Merging Criminal Justice and Social Welfare in Mental Health Court: The Disparate Impacts and Outcomes of Coercive Aid in the Era of Mass Incarceration

by

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Abstract

This dissertation is motivated by the expansion of the criminal justice system into the domain of social welfare as policymakers and practitioners increasingly look for innovative ways to mitigate the social and economic costs of mass incarceration. Specifically, it focuses on a burgeoning intervention that exemplifies this trend: mental health courts. Mental health courts are designed to solve problems associated with mental illness that result in criminal offending. They connect offenders with mental illness to court-monitored health and social services such as treatment rather than simply punishing them. In the process, they ideally offer a pipeline out of the criminal justice system and stop the so-called "revolving door," improving outcomes for institutions, communities, and the participants themselves. Yet, while some are optimistic about what these courts can achieve, critics are wary of their potential net-widening effects.

In this dissertation, I build on these two viewpoints by more closely examining when and how these interventions are delivering on the promise of aid versus widening the net of social control. To do so, I introduce a fundamental condition that shapes court operations: social service engagement is coerced, but supervision is partial. Participants spend significant amounts of time outside of the direct supervision of staff and staff do not have access to the innerworkings of participants' minds. As a result, I argue that mental health courts in practice are in part producing and intervening upon performance – how participants do or do not perform the type of engagement the court aims to coerce. By performance, I move away from working to identify who participants "really are" to instead examining how participants are pressured to present themselves and their problems in this context. My overarching argument is that participants are differently equipped to carry out and benefit from this performative work.

I make this argument by analyzing different dynamics of this performance across four empirical chapters. In my first empirical chapter – chapter 3 – I establish how staff come to value certain ways of being among participants that shape how they allot resources and sanctions. In my fourth

chapter, I examine these ways of being as types of performance that participants are differently equipped to carry out. In my fifth chapter, I build on the previous chapter by examining how participants are differently equipped to carry out their performances across time – a particularly important dimension to study given the lengthy duration of these court programs. In my final empirical chapter, I move beyond examining how participants are performing, to examining how they are grappling with the outcomes this performance is supposed to produce – outcomes unevenly achieved among the participant population.

Ultimately, this research joins a body of scholarship focused on the institutional reproduction of inequality to question how our institutions are working and who they are working for, specifically in the criminal justice context in the era of mass incarceration. My contribution is to draw greater attention to the tensions generated by merging social welfare and criminal justice institutional forms and to show the disparate effects of these tensions on the individuals caught up in these institutional contexts today. In the process, I more critically examine the mechanisms shaping participant outcomes in such contexts, particularly by focusing on the dynamics of performance.

Chapter 1
The Promise and Perils of Mental Health Court

Introduction

Well, you know, I'd been a judge for maybe half hour, forty-five minutes and I already had done it seemed like 50 of these kinds of hearings. I did two today so far. Someone comes in, usually it's a relative, sometimes a caseworker, but usually a relative comes in; they're crying, they're shaking, they're really upset. They have someone they care about that's mentally ill and it's just, you know they're just at their wits end, they don't know what to do. And all kinds of bizarre stuff was going on. And they tried to deal with it any other[way]...so they're here [at court] because usually the police send them. And they come before me and they fill out a Petition for Involuntary Hospitalization and I put them under oath. And they verify to me under oath that the person is mentally ill and a result of mental illness a danger to themselves or others or can't take care of their basic needs or they're so sick they don't understand they need treatment and they can't form an understanding and as a result they're in harm's way. And then I sign a Court Order but the police go pick them up and take them to the hospital and get them evaluated. And if two doctors say they have to stay involuntarily, they stay. And that is just, I mean, can you imagine to do that to your mother, to your father, to your brother, to your sister, to your child? I get parents all the time. And, you know, I've done that like in the first 45 minutes about a million times. And [a treatment provider] came up to me between hearings and he said, 'You ever heard of Mental Health Court?' And quite frankly I said to him, 'Is it better than this shit?' And he said, 'Yes.' I said, 'Okay.''" – Judge Ash on how she became involved with starting a mental health court

"*You start to see the same people being recycled over and over again through the criminal justice system, it just didn't seem to be working. When I was a very young prosecutor there was a judge who was sort of a mentor for me and she had an interesting comment to me one time. She asked me whether or not I knew why the elected prosecuting attorney…was such a good prosecutor and I said, 'Well, why do you think?' ...And she said, 'Because he's a recovering alcoholic, he knows the difference between evil and human weakness.' And I think that's a lot of what we see here as judges. I mean, we've seen – see – some genuinely evil people here, people for whom we have to be protected. But on the other hand, there are far more people who've just sort of made a mess of their lives. And the value I thought the drug court had was that as a judge it provides leverage for me to get people to go get help. If somebody is addicted to crack cocaine and I ask them would you like to go to rehab, they're going to say, 'Not really.' [Short laugh] Because they're still enjoying getting high. But I think that many people will tell you that people won't start to get clean and sober or won't start to turn around their lives until they bottom out and I think one of the benefits of being a judge is that you can raise that floor. People don't have to freefall to the point where their lives are totally wrecked*." -Judge Perry on how he became involved with drug court prior to starting a mental health court

When I met the judges quoted above (who are assigned pseudonyms), they had already spent years confronting vexing social problems while working within institutional contexts that were not designed to resolve them. For Judge Ash, mental health policies had increasingly ensured that individuals who struggled with serious mental illness were left unstable and vulnerable, often enough resulting in criminal justice involvement and, at an extreme, sometimes death, such as in the memorable case of a mentally ill man who was not committed to a hospital (by a jury) only to then sit outside until he froze to death later that night. For Judge Perry, criminal justice policies had swept up individuals with substance use problems and mental illness, often with little to no effect on their behavior, leading to repeat criminal justice involvement. Both believed these populations deserving of different institutional responses. Neither was waiting for others to act. As Judge Ash aptly put it: “The solution, who knows, right, who knows? But I’d rather try than just sit back and bitch about it.” These were the judges working to create new institutional practices that would provide better resolutions to the problems they were confronting, even though as innovators, the best path forward was far from settled.

