Wickham, 1994).

In the mental health court the disciplinary power of mental health practices is legitimized within the juridical system. But is it appropriate to view this as law being colonized and invaded by disciplinary practices, or to phrase the question another way, is it a matter of the disciplinary practice of psychiatry invading and colonizing the criminal courts? Would it be more appropriate to consider the state power of the criminal courts making use of the disciplinary practice of psychiatry? In criticizing Foucault’s view of
the relationship between the law and disciplinary power, Carole Smith (2000) poses a similar question with reference to case law on sterilization and caesarean sections. In Foucault’s conception law in modernity, specifically criminal law began to take an interest not just in the prohibited act, but in the individual committing the act. Law sought to understand the individual perpetrator in order to assess how best to rehabilitate him, to induce him to adhere to norms of behavior in the future. As experts from human science disciplines were relied upon juridical power became decentered and the juridical field effectively became another site among many where disciplinary normative judgments are made. But Smith argues that law has not been colonized by the disciplines but rather makes use of and constrains disciplinary power. In work unrelated to Foucaultian analysis, Erickson and Erickson (2008), as discussed in Chapter 1, make a similar argument regarding mental illness in criminal justice contexts. They argue that although both free will constructions of moral failure and disease constructions of the medical model are present in criminal court understandings of mental illness, as judges and courts often refer to and utilize the disease model, ultimately the model of mental illness as moral failure prevails when the two constructions come into conflict. Criminal courts refer to and utilize the medical model at times, but are fundamentally centered on judgments of moral individual worth.

Hunt and Wickham (1994) are also critical of Foucault in his de-emphasis of law, arguing that he denied the existence of intimate connections between legal mechanisms and bio-power in his strict association of law with prohibitive, juridical power tied to sovereignty. But Tadros (1998) argues that Hunt and Wickham failed to understand the
nuances of Foucault’s understanding of law because they equated the terms ‘juridical’ and ‘law.’ According to Tadros, juridical power is not simply reduced to legal power, rather juridical power is any form of power attempting to prohibit acts through the threat of sanctions, which can be legal or social. The term ‘juridical’ can also refer to the code which is used to describe power, the juridical discourse. The code which describes power is juridical, but the current mechanisms of power are disciplinary.

The law is not necessarily juridical (Tadros, 1998), as Foucault employed a more sophisticated conception of law in which the law itself may take a number of different forms which may or may not be juridical. Some legislation may be read as negative in the sense that it prohibits certain acts, but in the modern age the operation of law has largely shifted to the regulation of lives, now “intervening in the social construction and government of the subject” (Tadros, 1998, pg.93). In one sense this returns to the idea that law functions as the mask of disciplinary power, but Tadros is arguing that this does not necessarily mean that law operates in a juridical fashion. Much law is aimed at the government of population, aimed at intervening in the lives of groups of individuals based on knowledge collected and considered as economy. Law may be presented in the guise of juridical code, but in the modern age law functions as an instrumental tactic operating between disciplinary and governmental power, as it is written to govern populations but it operates at the level of the individual case. Tadros thus argues that law operates as a governmental tactic and as a part of a disciplinary network. Law operating in the mental health court introduces the juridical code in the form of a charge of legal violation against a mentally ill defendant, allows for a disposition involving the formal
planning of mental health treatment, and through this process enables the use of disciplinary power in the supervision and surveillance of the mentally ill subject in the community and in future courtroom meetings.

Although law may be somewhat constraining on disciplinary power when called to the service of the court as Carole Smith (2000) argues, it also unleashes the powers of surveillance and supervision used to construct the law-abiding, mentally ill subject in a setting outside the courtroom. In *Discipline and Punish: The Birth of the Prison*, Foucault (1977) referred to the panopticon designed by Bentham as the perfect expression of modern power. The panopticon was a prison design in which individual cells for inmates were placed around a central tower from which a prison authority would be able to view any cell at any point in time. But any given inmate would not be able to determine when the authority was looking at his particular cell, and as a result he would begin to govern his own behavior continually in order to not be observed committing an indiscretion. Surveillance from the prison tower thus becomes a powerful inducement to the individual to govern his own behavior and follow normative guidelines.

Foucault referred to surveillance as the fundamental technique of disciplinary power, involving the normalizing gaze. In Midwestern mental health courts, participants are monitored by probation officers and social workers through regular appointments. Participants are also required to meet personally with the judge by appearing at a court hearing. The collective gaze of the professionals falls on participants and communicates approval or disapproval regarding performance. At court hearings, most participants engage in a brief performance before the judge in which they are praised for their
performance and encouraged to "keep up the good work," whereas participants who have
been performing poorly meet with the judge for longer periods as the problems with their
performances are discussed and sanctions, verbal and otherwise, are applied. This
surveillance induces participants to perform better, and those that do eventually reach
graduation.

Surveillance of participants also occurs during regular treatment appointments
with psychologists and psychiatrists. Psychologists engage in various forms of group and
individual therapy with the participant that enables the normalizing gaze, but these
psychologists also report to other MHC workers how the participant is doing in terms of
performance in her mandated treatment program. Medication prescribed as part of the
treatment plan of a mental health court participant requires regularly scheduled
observation with a psychiatrist, whose normalizing gaze is cast on the mental health court
participant during treatment appointments. The psychiatrist’s normalizing gaze cast on
the mentally ill participant is not limited to visits to the mental health clinic; psychotropic
medication allows for continuous panoptic surveillance from the psychiatrist, and by
extension, the mental health court. Psychotropic medication not only chemically alters
the body (brain) of the mental health court participant; it also affects behavior and
thought. It is prescribed in the hopes of inducing a specific behavior, such as calmness,
and the behavior and speech patterns of the defendant might be monitored by anyone in
the defendant’s day-to-day environment: social workers, counselors, friends, family
members, roommates, other mentally ill persons, the police, a citizen on the street, etc. A
psychiatrist may utilize questioning or blood testing of the mental health court
participant, absences from treatment appointments, personal observations or reports of observations from other mental health workers, or reports of misbehavior from workers, family members, police, or probation officers, or some other method to determine if the participant is medication compliant and thus following the treatment plan agreed on in court. If the participant is not treatment compliant then the psychiatrist will report this to the court. The participant faces court sanctions in the form of admonishments by the judge, community service hours, or even incarceration. In this way psychotropic medication becomes an important surveillance technique, inducing compliance to normative guidelines of behavior and treatment. Regular taking of the medication becomes an important normative guideline for the mental health court participant to adhere to, and the medication itself may induce docility such that the treatment plan is closely followed. If the treatment plan is not followed, then surveillance discovers this and law in the form of the judge becomes engaged with the participant, applying sanctions.

