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Professional Interaction in Mental Health Courts: Processing Defendants with Mental Illness

Monte D. Staton

University of Illinois at Chicago, staton@uic.edu

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Abstract

In this paper, the author presents ethnographic research and analysis of how criminal justice and mental health professionals interact with each other and with criminal defendants with mental illness in running a mental health court (MHC) program. Ethnographic field research included observations of court programs, interviews of professionals, and gathering of textual documents, at nine MHCs in a Midwestern state. In MHC criminal defendants with mental illness participate in a program of regular court appearances, probation supervision, and mandated treatment, rather than being incarcerated in jail or prison. The author utilized the symbolic interaction perspective and examined how the professionals work together to select participants and judge their performances. Professionals interact and share case documents in socially constructing the participant. They operate the program as a filter so that a relatively small number of the population of incarcerated persons with severe mental illness in the state successfully graduate from the program. Implications of these findings are discussed.

Keywords

Mental Health Courts, Professionals, Interaction, Ethnography

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Professional Interaction in Mental Health Courts: Processing Defendants with Mental Illness

Monte D. Staton
University of Illinois at Chicago, USA

In this paper, the author presents ethnographic research and analysis of how criminal justice and mental health professionals interact with each other and with criminal defendants with mental illness in running a mental health court (MHC) program. Ethnographic field research included observations of court programs, interviews of professionals, and gathering of textual documents, at nine MHCs in a Midwestern state. In MHC criminal defendants with mental illness participate in a program of regular court appearances, probation supervision, and mandated treatment, rather than being incarcerated in jail or prison. The author utilized the symbolic interaction perspective and examined how the professionals work together to select participants and judge their performances. Professionals interact and share case documents in socially constructing the participant. They operate the program as a filter so that a relatively small number of the population of incarcerated persons with severe mental illness in the state successfully graduate from the program. Implications of these findings are discussed. Keywords: Mental Health Courts, Professionals, Interaction, Ethnography

Mental health courts (MHCs) are specialized criminal court programs established and run by criminal justice and mental health professionals for criminal defendants identified by the state as having mental illness. A limited number of such defendants become referrals to MHC if their respective cases meet qualifications for participation, and a smaller number are selected to become participants. MHCs aim to divert defendants with mental illness away from incarceration and toward community mental health treatment. Cases are processed by requiring that defendants have mandated mental health treatment monitored regularly through court hearings in which a judge imposes sanctions for non-compliance with treatment plans (Goldkamp & Irons-Guynn, 2000). In this paper I present ethnographic research and analysis of how criminal justice and mental health professionals work with each other and with defendants with mental illness to run an MHC.

The criminal justice and mental health systems are based on two different social constructions of human behavior. In criminal law, human behavior is understood from a perspective of moral reasoning where people freely choose their own behavior, which may be good or evil. By contrast, in behavioral science the causes or reasons for behavior are explained by considering psychological, biological, and social factors in a person's history (Erickson & Erickson, 2008). In MHCs, professionals from two institutions with differing perspectives on human subjects speak with each other during staff meetings, court calls, and other times using the language of professional criminal justice and mental health discourses while sharing understandings of how to process defendants in everyday work activities. Through ethnographic observation, I found that entry and progress in the program for the individual defendant is largely centered on important professional judgments. Professionals interact with criminal defendants with mental illness and make crucial decisions regarding acceptance of referrals and progression of program participants. Of course, when MHC professionals interact

with criminal defendants, the defendants make judgments about the professionals' work. But there is a fundamental asymmetry of power (Goffman, 1956) during interactions between MHC professionals and criminal defendants with mental illness. In MHC, professionals make judgments of defendants at key moments affecting program entry and outcome. The defendants with mental illness, on the other hand, have very limited and sometimes coerced choices, as the alternative to MHC is incarceration.

The ethnographic research and analysis that I present here focuses at the level of interaction within the MHC program, investigating how it is organized and run by criminal justice and mental health professionals working together to process defendants with mental illness. The aim of ethnography is to see the field setting through the eyes of the people who are engaged in the social action (Hammersley & Atkinson, 1995). Doing ethnography, a researcher does not test hypotheses, but can enter the field asking basic research questions (Warren & Karner, 2010). Two primary questions of this research were: (1) How do mental health and criminal justice professionals work together in running the MHC program? (2) How do professionals understand and process the criminal defendants whom they encounter? In the analysis I utilize concepts of Goffman's symbolic interaction perspective and research on professional work and textual processes in institutions. Goffman (1959) presented a framework by which human interaction based on shared understandings may be analyzed dramaturgically as the performance of roles on various stages. Criminal justice and mental health professionals play their roles from different institutional backgrounds and operate the MHC program through processes of interaction which share language and contain shared understandings, used in specific ways in specific contexts - such as the back stage (Goffman, 1959) of the staff meeting interacting with each other or the front stage (Goffman, 1959) of the courtroom interacting with participants. The present analysis also includes textual processes that provide legitimacy for professional actors and occurred as part of the observed interaction.

In this paper, I expand on the existing body of knowledge regarding MHCs by detailing, at the program level, the micro- and meso-interactions (Fine & Hallett, 2014) of professionals of different institutional backgrounds while working together and sharing understandings regarding defendants with mental illness. In the following background section, I cover prior research, followed by a methodology section in which I provide description of the ethnographic method utilized in studying nine MHCs in a Midwestern state. (All names of geographic regions and persons in this paper are pseudonyms.) Next, I present findings revealing how, in everyday work, MHC professionals interact with each other utilizing criminal justice and mental health terminology, share official documents, interact with referrals and participants, collaborate to make performance judgments of each, and run the program as a filter. These judgments may be affected by the personal story of the defendant learned by professionals over time. I conclude the paper with discussion of the implications of findings and criticism of how MHCs approach the problem of persons with severe mental illness (PSMI) in the criminal justice system.