Yet, while both were pioneers in their state in implementing an innovation that has come to be called “mental health court,” they were not alone in seeking out such innovation. They were becoming swept up in what has been called a “quiet revolution” taking place within the court system (Berman and Feinblatt 2005). After years of growth resulting in unprecedented levels of imprisonment and supervision (NRC 2014; McNeill and Beyens 2013), criminal justice professionals, policymakers, and advocates have increasingly looked for ways to stem the tide through adopting new practices that divert criminal offenders deemed deserving (frequently those charged with drug offenses) away from overburdened courts and correctional facilities. While diversion interventions have developed across the criminal justice system, within the court system, this has commonly taken the form of “problem-solving courts” of which mental health courts are one type.

Problem-solving courts represent a significant innovation in criminal justice practice (see: Wolf 2007; Miller and Johnson 2009; Higgins and Mackinem 2009; Castellano 2011a). They developed in criminal courts, but they differ significantly from them. They are not a space for adjudicating cases. Rather, they might best be understood as a form of judicially supervised probation aimed at reducing the social, psychological, and even biological problems associated

with participating offenders' criminal behavior, reducing the possibility of future reoffending. They link participants with problems like addiction or mental illness to community-based services (e.g., treatment and employment). The authority of the court is used to monitor and motivate their engagement in services, helping participants internalize the value of service goals such as reducing (if not eliminating) drug use or increasing adherence mental health treatment.

Starting as a grassroots initiative in different courtrooms across the country, problem-solving courts vary significantly in form and function, but they have generally coalesced around a similar set of features. They create a specialty docket (ranging in size from, for example, 10 to 75 participants) focused around a specific issue (such as addiction or mental illness) and work to identify eligible defendants awaiting traditional prosecution. Plea requirements for participation vary, but candidates typically must plead guilty to a criminal charge as a condition of participation or the plea is held in abeyance pending program completion. If candidates voluntarily agree to participate (often in lieu of incarceration), they begin engaging in services and submit to supervision by court staff, including appearing in court to review their progress with the judge. Meanwhile, court staff, which include treatment and criminal justice professionals, regularly meet as a "treatment team" to develop, monitor, and adjust the treatment plans of participants on a case-by-case basis, allotting rewards and sanctions to motivate behavior changes. If staff deem that participants have met requirements across their participation (which, for example, can last from one to two years), they can successfully "graduate," fulfilling their obligation to the criminal justice system.

These courts have been steadily expanding over the past several decades, starting with the most well-known type – drug court – in the 1980s and extending into many domains including mental health, domestic violence, prostitution, gambling, truancy, child support, prisoner reentry, and veteran's issues (Porter et al. 2010). By the time I was observing the work of Judge Ash and Judge Perry in their mental health courts, problem-solving courts had become a common feature of court systems across the U.S. (BJS 2012, 2016) and were expanding internationally (Nolan 2009). The optimistic view legitimating this expansion is that these courts tend to generate positive outcomes for institutions, communities, and their participants. From this perspective, they reduce reoffending and thus increase public safety. They also are promoted as cost-effective, reducing costs associated with (otherwise) incarcerating participants and inconsistent (and thus ineffective) treatment service utilization (as participants are motivated to engage in

treatment more consistently to their benefit). Moreover, proponents argue that they provide a humane response to troubled offenders who need help. And, while research is not yet conclusive, there is some evidence to suggest some of these outcomes are being achieved (e.g., see: GAO 2005; Wilson et al. 2006; Ridgely et al. 2007; Sarteschi et al. 2011).

Yet, another view of these courts is that they are accomplishing something more insidious. Under this lens, as the costs associated with mass incarceration and supervision have skyrocketed, problem-solving courts have emerged as a more sophisticated way to manage unruly social groups rather than help them. Within them, new domains become subject to criminal justice intervention from, for example, health and dental care to social relationships to housing arrangements and so on, and these domains can be more efficiently acted upon as participants are routinely sanctioned for minor misdeeds. In the process, following a Foucauldian logic, the courts aim to instill discipline, albeit almost solely among the poor and people of color without redressing the social marginalization and exclusion that drive much of their problems. From this vantage point, problem-solving courts are not simply diverting their participants from the criminal justice system; instead, they are extending its reach into their lives in the guise of treatment (e.g., see: Malkin 2005; Donahue and Moore 2007; Moore 2007; Tiger 2012). Of course, this type of analysis is not uniquely applied to these courts. Researchers have identified similar trends across criminal justice and social service interventions generally (e.g., see: Fox 1999; Hannah-Moffatt 2001; Kilty 2012; Gowan and Whetstone 2012; McCorkel 2013; Stuart 2016).