Law in the modern age may be written as juridical code but operates for bio-power as a link between governance and discipline (Tadros 1998). Law during the age of institutionalization legitimated involuntary confinement on case-by case basis for individuals with mental illness, thus enabling disciplinary treatment activity between psychiatrist and mental health patient/inmate. Any technique of law as governance faces challenges from other techniques of law as governance in a politics of law (Hunt and Wickham, 1994). Eventually, laws regarding involuntary confinement were changed and state hospitals were emptied during deinstitutionalization, ushering in the community
mental health center as the new governmental technique mandated by law (Cockerham, 2006).

The mental health court innovation is a new technique of law as governance that leads to the exercise of disciplinary power on the mentally ill subject who agrees to treatment. This technique has faced resistance from some analysts who suggest that the mental health court is inappropriate as it is coerced treatment achieved through the threat of incarceration, which is sometimes used as a sanction. Analysts resisting the use of mental health courts suggest other diversionary strategies should be employed, including pretrial release, deferred prosecution, and training police officers to better recognize mental illness, and to seek treatment for the mentally ill offender rather than arrest and incarceration (Seltzer, 2005). But to date, at least in criminal justice, psychology, and social work academic literature, those researchers who resist mental health courts are outnumbered by many who support the new governmental technique.

*The Difficulty of Resistance*

Some critics of Foucault argue his conception of society as a network of subjugating power relations leaves no room for the possibility of individual freedom and agency. Hughes (2005) is critical of the work of Foucault in terms of accounting for the possibility of agency in disabled subjects. The disability theorist acknowledges that Foucault’s thought can help in illustrating how the impairment of individuals is socially constructed. The Foucaultian perspective on disability can explain how normalizing judgment finds impairment in certain individuals and marks it as deficiency, thus creating a disabled population that is marginalized, invalidated, and separated out as pathological,
subsequently enduring disciplinary techniques of surveillance and supervision. But in Hughes reading, there is no possibility for the true emancipation of disabled people in Foucault’s thought. Foucault, Hughes argues, would view self-empowerment attempts by disabled persons as fiction, viewing emancipatory attempts to govern oneself rather than being governed as mere reflexes to practices of domination. The body of the disabled subject would be a docile target of power, but Hughes argues that this view seriously underestimates the disabled body’s potential for agency and self-determination.

However, Foucault did suggest that there was always the possibility of resistance to governmental practices, however unequal the relations between those who govern and those who are governed (Foucault, 1980). For Foucault, all instances of governance are necessarily incomplete and have the potential for failure (Hunt and Wickham, 1994). When he lectured on bio-power in the late 1970’s, he referred to bio-power as bio-politics, a politics concerned with subjects as members of a population, and concerned with issues of individual behavior as interrelated to issues of national policy. But modern bio-politics also inadvertently generates counter-politics, as individuals affected by governmental practices determine that a different set of needs and imperatives should be met and form counter-demands. Foucault (1980) referred to this as the “strategic reversibility” of power relations, because governmental practices have the potential to spawn focuses of resistance against them. However, Foucault also recognized the exercise of power to the point of domination, meaning effective resistance by subjects against power from above is possible but unlikely (Kelly, 2009).

Some academic researchers and legal theorists have analyzed mental health courts
and contributed to criminal justice discourse with writing that might be considered
resistances against their use (see for example Seltzer, 2005), but individual resistance to
mental health court practices by mentally ill defendants is problematic. Mental health
courts have been criticized for limiting the possibility of agency in mentally ill
defendants, who may opt to undergo treatment simply in order to be released from
incarceration (Seltzer, 2005). Many mental health courts describe participation as
"voluntary," but incarceration of a referral complicates the issue of voluntary
participation. Over the course of my research, on several occasions I witnessed
incarcerated defendants opt to enter the MHC program with immediate plans for release
from jail made by the judge. This situation might be described as a futile attempt at
freedom, in that freedom from incarceration involves undergoing regular supervision and
surveillance for the mentally ill defendant. The process of holding out the option of
mental health treatment to avoid incarceration has been viewed as coercive, but some
view coercion positively as a way to ensure that a defendant receives mental health
treatment, whereas others view it negatively as not allowing for true voluntary consent
from the defendant (Goldkamp and Irons-Guynn, 2000).

Competency of the mentally ill defendant is another important issue if the
defendant is to make an informed choice to enter the mental health court program. If a
defendant is not competent and unable to understand charges or possible options, than
making an informed choice is not possible. On the other hand, a defendant may be
judged incompetent and not allowed to opt for entering the mental health court when in
actuality the defendant is competent but simply scared and confused, as many non-
mentally individuals can be while being incarcerated (Goldkamp and Irons-Guynn, 2000). This raises another criticism of mental health courts, that those mentally ill defendants who are judged incompetent and unable to participate in the mental health court program may actually be those who would benefit the most from a program of supervisory treatment in the community. My research did not consider persons considered incompetent, as competency was determined in jurisdictions as a condition of referral. But the study reveals that many of the competent individuals were ultimately rejected by professionals during the referral process, which is why I conceptualize the MHC as a filtering process based on performance. These rejected individuals and others not accepted into the program are facing criminal charges, and have little ability to resist the decisions of the MHC professionals.

As discussed in Chapter One, Mirchandani (2008) analyzed her own transcripts of domestic violence court hearings in Salt Lake County, Utah, and found that there were elements of Foucaultian disciplinary practices operating alongside elements of Habermasian deliberative democracy. The court workers exercised power within the legal system to require therapeutic treatment of offenders, but also engaged in personal discussion with offenders and their victims, who had been and sometimes still were domestic couples, so that they could raise concerns and alter practices of court workers in some situations. However, in my ethnographic data gathered during a series of three or more site visits at each of nine Midwestern mental health court programs, there was little

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1 Such competency determinations would become a part of the textual representation of the offender-as-case, so that the performance filter extends back to competency determinations, although I did not observe this process.
evidence of deliberative democracy in terms of the mentally ill referrals and participants being able to effectively have a voice and counter practices of court workers.