Background

The problem of increasing numbers of PSMI being arrested and appearing in criminal courts developed after deinstitutionalization was put into effect in the 1960s and 1970s. Hundreds of thousands of PSMI were released from confinement and into communities across the country, ostensibly to be cared for by community mental health centers providing treatment and medications (French, 1987). However, law enforcement officials became the de facto managers of PSMI living in the community who were not receiving enough involvement from community mental health workers (Kiesler et al., 1983). Many encounters between PSMI 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 & Irons-Guynn, 2000).

MHCs are part of a broader category of specialized criminal courts described in academic literature as “problem-solving courts” (Berman & Feinblatt, 2005). Specialized criminal courts have been introduced by numerous criminal justice systems throughout the United States to deal with various social problems, including domestic violence, drug addiction, and mentally ill persons in criminal justice. 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). An important element of problem-solving courts is the relational approach whereby the judge establishes a personal relationship with each individual participant over repeated court hearings (Stefan & Winnick, 2005).

Following the establishment of drug courts, specialized courts for defendants with mental illness were established and have grown to more than 300 throughout the U.S. (Strong, Rantala, & Kyckelhan, 2016). In MHCs, a limited number of defendants diagnosed with mental illness become referrals if their respective cases meet qualifications for participation, and a smaller number are selected to become participants. MHCs were initially designed to hear misdemeanor, non-violent cases of PSMI, but as the programs developed, they began accepting felony cases, including some defendants charged with violent offenses (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005).

Although the evidence is mixed (Sarteschi, Vaughn, & Kim, 2011), a number of studies have demonstrated how MHCs reduce recidivism (e.g., Burns, Hiday, & Ray, 2013; McNeil & Binder, 2007). However, Wolff (2002) suggests that selection bias is present regarding those who enter MHCs, such that more capable individuals enter the programs relative to PSMI who undergo traditional criminal justice processing. Wolff, Fabrikant, & Belenko (2011) found variation in selection processes of six MHC programs they studied. Ineligibility was mostly determined by criminal offense and history, psychiatric disorder, and motivation of the defendant. Self-selection bias is present, as participants more amenable to treatment enter MHC programs, while other selection biases include judge opinions after meeting with referrals, and specific available treatments in the jurisdiction. MHC studies may find reduction in recidivism and benefits for participants, but the programs serve less than 2 percent of the target population in those jurisdictions where they exist, and participants may not be those most impacted by criminal justice involvement and a lack of services (Wolff, 2017).

Gallagher, Skubby, Bonfine, Munetz, and Teller (2011) interviewed 59 professionals working in 11 MHCs and explored how professional staff understand the goals of MHC, their own professional roles, and the roles of other team members. They found that the various mental health and criminal justice professionals understood each other’s roles and shared a common goal of serving participants’ needs. The professionals were aware of the different orientations of criminal justice and mental health but believed them to be beneficial in that a balanced approach could be applied to MHC participants (Gallagher et al., 2011). But the study did not include field observation of the professionals in everyday work, including their decision-making interactions.

The available research regarding mental health courts is mostly descriptive and written from a legal, psychological, social work, or criminal justice practitioner perspective (see for instance Hughes & Peak, 2013; Redlich et al, 2005; Seltzer, 2005). With this paper I aim to add to the literature by providing in-depth qualitative exploration of professional work in MHCs from a sociological perspective. I contribute to scholarly understanding of MHC processes with these findings and provide insight into how these courts work with defendants with mental illness and their complex issues. I also hope to inform those criminal justice and mental health professionals who work in MHCs or may be considering the use of MHC

programs. With an enhanced understanding of MHCs, professionals may be aided in determining how best to run the programs, or whether or not MHCs best promote the interests of defendants with mental illness.

The research and analysis presented here was made possible because, as a graduate student of sociology, I assisted my mentor in designing a multi-faceted, state-funded study of MHCs in which I was the only field researcher. This allowed me to conduct the field research piece of the overall study as an ethnographer immersed in the work world of mental health and criminal justice professionals at each MHC. One reason for this approach is that I had past years of experience as a mental health worker before becoming a graduate student which I could draw on to build rapport with professionals at the sites. It was my hope that, in carrying out the field research, I could explore new territory in the scholarly research on MHCs.

Methodology

In this paper, I present analysis of qualitative data that I collected as part of a larger, funded, state-wide study of MHCs, including ethnographic observation, interviews, and textual documents. We designed the overall study to be comprehensive and collect both quantitative and qualitative measures. Qualitative methods of observation allowed for exploration of how the professionals in MHCs conducted and understood their work with defendants with mental illness. By doing an ethnography, I could study how MHC professionals did their work and interacted with defendants with mental illness and attempt to understand MHCs and defendants from the perspective of those who ran the programs. Observational field methods are particularly suited for research from the perspective of symbolic interactionism (Rudy, 1986), which I utilized for analysis. Symbolic interactionists study 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). By conducting individual and focus group interviews of the professionals, and gathering textual documents used in the programs, I was able to triangulate the data, which strengthens the validity of findings (Berg, 2009).