In this study, I build on the current literature by drawing on scholarship focused on the institutional reproduction of inequality to more closely examine when and how these interventions are delivering on the promise of aid versus widening the net of social control. Scholars have long shown that public institutions reproduce inequality as individuals from disparate class backgrounds with varied cultural, social, and economic resources engage with them differently to the benefit of the middle class (Bourdieu and Passerson 1977; Lareau 2003, 2011). In other words, individuals have divergent experiences within institutions like schools given how they are equipped to navigate them. These experiences are both a product of and further amplify existing inequalities between them. This scholarship rightly draws attention to the fact that interventions like problem-solving courts are likely to generate different kinds of

engagement with participants given the resources at their disposal. Some participants will find ways of accessing aid, while others will likely struggle more with control and punishment.

Still, as a relatively new institutional form with unique features, how this happens is far from clear. After all, problem-solving courts are institutionally complex sites (Greenwood et al. 2011; Thornton et al. 2012). They yoke together different institutions and their associated logics within the same field, offering potentially conflicting rules, norms, and values to shape social action. Scholars have identified some micro-level processes by which agents on the ground navigate institutional complexity (Heimer 1999; McPherson and Sauder 2013; Chiarello 2015). However, more work is needed to examine contexts like problem-solving courts – or "people-processing" and "people-changing" organizations (Hasenfeld 1972, 2010) – from the vantage point of both organizational actors and subjects of organizational action. This is important because both groups play a role in determining how institutional complexity takes form. As will be discussed, neither is likely to simply reproduce a given logic; rather, through their routine actions, they constitute and reconstitute logics on the ground, shifting the standards by which different forms of engagement are privileged. Moreover, this kind of analysis is particularly needed within the criminal justice context given that it has been shown to reward distinct institutional knowledge, skills, and styles (such as deference to authorities versus making demands upon authorities) when compared to other public institutions (Clair 2018), to the detriment of the poor and people of color (Van Cleve 2016; Whetstone and Gowan 2017). Staff and participants are bound to face conflicting institutional demands in such settings, with new possibilities for how inequality takes form.

To better understand how inequality is being reproduced in such settings, I turn to an in-depth case study of the mental health courts of Judge Ash and Judge Perry. I closely attend to how both staff and participants are responding to similar tensions generated by conflicting institutional demands from very distinct vantage points. I ask the following questions: *What kinds of standards do staff come to value in this institutionally complex setting? How do participants, then, differently respond to the kinds of standards promoted by staff? What are the consequences for the institutional reproduction of inequality?* Drawing on ethnographic observation data of staff decision-making collected across two years in each court and interviews with 28 staff members involved in these decision-making processes (as well as 13 professionals with more indirect roles in these courts), I outline how staff promote and enforce standards, but

do so in non-standardized ways, creating room for participants to successfully navigate the program in diverse ways. I rely on data from two courts to emphasize similarities in how tensions emerge between standardization and non-standardization across similar institutional forms. Still, I also emphasize important forms of difference – most specifically in the content of standards promoted and enforced – to qualify the kinds of generalizations that can be drawn from my findings. I focus the majority of this study on participants in one court. Drawing on longitudinal interviews with a set of participants from Judge Ash's mental health court, I show that participants equipped with diverse cultural, social, and economic resources respond to the program in divergent ways and, thus also, are positioned to make very different gains from the program. To do so, I turn to participants that represent extreme cases, particularly relying on a select few interview subjects that emerged as relatively socially advantaged in this context (i.e., from the middle class). Such cases throw into sharp relief the ways in which existing inequalities between the participant base shape their experiences within the court. Yet, I acknowledge that foregrounding such cases can obscure a general trend in which most participants are socially disadvantaged. I thus also explore intersecting forms of inequality such as race and gender (Crenshaw 1991; McCall 2005) that differently shape the experiences of participants. I attend to how participants are subject to distinct constellations of advantages and disadvantages in this setting as they share some social identities, cultural practices, and historical communities that contribute to oppression and marginalization, and not others.

Ultimately, this study will advance our understanding of the shifting terrain of the institutional reproduction of inequality in institutionally complex sites. As settings like problem-solving courts are created to alleviate problems associated with existing institutional arrangements, they inevitably face a persistent set of tensions endemic to their predecessors. This is because reconfiguring institutional resources provides new opportunities for response, but it does not fundamentally change the conditions in which problems emerge. The majority of court participants, in this case, will continue to struggle with a set of conditions – inequality, poverty, employment insecurity, concentrated disadvantage in neighborhoods, criminal justice expansion and social welfare retraction, racism, sexism, and classism, and so forth – that make meaningfully changing their lives difficult if not out of reach despite the best efforts of highly dedicated staff.

Still, understanding how institutional resources are being reconfigured is important. Even if they are not redressing fundamental social problems, settings like problem-solving courts are creating new opportunities and constraints within institutions for social thought, evaluation, and action. In the process, they make unique kinds of agency possible with definite benefits, such as gaining reprieve from criminal sanction by aligning with treatment goals, just as they deny opportunity for agency in other ways, such as when courts mistakenly link participants' problems to individual pathologies rather than collective structures. Understanding the different sorts of agentic capacities that arise and how they are mobilized will shed light on how the institutional reproduction of inequality is being reconstituted in these settings.