Of course, a major difference between the mental health courts I observed and the domestic violence court that Mirchandani (2008) observed is that there are no victims participating in the Midwestern mental health courts; indeed, many of the crimes being processed in the MHCs were victimless drug crimes. Mirchandani observed a court process involving domestic couples where the judge engages both the offender and victim; their concerns expressed in interaction were likely very different from the types of interactions I observed. The good performers in Midwestern MHCs had brief, positive interactions with the judge during hearings, while bad performers, on being sanctioned, failed to engage in any effective resistance. Occasionally I witnessed participants bring up issues and make requests for things such as different living arrangements, changes in medication, or travel to visit family, which were then discussed with the judge, yet they showed no ability to effectively argue against a judge’s decisions on such matters. For instance, in Chapter Five a narrative example described a woman named Cleona during a Bevan City MHC hearing who discussed with Judge Jamison whether or not she could live with her mother. Judge Jamison refused to allow this, citing that the participant’s mother lived in a part of town that the participant needed to stay away from in order to recover. Cleona simply acquiesced to the judge’s wishes. I only observed a few instances of actual argument with a judge during Midwestern MHC hearings, and in every instance the judge indicated the argument was unacceptable, and represented a bad performance. Only when public defenders were adversarial in the backstage of staff
meetings, as in Lynne County and Ferry County MHCs, did I observe any type of effective resistance to court practices on behalf of participants. But most public defenders that I observed were decidedly non-adversarial, particularly during court hearings, and did not provide any effective resistance to the exercise of power from the judge or any other MHC professionals.

Fundamentally, power is about getting people to do things that they otherwise would not do (Kelly, 2009). As Foucault (1978) argues, resistance in some form is always present when power is exercised. But the resistances of individual participants and referrals in Midwestern MHC programs are resistances at the individual level that do not threaten the continued operations of the programs, provided that at least some of the select few allowed into MHCs are able to perform successfully to the point of graduation from the program. Individual referrals who resist the work activities of MHC professionals beyond a threshold of acceptability are simply not allowed into the program – these defendants with mental illness are filtered out in the referral stage as I have conceptualized it here. Individual participants who do not perform by too vigorously resisting the exercise of power by MHC professionals are terminated from the program – these resisting participants are filtered out during the performance stage. Again, at least as of this writing, none of this resistance threatens the operations of the MHC or the specific practices of MHC professionals as long as a few graduates can be held up as exemplars of the programs. These individual resistances are ever present yet unsuccessful in countering the exercise of power by professionals, and ultimately in countering the exercise of power by judges and other criminal justice officials.
establishing and continuing the programs.

Kelly (2009) distinguishes between micro- and macro-resistance in reviewing Foucault’s work on resistance to power. Micro-resistances to exercises of power do little to dramatically affect the overall structure of power relations; instead they congeal into a stable network of mutually-supportive power relations. For instance, criminals often resist efforts of workers in prison systems, but this resistance includes further criminality which supports continued exercises of power by prison workers. The overall prison system remains little changed from these micro-resistances. Macro-resistances to existing strategies of power, on the other hand, have the potential to dramatically affect the overall structure of relations. But macro-resistance must be strategic to meet the strategies of power effectively. Effective macro-resistances – such as a social movements affecting dramatic and widespread societal change (i.e. the civil rights movement, the women’s movement, and others) – are examples of strategic counter power, such that these macro-resistances are themselves forms of power exercised from below in a hierarchical network of power relations.

Effective resistances to MHC programs will have to be collective in some sense: resistances by a group of persons with mental illness who advocate for change, resistances by groups advocating on behalf of persons with mental illness, or resistances by researchers at various sites who collectively argue against the programs. Resistance in the form of scholarship by researchers may assist advocacy groups, while scholarship without advocacy groups may not be able to effectively resist the continued expansion of MHC programs. As I mentioned earlier, currently most of the research on MHCs is very
positive and supportive of the programs. For the view toward MHCs held by politicians and researchers to change to the degree that the programs are unfunded and dismantled, research findings at various sites may eventually reveal that the programs are ineffective or unjust, but additionally, some group may have to resist MHC programs collectively through a political process.

**Midwestern Mental Health Courts, Governance of Population, and Social Justice**

As in the preceding section, in this section I refer to Foucault’s (1991) conceptualization of governance of population but do not present anti-subjective Foucaultian analysis. Here I analyze the organization of MHCs in Midwestern as the result of intentional actors – politicians, judges, and other institutional actors – who joined the sociolegal (Miller and Johnson, 2009) problem-solving court movement, represented the state, and exercised power to implement a new rational and technical strategy for governance of persons with mental illness. These institutional actors operated in a local context but were affected by values and understandings present in the wider culture of Midwestern and America. After discussing the character of this new governmentality, I critique the establishment of Midwestern mental health courts using public health ethics which include the value of social justice in reference to population.

*The Governmentality of Midwestern Mental Health Courts*

Nolan (1998) contends that a therapeutic ethos has developed in American culture that is now present in state institutional structures. Building on work by Berger and Luckman (1966), Nolan theorizes two dialectical, reciprocal relationships that are connected in processes of state legitimation. The first relationship exists between the
structure of state institutions and the collective consciousness of a culture such that cultural sentiments are externalized and objectified into state structures, but then the state acts through codified laws and policies and these are internalized by members of society (Berger and Luckman, 1966). Over time, changes in state structures or culture affect the other. The second dialectical, reciprocal relationship is that between culture and ideological systems. Just as state structures influence and are influenced by the culture, the culture influences and is influenced by specific ideological systems. The two relationships are connected in legitimacy because once these systems are created and accepted by the wider culture, they eventually become present in state structures, and people internalize the structure’s legitimacy.

The therapeutic ethos, for Nolan (1998), is an important ideological system that has been accepted into the wider culture and is affecting the structure of state institutions, including the criminal justice system. Defining features of the therapeutic ethos include: an emphasis on reference to a self that is basically good; an ethic of emotivism in which one’s feelings are acknowledged and one is encouraged to express emotion; psychologists and psychiatrists as a new “priestly class” of leaders; and a tendency to define an ever-widening range of human behavior as disease or pathology. Nolan (2001) found the implementation of a therapeutic rationality in American drug courts, as judges and other MHC workers used the language of therapy and implored addicts to improve themselves, to get in touch with their feelings, to engage in treatment with counselors and therapists, and to accept themselves as diseased individuals.

Judges and other professionals in Midwestern mental health courts also displayed
these defining features of the therapeutic ethos. Thus is not surprising because at all but one of the sites drug courts had been established before mental health courts. In Midwestern, at the large majority of sites investigated, professionals in the socio-legal movement to establish problem-solving courts first established a drug court, and then those same professionals or others interacting with them established a mental health court. Professional informants at several sites related a process of operating the drug court over time leading to discovery of a number of participants with mental illness, which then led to the decision to establish a mental health court in their respective jurisdictions. Domestic violence courts are sometimes incorrectly included in the problem-solving court movement (see for example Berman and Feinblatt, 2008), as the battered women’s movement engaged in decades of struggle (Ptacek, 1999) before the widespread adoption of domestic violence courts (Mirchandani, 2004). But in Midwestern the establishment of drug courts directly influenced the formation and practices of mental health courts, such that both types of courts are connected and the result of the socio-legal movement of judges and others.