All methods were approved by a university Institutional Review Board as well as the state funding agency. For this study, I focused the qualitative research and analysis within the MHC program at the level of interaction. To begin the larger study, we conducted a state-wide survey of Midwestern criminal court jurisdictions identifying nine existing MHCs, each having been in operation for at least a year, and each located in one of eight counties in the state: Collins, Ferry, Gabriel, Gilmour, Hackett, Manzanera, Lynne, and Waters: one program in Bevan City and one in the suburb of Tandy. Officials at each of these sites gave permission to conduct further data collection, and I made multiple site visits to each program. I conducted field observations, including staff meetings and court calls, and spent time before and after these events with professionals at their work sites. There was a total of 90 site visits that I made for observation, with each site observed at least twice, and six sites observed eight or more times. In writing ethnographic field notes, I focused on the work activities of MHC professionals as they interacted with each other during staff meetings and court calls, and with participants before and during court calls. I took field notes during each observation and added extensive detail shortly after. Additionally, I utilized open-ended questions for focus group interviews at each site, exploring how professionals conducted MHC, and included a total of 82 criminal justice and mental health professionals: judges, assistant state's attorneys, public defenders, probation officers, court administrators, social workers, psychologists, and nurses. Additionally, key professionals participated in fourteen individual follow-up interviews conducted to clarify items and delve deeper into processes discussed during focus groups and observed during staff meetings and court calls. Finally, I gathered textual materials such as

official forms, unofficial meeting agendas, and court literature from each of the sites and added these to the observational and interview data for analysis.

I also made observations of MHC referrals and participants and conducted survey interviews of participants at three sites with a total of 30 participants, including all in the smallest MHC. However, I focused the ethnography on the perspective of professionals rather than program referrals and participants. This occurred for a number of reasons. A major goal of the state-funded research was to study how professionals had organized and were operating MHCs, thus focus groups were conducted at each site. Also, field observations at each site included attending the staff meeting limited to professionals only and then attending a court hearing with defendants and others present. This allowed for a backstage view of professional work in small group interaction followed by related front stage presentation in court (Goffman, 1959). Finally, during field observations I occasionally talked with defendants, but developed more in-depth rapport with a number of professionals who often talked to me informally. I introduced myself to them as a researcher on a state-funded study of its MHC programs. One way I developed rapport was to talk of my past work in vocational programs for adults with mental illness before becoming a researcher.

I analyzed the qualitative data from my field research by pooling interview transcripts, field notes, and textual documents in Qualrus, a qualitative analysis software program that enables line-by-line coding, memo writing, comparison, and the development of linkages and themes. I focused the data analysis on processes occurring within MHCs as professionals did their everyday work. After focused coding, I developed a thematic narrative (Emerson, Fretz, & Shaw, 1995) to explain how professionals work together and process defendants with mental illness. In the findings below, I present the collective story of how MHC professionals do their work with defendants with mental illness and analytic description of the program (Warren & Karner, 2010).

Findings

In this section, I describe the organization of MHC and present a conceptual sketch of the professionals and defendants with mental illness engaged in interaction. I also examine professional work activities, including judging referral acceptability, encouraging success and sanctioning bad behavior, judge's use of emotivism, learning a defendant's story over time, using value dichotomies, and making performance judgments allowing MHC to operate as a filter.

The Organization of MHC

The periodic MHC hearing is the organizational basis for each program. Professionals at each MHC hold a staff meeting before each hearing during which they discuss new referrals and current participants. Each of the programs followed the same model in which one of the professionals, typically holding a job title of "Program Coordinator" or similar, is the organizer of the program, and filling a boundary spanner (Steadman, 1992) work role as a bridge of communication between the criminal justice and mental health professionals. The Program Coordinator accepts written applications from defendants charged with crimes. These applicants are known as "referrals." The assistant state's attorney working MHC screens applicants first for legality and acceptability of case, then remaining referrals are discussed by the MHC team during staff meetings. Newly selected defendants agree through signed documents formally recognized by the judge during a court hearing to participate in the program for a year or two by following a treatment plan and other requirements.

Participants meet regularly with probation officers who monitor for the court, and with social workers and other mental health professionals who may directly provide mental health treatment services or serve as case managers linking participants to services. Probation officers and social workers in MHC play the most important monitoring roles, meeting with the participants often during individual appointments and service activities in between court hearings. The probation officer is responsible for monitoring for the court, while social workers are responsible for writing mental health treatment plans which are court mandated. Typically, a probation officer and social worker work together to form a monitoring dyad for each participant. Each MHC also has a public defender to represent the legal interests of participants. MHCs are non-adversarial programs, meaning that defense and state actors work together in the interests of the defendant. When participants enter MHC, they generally are transferred from an adversarial public defender to the MHC public defender working as part of a collaborative team of professionals. The MHC public defender serves a role as legal representative of defendants during staff meetings and court hearings, but some public defenders work with probation officers and social workers in monitoring and assisting defendants outside of court. Monitoring professionals report on the progress of each participant during staff meetings, which include the judge, and after discussion a plan is made so that professionals present a unified front during the court hearing.

MHC participants are required to attend periodically held hearings and appear before the judge to discuss progress in following program treatment guidelines since the most recent court appearance. The judge's personal relationship formed with each defendant during hearings is a primary component of MHC, thus the judge role is symbolic of state power and highly influential in motivating the defendant.

Participants begin the program by being required to attend every MHC hearing, which may be weekly or bi-weekly. The MHC professionals in the staff meeting before each court hearing discuss characteristics of referrals and the recent progress of participants and determine how the judge and others should respond to each of them during the court hearing. If performing adequately in the program, judges allow participants to attend MHC hearings less frequently as they progress. Over time a participant either succeeds in the program in the eyes of the professionals and graduates in court during a formal ceremony or is terminated from the program as an unsuccessful outcome. The judge may terminate the unsuccessful participant and consider time served on probation as adequate, transfer the case to another type of probation for further supervision, or sentence the unsuccessful participant to incarceration in jail or prison.