In so doing, this study will help improve our understanding of wide-ranging sites of institutional complexity (Greenwood et al. 2011; Thornton et al. 2012). Through examining the case of a people-processing organization from the perspective of both organizational actors and the individuals they process, it will draw attention to the ways in which inequality plays a role in how these different actors together enact institutional complexity on the ground. Moreover, such an analysis is particularly important for sociolegal scholars interested in how the criminal justice system reproduces inequality. Today the criminal justice system has taken on a primary role in stratification (Pager 2003; Western 2006), but with its authority increasingly devolving and diffusing beyond its walls to a wide range of service providers (Haney 2010; Miller 2014), it is important to look at how it is shaping inequality in institutionally complex sites like problem-solving courts. Finally, this study also helps draw attention to the role inequality plays in these settings for practitioners and policy evaluators. The staff members studied in these courts revealed themselves to be exceptionally committed to generating innovative practices to help individuals caught up in dysfunctional institutional dynamics. They often went above and beyond what might be expected to try to understand and help participants. Yet, as we continue to look for increasingly refined ways to respond to complex social problems like those confronting the criminal justice system today, it is critical to concomitantly examine how such innovative efforts can have the unintended consequence of reproducing and amplifying inequality.

Resituating the problem-solving court as part of broader institutional arrangements that reproduce inequality

Problem-solving courts emerged as an innovation in criminal justice practice designed to generate new kinds of outcomes for criminal offenders, changing their lives for the better. Policymakers and practitioners recognize that not all who participate will thrive in them, but the promise is intended to be universal. Yet, this kind of universality has long been criticized by scholars interested in the institutional reproduction of inequality. These scholars repeatedly demonstrate how institutions like schools, courts, and the workplace often appear to provide equality of opportunity, but instead recreate social stratification, for example, as the working class and poor moving through them tend to remain confined to their social positioning just as the middle- and upper- classes perpetuate their positions of privilege and power though them. This kind of scholarship suggests that understanding how problem-solving courts operate requires more closely attending to how participants of different social positioning are processed through them.

To do so, it is vital to turn to the work of Pierre Bourdieu, who provides a foundation for this scholarship. For Bourdieu, institutions are not level playing fields. Individuals are differently equipped to navigate them, forming diverse styles of engagement. For example, some children proactively ask questions and advocate for themselves in school, whereas other children submissively defer to the authority of teachers. These styles of engagement are not evenly distributed among the population; they reflect the social positioning of the students. However, institutions tend to render this divisions social background invisible, while rendering divisions in engagement styles as natural and inevitable (see also: Bourdieu and Passerson 1977; Bourdieu and Wacquant 1992). Teachers provide positive evaluations for the students they perceive as actively engaged and negative evaluations to the seemingly disengaged student. In the process, existing inequalities are reinforced as some social groups are systematically privileged above others.

Importantly, the kinds of resources – or "capital" – that can matter for how individuals maintain and enhance their positioning are relatively extensive (Bourdieu 1986). Economic capital – money and assets directly translated into money – is far from the only (or even principal under some conditions) kind of resources individuals need. Often, individuals are drawing upon other forms of capital as well. Most notably, this includes social capital, which comprises social connections and obligations through which individuals can mobilize resources (e.g., jobs), and cultural capital through which individuals can demonstrate competence in some socially valued

space. (Cultural capital can be embodied in tastes and practices, objectified in the form of cultural goods like books and works of art, and institutionalized through official credentials such as educational qualifications.) These different forms of capital are mutually constitutive as, for example, economic capital provides opportunities for the development of cultural and social capital, which in turn can be converted into economic capital.

However, for Bourdieu, inequality is not only reproduced through the accumulation of different forms of capital, but also through socialization processes in which individuals internalize ideas about the social world specific to their positioning within it. As individuals move through time and space, they collect ideas about how social structures work, consciously and unconsciously. Chances of success or failure of actions within these structures are transformed into taken-for-granted assumptions that shape expectations, evolving into "a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions" (1977, p82-83; see also: Bourdieu and Wacquant 1992; Swartz 1997) – or what is called "habitus." Habitus is a characteristic of individuals – or the "mental and behavioral properties" that shape how individuals mobilize resources (Edgerton and Roberts 2014). It serves as an evolving set of orientations that influence how individuals think, judge, and act. However, it tends to generate perceptions, attitudes, and actions consistent with the conditions in which they were produced. Thus, individuals often engage in self-fulfilling prophecies according to their social positioning, reproducing their social advantage or disadvantage as certain kinds of behaviors are deemed natural, inevitable, and beneficial, while others are deemed unlikely and unthinkable (Swartz 1997).

Taken together, the concepts of capital and habitus provide a foundation for conceptualizing the processes by which individuals like participants are differently positioned to be processed in settings such as the problem-solving court. They elucidate how resources and dispositions – structured by one's social positioning – structure how participants will act and be acted upon in ways that further reproduce this positioning. As will be elaborated on in this study, participants enter the court with very different kinds of resources and dispositions that shape both how they interact with judges, lawyers, and treatment providers and engage in requirements like community service and treatment. Critically, this kind of variation is often difficult to see (as Bourdieu argues). Staff work extensively to tailor the court intervention to each case and often express significant concern over the conditions in which participants operate – whether in terms

of tough family dynamics, backgrounds of abuse, mistreatment by other bureaucracies, racism, sexism, and so on and so forth. However, staff both face significant resource constraints and participants who vary remarkably in terms of their engagement (i.e., some appear very enthusiastic whereas, at another extreme, others disengage completely). Within this context, staff are not equipped to systematically attend to the unique social positioning of each participant. They must make efficient decisions about how to process cases in ways that legitimate certain forms of engagement over others regardless of the causal mechanisms that drive differences between them.