The governmentality of Midwestern mental health courts includes a therapeutic rationality (Nolan, 2001) directed at a participant to motivate improvement of self. In addition to the therapeutic ethos, this new strategy of governance also contains an emphasis on what Rose (1996) refers to as enterprise, an ethical rule in governance such that good governance is grounded in how persons govern themselves. Thus, judges implored mental health court participants to “work hard,” and evidence of an enterprising self in the participant was judged as good performance. Rose makes a very similar
argument to Nolan regarding current governmentalities, in that Rose, following Foucault, theorizes that “psy” disciplines – psychology, psychiatry, and related disciplines – have played a key role in defining the self, delineating how persons should engage with each other, transforming authority toward therapeutic approaches, and changing ethical techniques.

The theory of performance is limited to explanation of processes of Midwestern mental health courts but fits the broader theorizing of Nolan (1998) and Rose (1996). Performance judgments determine whether or not a referral will be accepted into mental health court, and whether or not a participant will become a successful graduate. Judgments of performance may involve practical, utilitarian evaluations (Can the person do this program?) as well as moral evaluations (Is the person trying to improve?). As discussed above, good performers are expected to work hard, to develop a personal relationship with the judge, to strive for self-improvement through therapy and treatment, to follow directions from the judge, psychiatrist, and others, and to accept one’s self as diseased and needing help. Referrals who have a case represented textually documenting unacceptable qualities of criminality or circumstances, or who fail to display motivation to improve during appearances before the judge, are not allowed into the program. Participants who fail to work hard, personally connect with the judge, cooperate with professionals, or accept being diseased are terminated from the program, sometimes to be sentenced to incarceration. Professionals in Midwestern mental health courts look for and encourage the emotivist and enterprising self in referrals and participants, and those who display such qualities during personal interactions with professionals move through
the program to graduation.

*Midwestern Mental Health Court Evaluation, Public Ethics, and Social Justice*

The question of whether or not mental health courts will continue to grow in number in Midwestern and elsewhere will be answered as the programs are evaluated in various ways. Perhaps the most important for MHC continuation involves the question of whether or not there are enough successful graduates from the programs in the opinion of those in positions to exercise power at a level above judges, namely the politicians who provide funding and support for the programs. This is one of the more important questions for the continuation and expansion of mental health court programs, as recognized by some of the professional informants for this study. Indeed, when I briefly discussed my research with Felix in Collins County after a number of site visits there, he expressed disappointment by saying “Hey this anecdotal stuff is interesting, but are you doing anything with the numbers? We want to show our programs are effective.” At the time, I had to hide my amusement because I felt that Felix had basically dismissed the work of qualitative researchers as insignificant! However, his comment spoke volumes about how new programs such as MHCs find continued support from politicians who fund them. Such politicians are not likely to read a long, qualitative study about new programs, but do rely on brief, quantitative statements that help them decide whether or not new programs are effective and cost-efficient.

My dissertation is not focused on answering questions about the relative effectiveness of programs in terms of outcome numbers; rather, my study was focused on discovering how professionals do work activities in operating MHCs, and how they
understand their work and the criminal defendants with mental illness whom they encounter. However, I did recognize over the course of the study that the numbers of participants and graduates were relatively small compared to the estimated total number of persons with severe mental illness in local jails according to several research estimates.\(^2\) As I analyzed the ethnographic data and began to recognize the performance filter as an organizing principle of the programs, the limited numbers of participants and graduates became apparent.

During the study, several professionals were very vocal in welcoming my research at their work sites. They explained that they wanted me to publicize their efforts so that MHCs gained more funding and prestige, and were established in other jurisdictions. These professionals believed that their work in MHCs represented how criminal justice systems should respond to persons with mental illness, and assumed my research findings would support this belief. But I did not provide my personal opinions about MHCs to informants during the study, and tried not to focus on such questions during initial data collection.

However, after analyzing the data and developing the theory of performance, I began to recognize a distinct criticism of the programs: that although they were directed at persons with mental illness whom professionals referred to and worked with as diseased and in need of treatment, everyday operations of the programs are largely based

\(^2\) Several sites did provide de-identified, case-level datasets for their referrals and participants, but the datasets were not uniform, and several other sites did not or could not provide such data. I have used some of this data occasionally in this dissertation, but overall it is an ethnographic study of professional MHC workers, not a quantitative study of outcomes at mental health courts.
on moral evaluations of participants as enterprising performers. As discussed in Chapter One, Erickson and Erickson (2008) detail the conflict between mental health and criminal justice understandings of mental illness. They argue that the meaning of mental illness has been socially constructed from in the past being understood as a medical problem requiring prolonged hospitalization to currently being understood as individual failing often leading to behavior requiring criminal justice intervention. Although the disease model is often invoked in criminal justice contexts, fundamentally mental illness in such contexts is understood as moral failing.

Erickson and Erickson’s (2008) argument also fits my findings in Midwestern mental health courts. Fundamentally, the programs are centered on moral evaluations of performance rather than treatment of disease. In the blended organizations that are Midwestern mental health courts, although both criminal justice and mental health institutional practices are displayed, the dominant model is the criminal justice idea of free will while the lesser model of disease is not fully recognized. Both criminal justice and mental health professionals that informed the study spoke of recognition of disease, but this occurred in a court arena that was fundamentally centered on moral evaluation. Even when disease was recognized as mitigating or entirely excusing certain instances of behavior among the referrals and participants, professionals utilized judgments - performance understandings - to determine who among them may be or are good performers (ability), and who were deserving of treatment in the community (morality). During programming, through personal and textual interaction performances of participants were consistently judged by the professionals in moral terms.
I do not mean to suggest that professionals used these judgments to limit services among the participants. Far from this, instead a high level of varied services was typically provided for all of the participants as long as they were in the program. Often the most problematic participants in the programs seemed to be receiving the highest level of services from MHC professionals and local mental health providers. But this provision of services occurred for troubled participants only after a balance had been struck by professionals on the front-end of programming in evaluating referrals. As discussed in Chapter Six, professionals tried to determine whether or not referrals had valid mental illnesses to justify their being accepted into the program, but did not want to accept referrals with mental illness so severe that they would not be able to perform. Referrals not accepted into the program had charges dismissed, were put on probation, or were sentenced to jail or prison. If their charges were dropped or they were put on probation, any services received were in the community along with non-criminalized persons, but without the amount of professional attention and involvement as with MHC participants. If sentenced to jail or prison, then any services they received were within incarceration. Overall, the result is a high-level of professional attention on focused and varied services from available community resources for offenders with mental illness during participation in the program, whereas other offenders with mental illness received services with less professional involvement in a limited market, or limited services during incarceration.