A Conceptual Sketch of MHC Interaction

I observed personal interactions in MHC as professionals did their everyday work, and in doing so noted the constant use, sharing, and discussion among professionals of documents tied to an individual defendant. This was especially true of staff meetings, where criminal records, court records, mental health assessments, criminal risk assessments, program applications, treatment plans, and progress reports on each individual defendant were freely shared. The sharing of information is made possible by having defendants sign waivers to release information. It seemed two forms of interaction were occurring simultaneously. There was the social, personal interaction among professionals and between professionals and defendants, and another type of interaction centered on each defendant that occurred among professionals as they shared textual documents and created the official case.

Personal interaction. Personal interaction occurred in MHCs as professionals engaged in direct, shared communication with each other and with each referral/participant, primarily

face-to-face conversation during private appointments and before, during, and after staff meetings and court calls. Many professional interactions away from the court with each other or with participants were not observable given limits on my data collection to staff meetings and court calls. But during observations and interviews I was able to gain information about work 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.

During field observation and focus group interviews there was little dissent among professionals as they personally interacted, although at times they disagreed. Professionals of one institution shared vocabularies of another. For instance, criminal justice professionals freely discussed mental health symptoms of defendants, while mental health professionals would refer to levels of criminality during staff meetings. At times, debate might ensue about whether a given defendant was a "criminal" who makes immoral choices, or a diseased person whose bad behavior is due to mental illness. But such debates did not fall neatly between professionals of criminal justice on one side and mental health professionals on the other. Often, the professional asking that bad behavior be excused was one who had spent most time learning the story of the defendant in question, such as the probation officer or social worker. There were disjunctions between criminal justice and mental health views toward human behavior among professionals, which I will return to below, but little open conflict. Overall, professional interactions observed in MHC were very friendly, cooperative, and collaborative.

During their interactions with professionals, referrals and participants engage in impression management (Goffman, 1959) in an asymmetric relationship (Goffman, 1956) in which professionals have power to define the relationship and control activities. In Midwestern MHCs these power relationships are overlaid with demographic characteristics of race, gender, age, and class. For example, all of the MHC judges were older and white; seven were male and two were female. All of the assistant state's attorneys (ASAs) were white. The vast majority of social workers were women, and more often African American than were other professional roles. The survey revealed that, although some MHCs are in predominately white jurisdictions, African Americans were overrepresented among participants relative to their prevalence in local populations, especially in the Bevan City MHC, while Asians and Hispanics were underrepresented across programs. Women were 46% of all participants, an overrepresentation relative to their numbers under supervision by state and local criminal justice agencies. Adults 35 and younger were overrepresented among participants relative to local population, as is common in criminal justice. Although some MHCs were in relatively affluent areas, in only a small number of cases were participants able to afford a private attorney, while the vast majority relied on public defenders.

Goffman's (1959, p. 22) "performance" referred to how the individual as an actor conducts her activities to influence other participants in a given situation of interaction. The individual criminal defendant performs in personal interaction when applying to the program as a referral, and, if admitted, when participating in the program. During appointments and court appearances, a referral must interact with professionals in such a way that they are persuaded that the referral could perform and would benefit from participation if accepted into MHC. A participant must display a willingness to give effort and to acquiesce to professional instruction in order to move further toward graduation, and to mitigate any indiscretions which might be committed. These interactions also involve the professionals preparing texts for the specific case of the defendant, such as the filling out of court forms or conducting of mental health assessments. Regardless, each personal interaction offers the professional an opportunity to get to know the embodied defendant in some way, and to judge her or his behavior, condition, and appearance. These interactions affect how textual documents are completed by

professionals and also affect the feelings and opinions the professionals have about the defendant. The performances of referrals and participants during personal interaction with professionals are crucial determinants of how far a defendant identified as mentally ill may move through the MHC program.

Goffman (1959) described how an individual performer in a social interaction uses a “front” (p. 22), 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. MHC professionals were mostly white, although a number of probation officers and social workers were African American and were typically dressed nicely ranging from business casual to suits. They carried briefcases and documents and approached defendants directly while taking charge of the situation. Referrals and participants varied in age, but for many their elements of personal front, such as shabby clothes and jail scrubs, or their minority status, marked them as lower-class and as criminal defendants. 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. Some defendants displayed problems with personal interaction, such as the disorganized speech associated with schizophrenia, but were praised by the judge during the hearing for their good performance in the program. However, often 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 negatively by the professionals, and were sometimes terminated from the program if they did not display improvement during personal interactions over time.

Textual interaction. Intertwined with personal interaction, other social activity that was notably important occurred in the use of official and unofficial documents by professionals who worked together with each individual case. During observation of staff meetings, court calls, and time before and after hearings, the use of textual documents by professionals was ubiquitous. Professional work is recognized by institutions as legitimate through textual documentation that draws from the abstract knowledge system of the professionals’ discipline (Abbott, 1988). Court orders, mental health assessments, drug test results, criminal records, and many more professionally produced documents are made available among professionals in varying contexts. To clarify, the research presented here did not involve a comprehensive examination and analysis of the content of all documents professionals used; such an undertaking would not be possible due to labor, time, and privacy constraints. Rather, in this ethnographic analysis of MHCs, what is emphasized is the *process* of professionals communicating with each other and shaping their collective judgments of performance of referrals/participants through the use of texts. Professionals regularly find, read, prepare, share, alter, and utilize bureaucratic documents that refer to each individual referral/participant, and through which, from criminal justice and mental health perspectives, they share understandings about cases and accomplish their processing. Each professional may not have exactly the same group of textual documents for each defendant, but often they share the same documents. The defendant-as-case exists in textual documents and performs in a sense during referral to and participation in MHC. Generally, when making professional judgments during staff meetings, the two types of professionals come to an agreement regarding the specific mental health and criminal qualities of each defendant by discussing events and sharing documents.