This study thus joins a growing body of scholarship that draws on a Bourdieusian framework (Lareau and Weininger 2003; Sallaz and Zavisca 2007; Edgerton and Roberts 2014). It largely reaffirms a prominent finding that dominant institutions are structured to reflect and reinforce mostly middle-class ways of being, which include being individualistic (e.g.., actively pursuing your personal interests) and demanding (e.g., expressing your personal preferences and challenging norms and rules) (Stephens et al. 2013). This finding is perhaps best exemplified by the work of Lareau (2003, 2011) who found that parents from the working- and middle-class backgrounds transmitted differential advantages to their children. Middle-class parents taught their children ways of pursuing their interests (e.g., reasoning and negotiation, questioning adults and addressing them as relative equals) that reflected dominant norms in settings like schools, doctor's offices, and job interviews, thus learning how to make institutional settings work in their favor. In contrast, working-class parents taught their children a set of skills that were out of sync with institutional norms (e.g., restraint and deference to authority) and instead often reflected a general sense of powerlessness within such settings.

In the court context, as will be shown, participants who are actively engaged with staff in making treatment plans work for them and advocating for themselves tend to be rewarded for such behaviors, with the caveat that they generally also must be able to signal they are meeting requirements. Of course, requirements themselves reinforce inequality as, for example, participants who can secure and maintain steady employment do not have to participate in community service (at least, after they obtain a job) and having personal transportation makes following through with requirements generally much easier, particularly in areas where public transportation is far from ideal. Moreover, being required to temporarily do community service on the way to better outcomes such as employment is a fundamentally different experience than

when such outcomes prove more elusive, especially for those such as black men who are likely to face significant employment discrimination (Bertrand and Mullainathan 2004; Pager 2007), and when such outcomes are part of a larger process of state intervention and domination of which court participation serves as only one point (see: Auyero 2012). This is important because many participants indeed have difficulty with requirements like community service but pursue their interests and advocate for themselves haphazardly as they also are caught up in both trying to use the court to meet basic survival needs while also deferring to its demands in the hopes of avoiding further criminal sanction.

Still, within these larger patterns, the court operates as a complex site that participants can engage in different ways. Already scholars have demonstrated the importance of attending to the diverse kinds of resources and dispositions that come to matter across social space (Hall 1992; Erikson 1996; Carter 2005). Most recently, Clair (2018) has argued that in contrast to typically studied institutions like schools and workplaces, the court system privileges unique kinds of institutional knowledge, skills, and styles, shifting the terrain by which the middle class reproduce their advantage. Rather than being demanding, they delegate authority to their lawyers to work on their behalf, deferring to their expertise. Conversely, it is the working class and poor who are more demanding, actively working to pursue their interests (given significant mistrust of legal institutions, see also: Bell 2017), but often incur penalties for such self-reliance as it is not privileged in courts (and likely also interpreted through raced and classed lenses by court professionals given endemic institutional biases, see also: Van Cleve 2016).

Building on this research, it becomes easier to understand that the court context generates unique opportunities and pitfalls participants must navigate. For example, in some cases, participants are expected to defer to legal authority like lawyers and judges as Clair finds in traditional courtrooms. Yet, in other cases, participants are expected to proactively engage in treatment processes, including with legal actors who are intended to serve a therapeutic role in their interactions with participants. Moreover, demanding accommodations can be viewed as manipulative behavior of criminal offenders, and, alternatively, as the committed effort of a participant trying to ensure they gain the help they need (see: Burns and Peyrot 2003; Mackinem and Higgins 2007). The processes by which these behaviors are enacted and interpreted unfold across time (participants can spend more than a year in the program) and space (from public courtrooms to treatment offices to community service placements) (see: Paik 2011). Hence,

while I maintain that participants are likely to have very different experiences in this context based on pre-existing inequalities, I also show that this unfolds through varied forms of engagement – or "strategies" as they are called here – which are employed based not just on class, but intersecting forms of inequality that differently position participants to the court and its goals, particularly across time. Middle class participants are the most likely to make the court work to their advantage, but class is far from the only variable that shapes participants' experience.

Yet still, to better understand how inequality is reproduced through this court setting, it is important to more carefully attend to how in contrast to schools, the workplace, or even the court system, the problem-solving court is unique in how it brings together distinct institutions – i.e., the criminal justice system and the community mental health system – in ways that pose particular kinds of challenges for court staff and participants. Participant's strategies – and how they are interpreted by staff – are inevitably conditioned by the diverse institutional rules, norms, and values operating in this context.