Mental health courts fundamentally engage in moral judgment of individuals, which affects the distribution of mental health services. But this criticism does not
suggest that morality should be absent from governmental processes affecting individuals considered mentally ill. Rather, as I argue below, the moral value informing government of these individuals by politicians and public officials should include persons with mental illness as an entire population - a plurality - rather than being restricted to celebrating governmental strategies aimed at only a relatively small number of individuals.

Foucault described how resistance to existing governmentalities may involve strategic reversibility, meaning that the rationality present in governmental practice is turned against that practice (Gordon, 1991). Following this line of thought, and recognizing that mental health courts operate through judgments of performance that are often moral evaluations, I suggest that the programs themselves should be evaluated and criticized on moral terms. Mental health courts should not be evaluated in terms of the percentage of successes from the small number of persons allowed into the program, but rather in terms of public ethics which include values of social justice. The question is whether or not mental health programs engage in practices that are considered just from a moral perspective.

Rather than considering how effective the programs are in working with a relatively small number of individuals, one can instead consider how just the practices of MHCs are in the context of communities with a limited market for mental health services. To do this, I draw on ethics presented in public health literature to guide practitioners and policymakers. Ethics in clinical medicine focus at the individual level on the relationship between patient and provider, while public health ethics, on the other hand, take a wider, more inclusive perspective by focusing on responsibility for the health of the entire
community (Lee, 2012). This, of course, can be connected to governmentality directed at a population. Are the governmental practices of the new strategy of mental health courts directed at the population of persons with mental illness found to be just when evaluated from a moral perspective? When one considers the content of several different articulations of public health ethics presented in recent years, mental health courts as I found them to exist in Midwestern become problematic in terms of social justice.

Upshur (2002) discussed differences between public health and clinical practices which inform ethics of public health: “care” in public health is the state versus the clinician, the focus is on the community or population versus the individual, there is no analogous role in public health to the fiduciary one played by physicians, and there is recognition in public health that populations are diverse and require pluralistic approaches as opposed to the individualized approaches of clinical medicine. He also suggested underlying values to practices, including the importance of autonomy, nondiscrimination as social justice, social duty, honesty, and truthfulness. Later public health ethics models expanded on Upshur’s description and continued to include the notion of social justice as nondiscrimination in health service provision, which includes pluralistic approaches so that everyone in a population is treated (Lee, 2012). The Nuffield Council (2007) in the United Kingdom outlined public health ethics and referred to a stewardship model in which the state looks after the needs of people individually and collectively. They discussed the importance of community, defined as “the value of belonging to a society in which each person’s welfare, and that of the whole community, matters to everyone.” Inclusiveness, the concern for the welfare of all, is an important
aspect of social justice present in public health ethics and elsewhere. Social justice involves providing for equality and justice for all people, regardless of differentiations such as race, class, ethnicity, and gender (Jun, 2010).

Relevant findings presented in Chapter Three from the state-wide survey that preceded the ethnographic site visits provide information for evaluating mental health court practices in Midwestern in terms of social justice. The acceptance rates of individuals who apply to mental health court programs were reported in early 2010 as follows: the Collins County MHC accepted about one-fourth of all referrals; in Ferry County, the acceptance rate for referrals was forty-four percent; in Gabriel County, the acceptance rate was seventeen percent; in Gilmour County, the rate was eighty percent; in Hackett County, the rate was about thirty-three percent; in Lynne County, the rate was twenty-one percent; in Manzanera County, the rate was sixty-four percent; in Bevan City, the acceptance rate was fifty-five percent; and in Tandy, the acceptance rate was ten percent. These numbers reveal that the programs are selective at the referral stage, some to a high degree. The theory of performance I presented above reveals how this selectivity occurs during the referral stage, and how selectivity continues after acceptance into the program so that eventually a relatively small number of total applicants eventually become mental health court graduates. Why is this problematic in terms of public health ethics of social justice? The answer involves the distribution of mental health services to the entire population of persons with severe mental illness in Midwestern.

Throughout the study conducted from January 2010 to February 2012
professional informants at every site spoke to me about Midwestern state budget cuts occurring in mental health funding. Several informants referred to a state budget crisis dramatically affecting mental health funding, and referred to the closure of specific treatment and residential facilities resulting from the cuts. I confirmed this as a significant issue during the period from early 2010 through 2011 after a perusal of various forms of news published within the state. Several times over the course of the study I perused local news web sites across the state and confirmed the informants’ accounts - budget cuts had been made at the level of state government, and were across a variety of areas including mental health funding. A report published by the National Alliance on Mental Illness in November of 2011 documented how the federal government had also cut back support to states for mental health funding. I also found several stories about the closure of specific facilities that informants had lamented. However, also during this time, a number of these same informants obtained and continued to access financial and service resources specifically for mental health court operations and participants. These professionals were locating federal and local funding to begin or continue mental health court programs, which consumed local mental health services. The problematic issue in all of this is that the limited market for mental health services in Midwestern was shrinking while the usage of services by mental health court participants was growing.

I began to recognize this as a significant problem of Midwestern mental health courts after reviewing field notes from a staff meeting in Manzanera County. Judge Bradford, the MHC judge, had initiated a friendly conversation before the meeting and
we had chatted briefly about the program. Later, the professionals discussed an issue involving getting a participant into local residential housing. Judge Bradford turned to me during a lull in this conversation and said "Our clients don't get any special treatment. They have to compete for services just like anybody else." At the time I remember wondering about the implications of this statement, and later, when analyzing the notes, I realized that it represents a major criticism of mental health courts, although the judge had intended it differently: diverted participants are now competing for local services with the non-criminalized. If there is no increase in local services to account for these persons, then fewer services become available for the non-criminalized. Service delivery is assured by the efforts of professionals for these select few MHC participants. This new competition combined with overall cuts in mental health funding means the problem of less mental health services for the non-criminalized persons with severe mental illness is exacerbated further. Thus, one can refer to public health ethics and the specific value of social justice to find injustices in service provision for the non-criminalized portion of the population of SMI in Midwestern during the two-year period of the study. Specifically, my argument is that the distribution of mental health services becomes unjust through mental health court programs during times of state budget cuts. During the two year period of the study – from early 2010 to early 2012 - there were more and varied services benefitting a select few in programming, while the non-criminalized mentally ill received fewer services as state mental health budgets were cut, federal supports were cut, and other federal initiatives focused a share of the limited services on the select few criminalized individuals. Although my study was not centered on investigating overall
mental health service provision, I believe that ethnographic findings and other research I conducted in local papers demonstrate that this is an accurate representation of mental health service distribution in the state during the period of the study.