Smith (2005) described the importance of textuality for coordinating the work of institutions, as workers use institutional discourse in texts to describe actualities of experience so that they become actionable. Through textual documentation professionals make possible and legitimize their work while they also share information and collectively shape how each

defendant is understood in relation to the MHC program. Over time, MHC professionals who work together do not just share past documentation of each case; they also continuously produce new texts that are shared, utilized in the program to accomplish actions (e.g., obtaining services, having an defendant jailed), and affect the production of future documents by various MHC professionals and other institutional workers. This textual process is interactive as professionals at each MHC communicate through their use of texts and work together to shape each textually represented case.

Conceptual sketch. Figure 1 below presents a conceptual sketch of how criminal justice and mental health professionals engage in interactions within MHC resulting in the textual construction of the defendant, a social construction collectively made and shared by professionals. The figure does not represent a closed system of interaction, nor is it meant to suggest small groups of three. Rather, it displays personal interaction between the criminal justice and mental health professional, personal interaction of each type of professional with the individual defendant, and individual case texts of two different institutions being shared by professionals as part of interaction in understanding the defendant. The embodied defendant is always linked to her case through some form of identification, for example name, case number, or birth date. Professionals engage in direct personal interaction with referrals/participants and with each other, and also communicate with each other through the defendant-as-case as they gather, read, share, and add to textual representations of the defendant.

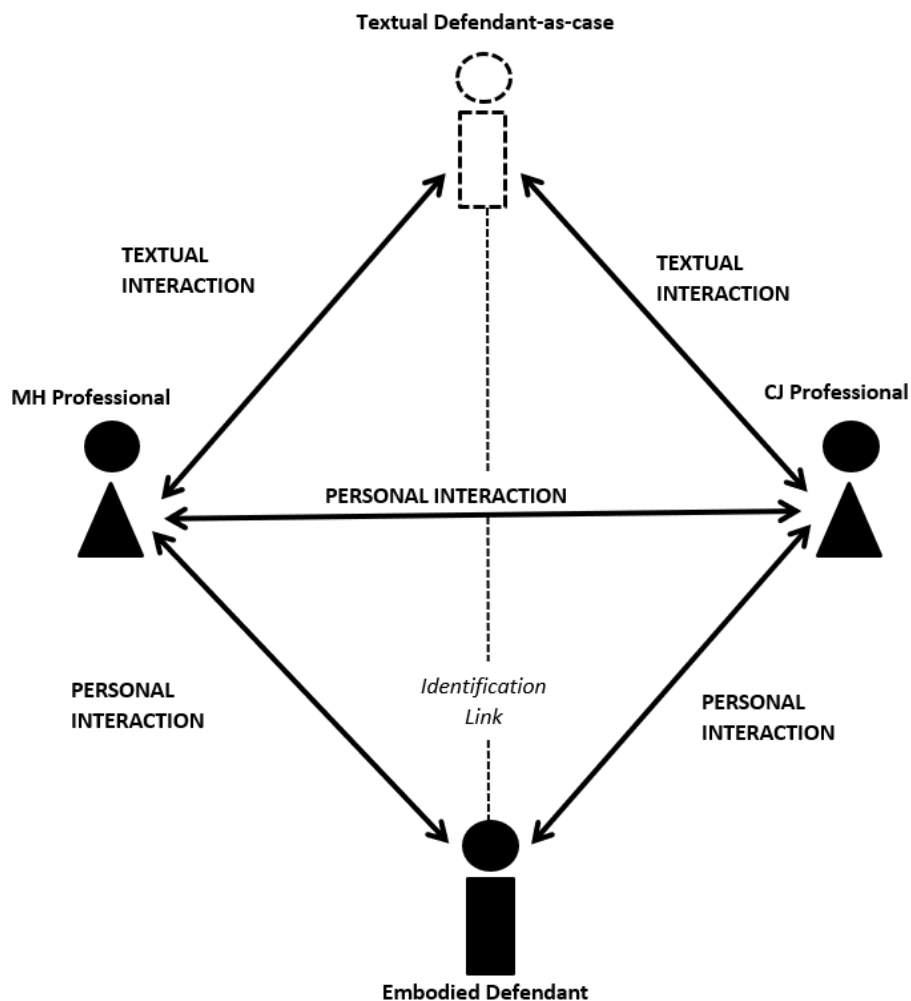


Figure 1. Conceptual sketch of MHC interaction.

Smith (1990) argued that particularities of individual context are erased from institutional accounts in texts. Across MHC sites the professionals spoke and wrote of groups of individuals known as “mentally ill offenders” who had “schizophrenia” or “depression” or some other acceptable “mental illness,” and who were “non-violent” or “violent” offenders and may be “substance abusers.” On entering MHC defendants 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 professionals continuously construct the defendant as a case by developing a set of documents which often contain an individualized story unique to the defendant. For instance, one MHC had an “intake form” shared at meetings which included items such as criminal offense but also had a narrative section in which the Program Coordinator presented a brief summary of the defendant’s current employment, financial, housing, and family situation. Events of personal interaction combine with textual interaction through construction of the defendant-as-case, and the unique, personal story of each defendant becomes part of the professionals’ shared work knowledge. This analysis does not suggest that the textual representations are entirely accurate. Gubrium, Buckholdt, and Lynott (1989) reveal how the production of human service bureaucratic documents such as treatment plans and progress reports must meet reporting expectations of chronology, acceptable style, and interpretation of client need, but may not reflect the actual reality of the client’s situation, or of events that occur between worker and client. MHC professionals prepare and share documents on each defendant that fit the organizational process. These documents may gloss over realities of the defendant’s life, but the use of case texts combined with repeated personal contacts develop increased understanding for professionals of each defendant over time.