Institutional complexity and the shifting terrain of the institutional reproduction of inequality

Understanding the institutional reproduction of inequality in many sites such as problem-solving courts requires attending to institutional complexity – fields in which multiple institutional logics coexist, generating incompatible prescriptions for how actors should make sense of, respond to, and enact the rules, norms and values of the setting. Institutional logics are macro-level belief systems that provide templates for action and cognition, frequently operating as taken-for-granted prescriptions for organizing social life (Friedland and Alford 1991; Thornton and Ocasio 2008; Thornton et al. 2012). They present frames of reference that condition the interests, identities, values, and assumptions of individuals embedded within an institutional environment with structures, practices, and meanings of its own. Thus, court systems, universities, banking, and French cuisine all are oriented by distinct logics that provide the actors within them a unique set of principles that orient reasoning and interactions. The commonsense way for a judge to talk with a criminal defendant, for example, is far different from how the chef approaches the fine diner and the university administrator the student, as each response is embedded in a different prevailing logic that provides unique prescriptions for how to interpret reality and act.

Institutional logics condition the kinds of institutional rules, norms, and values that gain legitimacy.

Yet, this is not an entirely clear-cut process. Mirroring trends in sociological studies of culture, the concept of institutional logics has emerged to provide greater analytic leverage over institutional complexity (Greenwood et al. 2011). The institutional logics perspective recognizes individuals and organizations as nested within multiple institutional orders and typically subject to multiple logics. For example, schools must contend both with the logic of providing education (e.g., tailoring teaching to students' needs) and the logic of market accountability (e.g., standardized testing) (e.g. see: Hallett 2010). Moreover, teachers coexist in a range of institutional spaces, from the family to professional associations to larger political structures. Thus, even while logics condition social action, they also provide the possibility for agency and change as actors confront incompatibilities between logics (Kraatz and Block 2008; Pache and Santos 2010; Cloutier and Langely 2013). After all, when actors must respond to multiple, conflicting demands, they cannot do so without some degree of reflexivity (Kraatz and Block 2008; Jay 2013). Incompatibilities might drive agents' responses in a range of ways as they become aware of alternative courses of action and decide what demands to prioritize, resist, or ignore (Seo and Creed 2002). Hence, while actors may reproduce behaviors consistent with one logic, they face heterogeneous possibilities for reasoning and action, creating opportunities to shift the contours of how institutions – and their accompanying rules, norms, and values – are enacted on the ground.

This kind of institutional complexity – and its potential for more heterogeneous process and outcomes – is intensified in settings like problem-solving courts that are characterized in terms of criminal justice and social welfare hybridity. Like other "hybrid organizations," they merge potentially conflicting logics (i.e., those of the criminal justice and social service systems) under one organizational umbrella to generate innovative solutions to problems going unaddressed by current institutional arrangements (Battilana and Dorado 2010; Battilana and Lee 2014). Yet, this poses challenges as organizations must find a way to respond to the inherent tensions of exposure to incompatible demands. We know that organizations might eliminate or resist some demands through resistance, conflict, and control (e.g., Dhalla and Oliver 2013; Huisang and Silbey 2013). We also know organizations might respond to institutional demands partially, incorporating some components and resisting others (e.g., D'Aunno et al. 1991; Reay

and Hinings 2009; Huisang and Silbey 2011), or sustainably manage coexisting institutional demands through structures and practices that balance disparate demands (Kraatz and Block 2008; Battilana and Dorado 2010; Jarzabowski et al. 2013; Battilana and Lee 2014). As this research suggests, institutional complexity indeed produces heterogeneous pathways by which competing institutional rules, norms, and values can gain ascendance.

To better understand these processes, it is important to turn to the micro-level, where actors inevitably determine how incompatibilities are managed in practice through their routine actions and practices (e.g., see: Binder 2007; Lawrence et al. 2011). Already research is beginning to show how actors navigate different logics, often likening them to "tools" that serve specific ends. For example, Heimer (1999) shows how professionals in neonatal intensive care units draw on different institutional logics to influence decision-making, with some logics more likely to be used than others because they are deemed helpful (e.g., medical professionals turn to the law to the extent it increases their discretion and elicits cooperation from parents but otherwise work to retain autonomy from the legal sphere). McPherson and Sauder (2013), however, demonstrate a more flexible use of logics as professionals from different institutional backgrounds work together in a problem-solving court. They find that the discretionary use of logics depends on constraints such as the effectiveness of a given logic for solving an organizational problem. Without explicitly drawing on a toolkit approach, other scholars have focused on the distinct use of logics by various kinds of professionals who must confront institutional complexity and select among logics in their daily work (Castellano 2011; Baker 2013; Chiarello 2013, 2015). This kind of scholarship demonstrates the importance of investigating these frontline workers – or "street-level bureaucrats" (Lipsky 1980) – to better understand how actors on the ground participate in determining the kinds of institutional rules, norms, and values that are upheld.

Building on this literature, I offer a more fine-grained analysis of the kind of evolving institutional rules, norms and values taking shape in these hybrid criminal justice and social welfare organizations, as well as how they are differently instantiated by heterogeneous workers. For the sake of conceptual clarity, scholars often neatly parse logics, when in fact, my data reveal that logics are likely to offer a range of potentially conflicting, but also overlapping elements and thus, like cultural templates, are drawn upon in partial and fragmentary ways (see: Harding 2010). Hence, rather than simply contributing to or resisting the institutional order, staff

reconstitute it as they draw on elements of logics in a range of new ways (for example, moving fluidly between logics by responding to participants as both treatment recipients in need of care and criminals who are morally suspect – a prominent finding for both medical sociologists and sociolegal scholars as discussed below). Moreover, given that staff are nested in multiple institutional orders, they enact elements of logics based on diverse individual experiences, knowledge, beliefs, and identities developed outside of the professional setting (Binder 2007; Watkins-Hayes 2008). In other words, staff sharing similar professional backgrounds enact logics in very different ways. This results in greater ambiguity (i.e., the institutional rules, norms, and values remain underspecified) than might be anticipated. Ambiguity, in turn, creates opportunities for participants to find different ways to work the setting to their advantage, relying on different kinds of strategies with some success. However, it also can generate pitfalls as participants struggle with which institutional rules, norms, and values to follow.