The issue of mental health court consumption of services and overall service provision in a community is seldom discussed in academic literature on mental health courts, but many researchers call for more funding and improvements for overall mental health services. Seltzer (2005) argues that the presence of mental health courts may be distracting authorities from the need to improve services overall. She comments:

Given that mental health courts are largely reactive to failing mental health systems, they cannot be evaluated without considering whether reform efforts toward identifying and making services available to people with mental illnesses who are at risk of arrest are underway by the public mental health system. There is an inherent risk that any court-based diversion program, if not accompanied by such reforms and an effective prebooking diversion program, might lead law enforcement officers to arrest someone with a mental illness in the expectation that this will lead to the provision of services. (P. 581)

In other words, mental health courts cannot become for law enforcement the “back door” to mental health services, and the establishment of the programs must be recognized as an indication that the local mental health system needs improvement. Similarly, Erickson, Campbell, and Lamberti (2006) caution that “[c]ourts should avoid myopic approaches that obscure the more critical long-term efforts needed to reform our fragmented mental health system.” (P 341) Despite this warning, mental health court programs were established and funded across Midwestern over the next few years while services of the mental health system were lessened.

Erickson, Campbell, and Lamberti’s (2006) comment influenced my suggestion
of the concept organizational myopia presented in Chapter Six, which can be defined as
the inability of an organization when focusing on its target issue or clients to recognize
the effect of its efforts on the wider social context. Over the course of the study, only the
professionals in Gabriel County brought up the issue of mental health courts being
indicative of a wider lack of services, rather than a real solution to a problem. Others,
like Judge Bradford in Manzanera County, seemed not to recognize the issue of limited
services.

Organizational myopia seemed to exist at the professional meetings I attended as
well. For two years, I regularly attended meetings of a new organization for Midwestern
mental health court professionals held every three months. The professionals were
creating a new organization, so much of the meeting time was spent discussing things
like coming up with a mission statement, setting up committees for various purposes, and
pursuing federal tax-exempt status. Professionals also discussed problematic issues and
long-term goals, but all of this talk was insular - aimed at improving and stabilizing
operations of the mental health courts. There was simply no talk or recognition of the
wider context of mental health service needs in the community during the meetings - all
needs considered were MHC client needs, and all plans made were for improving MHC
programs and securing their long-term future. Negative aspects of the implementation of
mental health courts, or the needs of those not served by mental health court, were simply
not discussed, at least during the eight meetings I attended.

The criticism here is that intensive and varied services are provided for a select
few who manage to enter the MHC program, while others who have been criminalized
receive limited services in jail or prison, or possibly some level of community service on probation, and the rest of the population - including the entire population of persons in the jurisdiction and the subset of non-criminalized severely mentally ill individuals - find mental health service provision reduced overall. The organizational myopia comes from the lack of recognition among many professionals in Midwestern that as their mental health court participants are diverted from mental health service provision in jail or prison to provision in the community, they are now competing for mental health services in a limited market with the rest of the population, who are non-criminalized, at a time when those services were being lessened. No one seemed to be considering the negative effect of the programs on the availability of services for the non-criminalized persons with severe mental illness at a time when services overall were fewer. In those areas where state budget cuts resulted in less overall mental health services in the state of Midwestern, judges through mental health court programs were able to ensure and even add monitoring personnel and claim a share of varied mental health services in a limited market for their select few.

Other Moral Criticisms

Strategies of governance for persons with mental illness in the form of performance judgments are also unjust because many behaviors – such as a negative or unmotivated attitude – are often a function of illness (Emery and Oltmanns, 2000) but at times are used to make moral determinations of who deserves to receive treatment in the community, and who does not. It is fundamentally unfair for the state, represented by judges and other MHC professionals, to engage in non-clinical, moral judgments of the
attitudes of individuals with severe mental illnesses as a way of determining the
distribution of mental health services. As suggested above, those who were not accepted
into or who were terminated from the program generally faced less mental health services
overall within the community - if given regular probation or charges were dropped - or
they faced limited mental health services in jail or prison.

Another criticism is both moral and practical, refers back to Foucault, and
involves focusing only on the criminalized, severely mentally ill population. Recall that
for Foucault, all strategies of governance are incomplete - no strategy enables the
exercise of power completely over a population (Hunt and Wickham, 1994). When
considering statistics presented in recent studies of mental health courts, it appears that
the technical and rational strategy of mental health courts as governance of the population
of persons with mental illness who are incarcerated in jails and prisons is dramatically
incomplete. Clinical studies have estimated that between ten and nineteen percent of
persons in jails in the United States have severe mental illness, as well as eighteen to
twenty-seven percent of persons in state prisons, and sixteen to twenty-one percent of
persons in federal prisons (Lamb et al, 2007). In Clark County/Las Vegas, Nevada,
researchers estimated that approximately 700 of 3,200 jail inmates were in need of
psychological treatment, but the Mental Health Court enrolled 19 mentally ill inmates
over a six month period (Skolnik and Hoogland, 2005). Between January of 2003 and
November of 2004 more than 8,300 inmates entering the San Francisco jail were
diagnosed with a mental disorder, and during this period only 172 inmates were served
by the Mental Health Court (McNeil and Binder, 2007). Although these studies present
favorable outcome findings, so few of the inmates incarcerated in these jurisdictions and diagnosed with mental illness are actually served by mental health courts that the programs would have to be greatly expanded to be considered a realistic attempt to govern the mentally ill inmate population. Many persons with mental illness who might be diverted successfully are never given the opportunity, despite the claims of mental health court advocates that the programs can help solve the problem of persons with mental illness being incarcerated unfairly. Of course, if massive expansion of MHC programs were to occur, then the problem of courts being overwhelmed with cases of persons with mental illness would become a major issue, which would contradict the claim by advocates that specialty courts address the problem of courts being overwhelmed by large numbers of drug and mentally ill offenders.