Professional Work in MHCs

Judging referral acceptability. Determining a referral’s willingness to put forth effort in the program was an important part of judging a referral’s acceptability to MHC, in addition to the screening of the referral’s criminal charge by the assistant state’s attorney and documenting the level and validity of mental illness. A mental health professional conducts and documents an assessment as a clinical means to determine a referral’s appropriateness. Professionals must find that a participant has a valid and acceptable mental illness to justify acceptance into the program. But the MHC team does not want to accept referrals with mental illness so severe that they are not able to do the program. In the following interview excerpt from Lynne County, Judge Sentzsky describes the importance of finding referrals who have valid mental illnesses but are not too mentally ill to perform:

Judge Sentzsky: 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.

Five of the programs did not accept defendants with personality disorder. In the following interview excerpt Dr. Peete, the head court psychologist from Gabriel County, explains why personality 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. 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 or collectively made. In the following field note 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 if that is 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."

The judge, attorneys, and social workers discussed the referral in the previous staff meeting as an acceptable case for MHC. But 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 during the hearing 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 such as depression and 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 program success and sanctioning bad behavior. Professionals in MHCs utilize the process of court adjudication to affect change in participants by rewarding good progress and sanctioning problematic behavior. 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 but listens to input from other professionals and usually follows their advice regarding how to deal with a given participant. 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 (e.g., missed appointments, failure to take medication) will receive some type of punishment from the judge. 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. 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, a short, older, white man with thinning white hair and glasses and seated at his bench in black robes, calls a name, and the man in the shabby black suit gets up from the audience area and moves before the judge's bench. 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 been living in a residential home allowing freedom to leave during the daytime. But when meeting with his probation officer he tested positive for cocaine and went back into the county jail's medical facility for what was likely a ninety-day stint. The wearing of the suit may have been his attempt to avoid going back to jail. 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. Jail was utilized as a sanction at all but the Gilmour County MHC, but professionals described using it sparingly, and only for the most serious misbehaviors.

Judge relationship with defendant and emotivism. Hochschild (1979) expanded on Goffman's analysis by considering emotional processes within the individual during interaction, recognizing social structural determinants of individuals and situations in which their interactions take place. She introduced the concepts of "feeling rules" and "emotion work" (Hochschild, 1979, p. 560). A feeling is appropriate in a given situation based on "feeling rules," social guidelines for how one should feel in a given situation (Hochschild, 1979, p. 560). "Emotion work" refers to how individuals in certain work contexts must act by changing their emotion or feelings (Hochschild, 1979, p. 561). MHC professionals engage in emotion work, such as displaying happiness during a court hearing when a participant has been doing well or displaying disgust when a participant has gotten into trouble. 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. In MHC, referrals and participants need to follow feeling rules if they are to conduct a good performance during personal interaction with professionals. When considering 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 MHC. On being verbally sanctioned by the judge, a participant who has misbehaved should display a somber attitude in recognition of the gravity of the mistake and in acknowledgment of the need to improve.

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 refers to the agenda and names participant 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. Judge Harrington says Bill had to learn to expect monitoring at all times. The judge also says that he thinks Bill will now improve, and looks around the conference table at the other professionals. He says "You've all done a great job [working with Bill]. Do you agree?" and looks 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 twelve-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 black 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 eight 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." But then 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. The 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 him. Bill thanks the judge, says something quietly to Martin, then turns and leaves the courtroom.

The preceding is an example of the personal relationship between judge and defendant considered in the literature as fundamentally important for problem-solving courts (e.g., Miller & Johnson, 2009; Stefan & Winnick, 2005). Judge Harrington is stern, dramatic, and intense during the interaction with Bill. The judge also refers to substance abusers eventually reaching their "bottom," using the language of twelve-step substance abuse programs (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. The language of twelve-step programs is an important part of the work vocabularies used by MHC professionals.

Learning the defendant's story over time. Some referrals to an MHC are already known by several of the professionals of the program, being long residents of the county who have already received local services or were already known by the judge or other criminal justice workers for prior arrests. But many professionals learn the in-depth story of defendants over time during the MHC process. During counseling sessions, group sessions, case management and probation appointments, public defender meetings, service assistance, and, for the judge especially, court hearings, the various professionals get to know the individual participant on a personal level that goes far beyond professional discourse of mental health or criminal characteristics.

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. Similarly, professionals in Midwestern MHCs learn a unique story from each defendant over time during a series of interactions that allow

for evaluation of potential or actual program performance. The longer the period of time in which professionals interact with mentally ill defendants, the more in-depth the story learned. Social workers and probation officers are the two professionals most involved in learning and sharing the defendant's story. The story must be acceptable to the professionals on a moral level, meaning that the defendant may have some missteps during MHC participation, but these are forgiven as long as the defendant accepts sanctions and continues participation in an acceptable way. Dunn (2010) refers to vocabularies of victimization utilized by attorneys representing cases of battered women in court, as these attorneys tell each woman's story using the vocabularies in a way portraying her as victim. The story of each MHC referral and participant is shared among professionals using vocabularies of program performance in addition to other vocabularies drawn from criminal justice and mental health discourses. Whether known beforehand or through referral and participation in the program, if a professional learns the story of an 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 field note 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 learned the story of a problematic individual on a personal level, and defends him as they debate how to sanction him:

The professionals are all gathered at a conference table for their staff meeting. All are white, most are middle-aged to older, and several are dressed in suits. Tina is the MHC program coordinator and probation officer, a woman in her early 30s who looks down at the staff meeting agenda, names Nasir, and begins explaining that he recently dropped by her office without an appointment. Nasir admitted that he had forged the signature of a counselor to fake verification that he had attended a group therapy session. Dr. Peete, court psychologist, says "Boy, that is popular" because it happened with other participants. Tina already knew about the forgery, and said that Nasir had also missed another group because, as he explained, he took too many Tylenol PMs the night before. Tina explained to Nasir that forging a signature is a criminal offense, and they would have to sanction him. She 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.'" A clinical social worker who serves as consultant, Dr. Hammond, advocates that Nasir "lose a level," meaning he be moved down in the MHC program, increasing his time in the program and moving him further from graduation. Dr. Hammond explains that MHC should sanction bad behavior in order to encourage change in participants. Tina counters that lesser sanctions have worked well 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 man, says "I agree with Dr. Hammond. We should put him back to level two." Mike, the probation supervisor, a 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 attending court more frequently could hurt his ability to keep the job. She says emphatically "This court isn't about limiting opportunities." 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. 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 wryly and explains he may 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 does criminal behavior.” 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, 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 male psychologist, comments “I think he [forged the signature] because he was frantic, not to manipulate.” Penny, a 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 has to attend the MHC hearing every 2 weeks rather than once a month. They settle on this. Tina adds that 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 learned the personal story of Nasir to the point of excusing his misbehaviors, although she does not ignore how they represent his need for more mental health treatment. She is also culturally sensitive in sharing the story. Dr. Hammond is concerned about use of sanctioning for bad behavior, while Dr. Peete, Adam, and Penny debate criminality as a characteristic of Nasir. Personal interaction is fundamentally important in learning the defendant’s story over time, but textual processes are also important. For professionals, repeated interactions lead to meaningful understanding of the embodied

defendant that affects how they judge him, how they work with him, and how they represent him in writing.

“Bad” versus “mad” and other dichotomies of performance judgments. During observation of a hearing in the Bevan City MHC, located in a large, urban county in Midwestern, a young white male participant was called before the judge, and Phil, the program coordinator, turned toward me and explained in a whisper that the participant was being released from the MHC program because “he just can’t keep out of trouble.” Phil explained “It’s not that he is defiant, it’s just that he can’t *do* the program” [emphasis in original speech] because he is too mentally ill to improve. Later, during the same hearing, a middle-aged black male participant was called before the judge, and Phil leaned over to me explaining “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]. In describing the two unsuccessful outcomes, Phil indicated 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 who are incapable of working the program despite their best efforts. The dichotomy displayed is that 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 & Schneider, 1992, p. 1). Professionals judge participants in terms of disease, but they also judge in terms of moral choices of free will by which participants could work and be successful graduates.

Professionals may draw their judgments of criminality about a particular individual from multiple sources. Those working in criminal justice contexts are able to access the criminal background, including a record of arrests and convictions. Criminal records are shared among professionals at MHCs and are an important part of their understanding of each participant. Additionally, some of the mental health professionals perform psychological tests with referrals, or set up such testing indirectly, and the results of such testing are then added to the other textual documents representing the defendant-as-case and shared with the other MHC professionals. Both criminal justice and mental health professionals consider the level of criminality of each referral or participant and distinguish this from the level of mental disease. The professionals share understandings containing a subtle calculus in which health and moral factors are combined in making judgments. In various contexts, understandings of the mentally ill defendant as diseased individual mitigate understandings of the defendant as moral actor. When professionals decide how much to hold a mentally ill defendant 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 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 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 file folders in front of her. She is a

middle-aged 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 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, an older woman seated at the other end of the conference table, asks "Yeah, are there borderline issues?" referring to borderline personality disorder. 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, a state's attorney, 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 state's attorney, 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.

Badness versus sickness is a fundamental vocabulary of performance. Although professionals displayed nuanced understanding of moral and mental health factors in individual cases, dichotomous decisions based on performance judgments, such as whether or not to accept a referral, or whether or not to terminate a participant, often required the use of badness versus sickness and other dichotomous vocabularies: genuine versus manipulative, invested versus non-invested, able versus unable, hard-working versus lazy, coachable versus not coachable, and others. These other dichotomies can be connected to the fundamental judgment of badness versus sickness.

Vocabularies of performance are reflective of professional and wider cultural values. Each MHC has its own organizational or workplace culture (Volti, 2008), but isomorphic processes make these localized cultures similar within a field of organizations (DiMaggio & Powell, 1983). Fine and Hallett (2014) stressed the importance of considering meso-level group culture and interactions related to micro- and macro-level processes. Groups are areas of behavior between the individual and institutional structures and power systems (Fine & Hallett, 2014). MHC attempts to solve a social problem through linkages between two institutions, and thus contains values and norms from the culture of those institutions, embedded in a wider, societal culture. In working with defendants and making performance judgments, both types of professionals recognized health values such as the duty of providing treatment for disease and criminal justice values such as punishment deserved and incapacitation for public safety. They

also stressed white American traditional values (Sullivan, Henderson, Parent, & Winburn, 2018) such as working hard and being responsible for one's self.