Hence, perhaps most importantly, I build on this literature by drawing greater attention to participants. In organizations like problem-solving courts that are "people-processing" or "people changing" (Hasenfeld 1972), frontline workers are not the only agents shaping how institutional complexity is instantiated. These organizations are designed to intervene upon people, which serve as the "raw material" to be processed and transformed (Hasenfeld 2010). They are given new statuses – turned into patients, consumers, participants, or other "institutional selves" (Gubrium and Holstein 2001). It is participants, then, who must do the heavy lifting of enacting institutional mandates in their lives.

Participants are not merely passive recipients of institutional mandates. Rather, they react to and influence their course, as has been demonstrated across wide-ranging domains. For example, treatment recipients often do not comply with medical advice as they adopt their own ideas about how best to engage in treatment rooted in their lived experience (e.g., see: Conrad 1985, 1987; Shoemaker ad Ramalho de Oliveira 2008). Welfare recipients – knowingly and unknowingly – work within and around welfare rules to make ends meet (Edin and Lein 1997; Gustafson 2011). Citizens rely on legal agents like the police and public defenders strategically, to the extent they trust that doing so can help them achieve desired ends (Goffman 2014; Bell 2016; Clair 2018). Such individuals are likely to engage in "everyday forms of resistance" (Scott 1985) or "small acts of living" (Goffman 1961) in which they subtly resist dominant (and oppressive) rules, norms, and values. Such resistance often unfolds alongside and through

strategic displays of compliance (see also: Wade 1997), making it difficult to detect through study of frontline workers alone. Therefore, understanding how institutional complexity is shifting the terrain of the institutional reproduction of inequality requires attending to participants, who have agency in how they conform to institutional rules, values, and norms – albeit agency shaped by the resources and dispositions they have developed across time.

Still, while examining both groups – frontline workers and their subjects – is useful for better understanding generally how institutional complexity is instantiated and how, then, this institutional complexity in practice shapes the institutional reproduction of inequality, it is also important to examine the unique contours of criminal justice and social welfare hybridity specifically. Unlike other institutions, the criminal justice system primarily serves to control, punish, stigmatize, and exclude those deemed deserving of intervention. It also plays a "peculiar" role in our society in perpetuating racial hierarchies and other forms of inequality through these processes (Wacquant 2000, 2009; Alexander 2012). This setting, then, raises distinct issues for how institutional complexity is negotiated in practice.

Investigating the changing contours of institutional complexity and inequality in the era of mass incarceration and supervision

Problem-solving courts are embedded in an institution – the criminal justice system – that has increasingly come to play a pivotal role in stratification. This in part can be understood through a myriad of deleterious effects. Incarceration limits opportunities over the life course (Western 2006), as well as has pernicious effects on families and social networks (Comfort 2007, 2008; Foster and Hagan 2009; Goffman 2009, 2014) and communities (Lynch and Sabol 2004; Clear 2009). Probation and parole are accompanied by significant legal constraints and can result in reincarceration for technical violations or new minor arrests (Simon 1993; Goffman 2009, 2014; Harding et al. 2017). Even low-level offenses carry wide-ranging burdens including criminal records, supervision, participation in lengthy legal proceedings (with resulting opportunity costs of, for example, lost work), and requirements such as community service (Kohler-Hausman 2013; Uggen et al. 2014; Natapoff 2015). Further, criminal prosecution can diminish the rights and privileges associated with citizenship – imposing "hidden sentences" (Kaufman et al. 2018) – in numerous ways from the imposition of fines to disqualification from public aid and restricting occupational licensures to disenfranchisement (Travis 2003; Wheelock 2005; Harris et

al. 2010; NRC 2014). Criminal records can result in durable stigma, shaping employment and housing opportunities (Pager 2007; Pager and Shepherd 2008).

Moreover, the pernicious effects generated through criminal justice expansion are extensive. Today, families experience pressures and pulls to turn to police to solve various disciplinary issues and other sorts of problems given a lack of viable alternatives (Rios 2011; Bell 2016). Schools have become "pipelines" to the criminal justice system with school personnel participating in criminalizing a range of youth behaviors (Wald and Losen 2003; Kim et al. 2010; Rios 2011). In terms of medical care, law enforcement agents patrol hospitals and disadvantaged individuals avoid care out of fear of legal surveillance and sanction (Lara-Millan 2014; Goffman 2009, 2014; Brayne 2014). Social service programs have increased surveillance and sanctioning of noncompliant behaviors as well as banning those convicted of certain felonies from receiving services altogether (Haney 2004; Gustafson 2011; Soss et al. 2011). For many disadvantaged individuals, avoiding the reach of the criminal justice system has become an increasingly difficult feat.