I found dramatic incompleteness (Hunt and Wickham, 1994) in Midwestern mental health courts as well, and this incompleteness was more pronounced in larger jurisdictions. For example, in Bevan City, given the size of the county jail population and using a conservative estimate of six percent of that population being severely mentally ill, well over five hundred persons incarcerated there have severe mental illness, but the mental health court had fifty-five persons in early 2010, and these numbers did not dramatically change over the course of the study. The Tandy MHC in Waters County was very small, with only six participants, and the program only accepted ten percent of referrals. Also, it seems possible and needs to be researched that a number of participants in Midwestern mental health courts are drug abusers with situational depression rather than persons with the severe mental illness of Major Depression. Even though many
hundreds of persons with severe mental illness in the Waters County jail might benefit from diversion, I attended a staff meeting of the MHC there in late 2010 in which the professionals complained that they simply could not find enough “good” referrals for their mental health court program. The narrow parameters for MHC participation in Bevan City and Tandy, which include most fundamentally the ability to perform in the program, prevent diversion of the vast majority of severely mentally ill defendants in Waters County. 3 Narrow parameters for mental health court participation were present at all MHC sites, and as referral statistics presented above suggest, selectivity to some degree is a characteristic of all of the programs.

**Concluding Suggestions**

At the risk of suggesting a utopia, in this concluding section I humbly offer suggestions for how state practices toward persons with mental illness who become involved in the criminal justice system may be changed and improved for both the state and for the population of persons with severe mental illness. Rather than suggest ways to improve mental health court programs, I advocate the abandonment of MHCs as they exist in Midwestern. Instead of establishing MHCs, I argue instead for the implementation of dramatic changes in how persons with mental illness are governed.

First, there needs to be significant, lasting increases in funding for mental health

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3 As explained in the text, competency was a requirement for mental health court referral in all of the jurisdictions, but I did not study or have any contact with incompetent mentally ill persons over the course of the study. However, they may be the most severely ill, and the ones most in need of diversion out of the criminal justice system. But individuals ruled incompetent cannot enter the mental health court program, and if they are charged with a crime and not bonded, they are typically held involuntarily in a medical facility at a jail, or in some other facility contracted with the jurisdiction, until competency is restored according to psychiatric authorities.
services, with a focus on providing a variety of services for the persons with the most severe mental illnesses. This is, of course, an obvious suggestion but cannot be ignored. Advocates for deinstitutionalization had laudable goals, but sufficient funding was not provided to care for persons with mental illness in the community after the release of hundreds of thousands of them from state mental hospitals (Cockerham, 2006). If balloon theory (Erickson and Erickson, 2008) is correct, and there is an inverse relationship in a society between the number of persons held in prison and the number of persons held in state mental hospitals, then an increase in the amount of state inpatient hospital beds would be a start at lowering the number of people with mental illness in jails and prisons. However, many persons with severe mental illness can live in the community rather than being hospitalized so long as adequate services are provided, including appropriate housing. The number of housing facilities needs to be increased, and they need to be designed and operated specifically for persons with severe mental illness, rather than simply relying on beds in nursing homes or other non-specialized facilities. Mechanic (2008) stresses the importance of transitional programs for people moving from mental hospitalization into the community. Such programs represent a gradual transfer to the community and a continuous involvement in treatment after housing has been achieved. Similar transitional programs need to be in place for persons with mental illness released from jails and prisons to lessen recidivism.

Prioritization of services should be made for persons with the most severe mental illnesses. One problem identified with the community mental health care centers set up after deinstitutionalization was that workers at the centers often focused on less severely
mentally ill persons, and ignored or turned away seriously disturbed individuals (Lamb and Weinberger, 2001). In today’s era, managed care practices often do not serve the needs of the most seriously mentally ill persons, failing to differentiate between the more and less seriously mentally ill, and reducing services for those most ill (Mechanic, 2008). Professionals in the fields of psychology and social work need to prioritize treatment for the most severely mentally ill persons, while policy makers need to recognize and fund their long-term treatment and care needs.

Another suggestion for change is that criminal justice systems should dismantle mental health court programs which serve a small number of persons, and instead develop ways to divert much larger numbers of persons with mental illness from jails and prisons, with prioritization on the most seriously mentally ill. I argue for pure diversion from criminal justice rather than programs like mental health courts that divert from incarceration but still require much criminal justice involvement. One dramatic change would be to simply dismiss minor criminal charges for persons with severe mental illness. This already occurs when police officers encounter persons with mental illness and decide to deliver the persons to an emergency hospitalization facility rather than make an arrest and file charges (Teplin and Pruett, 1992). But lawmakers could do much more in this area. Judges could be authorized through new legislation to dismiss minor criminal charges of persons with severe mental illness at any point beyond arrest in order to move them out of jail facilities and into state treatment facilities. Of course, malingering may become an issue, but jail psychiatrists already deal with this. If a person is already receiving services for severe mental illness and is arrested, then it could
be made a matter of routine for the judge to dismiss criminal charges. If multiple arrests of one particularly problematic individual were to become an issue, then courts could develop a system in which each subsequent arrest leads to longer involuntary inpatient hospitalization or more intensive and long-term treatment. In other words, judges could still exercise power from the bench and mandate treatment of particularly problematic individuals without having a program that requires many visits to probation and the courtroom.

As detailed above, flexibility is an ethic of professionals in Midwestern mental health courts referring to their willingness to be flexible in work roles but also to be flexible in approach to their work with participants. This ethic is much celebrated in the academic literature on mental health courts (see for instance Miller and Johnson, 2009). But this ethic of flexibility is simply inaccurate and over-stated, although it is often held up as the reason why mental health court programs are appropriate for working with persons with mental illness. How flexible are programs that only accept one-third of all referrals? How flexible are programs designed to solve the problem of persons with mental illness being held in jails and prisons when only a small proportion of these individuals are considered acceptable to the program? I would argue that mental health court programs are flexible like cookie cutters are flexible. Cookie cutters are made of soft metal or plastic that can be molded into any number of shapes. A cookie cutter can be made into the shape of a star, a moon, a cat, a dog, Santa Claus, a jack-o-lantern, or whatever other shape depending on occasion or preference. So cookie cutters are very flexible. But as a cooking instrument a cookie cutter only works to make cookies. A
cookie cutter does not work to roll dough, or to stir eggs and flour, or to filet a fish, or to prepare many other types of foods.