The MHC filter. MHC professionals primarily understand participants and referrals in terms of performance in the program. In making performance judgments, professionals operate the MHC program as a filter by which a relatively large number of referrals are narrowed down to a small number of graduates. Screening occurs before defendants are referred and apply to MHC because basic requirements for participation are communicated to jail personnel, ASAs, and public defenders. Six of the programs accepted only a minority of referrals, with Gabriel County reporting less than one-fifth of referrals being accepted, and the Tandy court in Waters County reporting one-tenth being accepted. Lipsky (1980) described how public service workers interact with clients in ways that control their relationship and reinforce the power of workers. Lower courts and other agencies whose workers interact with the public have wide discretion over the allocation of sanctions. Professionals in MHC make decisions accepting referrals and sanctioning or terminating participants that dramatically impact punishment outcomes and distribution of mental health services. Such decisions are often informed by monitoring professionals who share a defendant's story and affect the others' opinions. MHCs have relatively low caseloads, allowing for individual-level service, unlike the street-level bureaucrats overwhelmed with clients that Lipsky (1980) describes. But such bureaucrats may be selective, choosing to distribute services to clients whom they believe are most likely to succeed with program goals (Lipsky, 1980). Professionals engaged in the referral process of MHC are focused on selecting those who are appropriate and likely to be successful in the program. 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.

As a participant interacts with professionals over time, they get to know the participant as an individual, develop opinions regarding her mental health and criminality, and make performance judgments. Such judgments lead to sanctioning decisions and, for those participants who are unable to comply with program requirements, unsuccessful termination. But other participants are judged to be doing well, leading to program graduation. Graduation from MHC culminates in an official ceremony during the MHC hearing, during which graduates make personal testimonies to an audience that often includes family members. These select participants become successful outcomes of MHC. Those participants who are unsuccessfully terminated from the MHC face conviction with incarceration or probation or may no longer require supervision if the judge determines a sufficient probationary period was already served.

Discussion

Erickson and Erickson (2008) 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, ultimately the model of mental illness as moral failure prevails. Their argument somewhat fits my findings in that in Midwestern MHCs there is a moral element to the performance judgments of professionals whereby in some cases individuals are deemed non-deserving of help, criminal, or lazy while their treatment needs are relegated to other contexts. On the other hand, a high level of individualized treatment is provided to MHC participants, and many reported greatly benefiting from the program. The differences between the criminal justice and mental health perspectives did not cause confusion among professionals, as they shared each other's disciplinary language, while also sharing vocabularies of performance containing institutional and broader cultural values. They work to

meet program goals by selecting participants in need of mandated treatment and intensive criminal justice supervision who also display qualities suggesting that they are deserving of help and may complete the program successfully.

One finding of this study is that probation officers and social workers play a major role in how a given referral/participant fares in the program. They share the most time with the defendant and often gain the most information about her. They share this information and their opinions with other professionals, and this fundamentally impacts the collaborative process of judging performance. The role of the judge in relation to the defendant has been emphasized in MHC scholarship, but future research should focus on social workers and probation officers and their impactful relationships with defendants.

This study's major limitation is that the professional perspective is emphasized for reasons described above while the perspective and agency of defendants is relatively unexplored. Throughout the study I observed participants in hallways and the courtroom before and during hearings, and I also conducted 32 survey interviews with participants from three of the sites, asking questions about what they liked best and least about their respective programs. Participants I interviewed and observed tended to speak positively about MHC, but I was not allowed contact with jailed or hospitalized participants, thus the participants studied were weighted toward relatively non-problematic cases.

A major implication of the ethnographic analysis is that defendants with mental illness lack power and autonomy in MHC programming. Many referrals voluntarily seeking to participate in MHC are facing the alternative of incarceration and must be acceptable as determined by professionals for program entry. Defendants not accepted into the program have no ability to resist the decisions of the MHC professionals. Those who become MHC participants are mandated to adhere to program requirements, including treatment, medication, twelve-step meeting attendance, and other requirements, or face termination from the program and, for many, incarceration. A number of researchers criticize the idea that defendants referred to MHCs are voluntarily choosing to enter the programs (e.g., Redlich, Hoover, Summers, & Steadman, 2010; Seltzer, 2005; Stefan & Winick, 2005), and Hughes and Peak (2013) are critical of how MHCs mandate medication and treatment with no participant choice. Kelly (2015) advocates changing the basic structure of MHC so that the staff meeting is not held behind closed doors with only professionals, but instead is held with the participant in attendance and included in decision-making regarding treatment planning. This structural change would enhance voluntariness and decrease coerciveness in MHC operations.

Another implication of the ethnographic analysis is that a group of severely mentally ill defendants who may be diverted out of criminal justice contexts are not diverted by MHC because they cannot perform for reasons such as displaying a poor attitude or being too disorganized to regularly attend hearings and appointments. Using an estimate of 16% of jail and prison inmates being severely mentally ill (Castellano & Anderson, 2013), Midwestern MHCs served only 3% of such inmates in the eight county jails and state prison population. Programs designed to divert PSMI from incarceration should not be designed so as to exclude persons who are judged to be too disabled. Inclusiveness, the concern for the welfare of all members of a population, is an important social justice value present in public health ethics (Lee, 2012). MHC programs do seem to help those persons who are able to participate in them, and almost all of the participants I interviewed claimed that they had been helped. But in terms of social justice values, the programs must be evaluated not only in terms of success with their participants, but also in terms of the entire population of PSMI in the community, and the entire subset of this population who are arrested and enter the criminal justice system. MHC programs consume limited mental health resources but are too selective to serve the large majority of PSMI ensnared in criminal justice systems.

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Author Note

Monte D. Staton is a Research Assistant Professor in the Center for Dissemination and Implementation Science of the Department of Medicine, College of Medicine, of the University of Illinois at Chicago. After receiving a Master of Arts in Sociology with a specialty in Criminology and Deviance from Bowling Green State University, he worked for eight years in Chicago as a counselor in rehabilitation programs for persons with mental illness. He received his Ph.D. in Sociology from Loyola University Chicago. Correspondence regarding this article can be addressed directly to: staton@uic.edu.

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