As I have argued throughout this dissertation, mental health courts require a level of performance from the offender - a capability to attend numerous appointments for various reasons while displaying a willingness to improve, especially when appearing before the judge. The programs are very selective regarding who may participate and do not help many persons who could be diverted in other ways. This is not to deny the successes of MHC programs. I did observe a number of participants who told success stories at graduation ceremonies, and I believe that these people were genuinely helped and made dramatic changes in their lives because of participation in the mental health court. But there are many types of persons with mental illness who would find it very difficult because of their disability to participate in MHCs successfully, and this is an unfair situation for those who could reasonably be diverted from incarceration. For instance, several professionals in Midwestern, without complaining about the programs, related to me at various times that persons with cognitive issues have difficulty in the program in learning the connection between sanctions and behavior in the community. Some even indicated that such persons were not appropriate for their programs, and were rejected at referral on occasion. I witnessed negative commentary about people with cognitive disorders on a couple of occasions during staff meetings. People should not be kept in jail or prison rather than diverted because the diversion program is not designed to handle their disabilities.

Additionally, the most severely mentally ill persons may not be able to apply for
mental health court because they are found incompetent by jail workers. Programs of
diversion should not be designed so as to exclude persons who are the most severely
mentally ill. If the ethic is that having mental illness can excuse criminal behavior, then
those who are the most ill should be the most excused, and should be prioritized in
diversion. Unless such individuals represent a danger to the community, or their crimes
involve major victimization or violence deserving of retribution, why not as a matter of
routine simply dismiss minor criminal charges for persons found to be incompetent,
move them out of jail hospital facilities, and into state mental hospitals?

When I refer to “minor criminality” I am not talking of the distinction between
felony level and misdemeanor criminal charges. In fact, a major flaw of the criminal
code regarding the current situation for people with severe mental illness is that in
Midwestern, as in many states, the same repeated misdemeanor charge eventually
becomes a felony-level charge. I observed a couple of examples of felony level charges
directed at MHC referrals who had allegedly stolen less than fifty dollars of merchandise
from a retailer. The criminal charge was felony level because each offender had gone
beyond the threshold for repeat misdemeanor offenses, and new instances of the offense
were now felonies. Hiday (1999) developed three categories of mentally ill offenders,
and identified a category of mentally ill offenders who are homeless, abuse substances,
and may shoplift or commit other minor survival crimes. Such individuals should not be
charged with felonies because of repeat offenses of minor crimes, and even their
misdemeanor level offenses should be dismissed. Simple possession of illicit drugs
should not result in criminalization of persons with severe mental illness. If these
offenders are problematic precisely because they keep committing minor survival crimes or abusing substances, the blame should not be placed on them as individuals but rather on the wider society that fails to provide comprehensive care for the most vulnerable. Improvements in the use and availability of community treatment and inpatient treatment, including extended inpatient admissions when needed, reduce criminality of severely mentally ill persons (Lamb and Weinberger, 2005). Persons in this category should be treated as diseased individuals in need of care rather than criminals to be arrested, charged, and convicted.

Another important reason to dismiss the minor criminality of persons with severe mental illness is the negative effect of stigma (Goffman, 1963). Both “mentally ill” and “criminal” are stigmatizing labels, so mentally ill offenders have a double stigma attached through institutional records of them as cases. The offender-as-case is represented beyond the mental health court to other institutional workers, and such textual representations result in stigmatizing labels following an individual to various settings. There is no question that a criminal record, especially a felony record, affects the ability to obtain employment, meaning mentally ill individuals have their difficulties in finding employment compounded when they gain criminal records. Lamb and Weinberger (2005) contend that new technology allowing easy access to electronic criminal records for police and courts is problematic for persons with mental illness, because a record of arrest may influence the decision to choose the criminal justice system over the mental health system when encountering mentally ill individuals. Authorities need to reconsider how persons with severe mental illness are affected by
criminal charges, and work toward dismissing their criminality if victimization of other individuals or violence is not at issue. When retail theft occurs, the company owning the store is victimized. However, if companies have a problem with dismissing charges against persons with mental illness who commit minor theft, then perhaps a law could authorize a tax break for the company to cover the losses from minor crimes when charges are dismissed for mentally ill individuals.

The changes I suggest above may be viewed as unrealistic, but I firmly believe that if we are to make a real impact with approaches to the problem of persons with severe mental illness in jails and prisons, then we must dramatically improve mental health services overall, prioritize those most in need of treatment, and recognize that the criminality of many persons with mental illness is the result of disease rather than moral failing. I end this dissertation with a suggestion for future research of mental health courts. Numerous studies have been conducted over the past ten years evaluating their effectiveness. But the large majority of studies look within the programs for evaluation, determining whether or not those who become involved in the programs are successfully impacted. I suggest that more research is needed to explore how mental health court programs affect the wider context of mental health services in a locality, as well as to explore how those with severe mental illness and charged with crimes who are unable to apply to the MHC program, or who are unable to perform at the referral stage or the programming stage, may be diverted successfully from the criminal justice system.
Focus Group Interview Questions for Mental Health Court Team Members

1. How was the MHC in this jurisdiction created? What was the impetus or driving force for its creation? How was it conceived and implemented?

2. How does the mental health court operate? Can you describe its organization and how it functions?

3. Can you describe how a person becomes a participant in the mental health court and what then happens?

4. How are clients assessed when they enter the MHC program? How are their needs identified?

5. How are client service plans developed? Who are the professional role players in service planning? How are clients provided services?

6. Who is responsible for case management? How does this role player coordinate services from various providers? How does this role player work with the judge in motivating clients?

7. How are clients monitored? What type of sanctioning is used when clients are non-compliant? How are clients terminated, and how often does this occur?

8. Can you describe the relationships between the clients and the MHC team? How much contact do clients have with the team? What is the quality of those contacts?

9. Can you describe the collaboration that goes on between the MHC team and criminal justice partners that you work with? Are there any issues limiting the level of collaboration with criminal justice partners?

10. Can you describe the collaboration that goes on between the MHC team and community partners that you work with, such as service providers and client advocates? Are there any issues limiting the level of collaboration with these groups?

11. Has there ever been an issue with a lack of services? Can you describe the issue or issues? How were service gaps filled?

12. Can you describe the communication and information sharing that goes on between team members? How have clients and client advocates played a role in these communicative processes?
13. Can you describe a particularly problematic case in the mental health court? How was the case resolved or what was its outcome? How might the problem be avoided in the future?

14. Can you describe a particularly successful case in the mental health court? How was it successful?

15. How successful has the mental health court been since its inception? What are the current issues facing the mental health court?

16. How has the mental health court changed since it began?
REFERENCE LIST


VITA

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