In ideal, problem-solving courts provide a new alternative to criminal justice expansion. They are diversion programs. While they vary significantly, in the best-case scenario, participants avoid incarceration and a criminal record altogether due to their participation. Of course, many will experience much less favorable outcomes, with some being sent to jail and prison. Moreover, as Kohler-Hausman (2013) and Kaufman and colleagues (2018) argue of similar levels of criminal justice involvement, participation itself is likely to be relatively burdensome given extensive supervision and requirements. Still, problem-solving courts create the opportunity for better outcomes than would be generated through traditional prosecution.

Yet, it is critical to recognize that even though problem-solving courts offer a significant innovation, they still operate under the logic of the criminal justice system, which is distinctly punitive. What we know is that under a punitive logic, rhetoric around personal responsibility, dependence, and risk animates interventions through the criminal justice system over, for example, other institutions such as the family or the social welfare system. Problems individuals face are framed as moral failings that should be addressed through control and punishment, resulting in durable social exclusion both in the form of incarceration and criminal stigma. In the process, models of citizenship and rights are reconstituted. In principle, this can be—and often is—contrasted with, for example, a medical logic in which behaviors are viewed as the product

of disease or disability to be remedied by medical interventions or a welfare-based logic in which the same behaviors are at least partially framed in relationship to larger collective structures that produce or reproduce them, ideally mitigating moral blame (e.g., see: Conrad and Schneider 1980; Beckett and Western 2001; Wacquant 2009, 2012).

However, importantly for the problem-solving context, scholars have shown that even with (in ideal) distinct properties, a punitive logic can operate with and through these other logics. Medical sociologists have long examined the relationship between medical and penal logics – or interpreting behavior as sickness or badness – and drawn attention to how a medical logic can mitigate *and* exacerbate some of the consequences of a punitive logic (such as stigma and exclusion) as behavior increasingly falls under the scope of medical control (Conrad and Schneider 1980; Conrad 1992). More recently a nascent body of literature has focused on unpacking the bidirectional relationship between logics that results in collusion between them. For example, Armstrong (1998, 2003) and Hoppe (2013, 2014) have documented how medical logics can animate social control, leading to the development of criminal law around medical conditions through moralizing narratives. At the micro-level, Anspach (2011) argues that medical categorizations unfold through a complex interplay of cultural schemas and can coexist alongside ideas about bad behavior. Building on this insight, Bosk (2013) shows how perceptions of youths' troubling behavior can shift between badness and sickness at the micro-level dependent on context and interests of those involved.

Alongside medical sociologists examining the bidirectional relationship between medical and punitive logics, sociolegal scholars have explored how a range of service delivery logics operate in tandem with a punitive logic in criminal justice and criminal justice adjacent contexts such as transitional housing for former prisoners. A key theme in this literature has been the convergence of logics as rehabilitation becomes focused on individual responsibility in the form of intervening in the character and cognitive processes of subjects at the cost of failing to grapple with the social problems subjects confront (Gowan and Whetstone 2012; Tiger 2012; Kaye 2012; Miller 2014; Stuart 2016). Thus, for example, Haney (2010) studied two programs over the course of a decade and demonstrated a shift in intervention focus over time from the means to achieve goals (e.g., education) to the therapeutic domain (e.g., treating addiction). In so doing, the subjects of the intervention were taught that they must take responsibility for their problematic desires over attaining the supports they need to achieve material stability (see also:

Fox 1999; McKim 2008; McCorkel 2013). Similarly, in their study of former women prisoners, Sered and Norton-Hawk (2014) describe medicalization and criminalization as "two sides of the same coin" as women became captives of an institutional circuit of interventions (penal and medical) in which their problems were systematically and detrimentally translated into personal flaws and poor choices.

This research draws attention to the pernicious effects of criminalizing and medicalizing social problems. Frontline workers and their subjects alike must contend with logics that translate social problems into individual problems and make outcomes like punishment, stigma, and exclusion commonsense. Thus, these individuals not only must determine how best to pursue interests like providing and attaining various forms of aid as in other human service contexts (Hasenfeld 2010), but they are also must navigate significant costs that could be triggered through their actions. This creates a context in which both parties approach each other with fundamental mistrust (e.g., see: McCorkel 2013). On the one side, frontline workers cannot trust that subjects will self-disclose important information given the stakes they face. On the other side, subjects inevitably cannot trust that certain kinds of self-disclosure will not trigger undesirable outcomes, amplifying the likelihood that any resistance they might mount will be masked. Thus, while both parties together are constituting institutional complexity, they are doing so often from opposing positions (i.e., controlling versus being controlled).

Of course, these processes cannot be viewed without acknowledging how inequality operates through the criminal justice system. Scholars have argued that the criminal justice system has created and sustained a social order that systematically privileges whites over people of color (Wacquant 2000, 2009; Alexander 2012) as well as reinforced other forms of inequality, with concentrated effects for black men without college education[1] (Western 2006; NRC 2014). These outcomes must be viewed in relationship to structural and institutional racism in which race is baked into structures and institutions that organize society (Stokely and Hamilton 1967; Omi and Winant 1994; Feagin 2006). Discrimination, exploitation, and domination are thus often difficult to see (as a Bourdieusian framework also highlights). They rarely materialize as

[1] Critically, college education both is a resource (i.e., a form of capital), but also an indicator of other kinds of social problems that have disproportionately impacted black men caught up in the web of the criminal justice system such as poverty, racial and class segregation, lack of employment opportunities, poor performing schools, racism, and the expansion of the criminal justice system. Hence, this should not be read to suggest that education alone would be a panacea, but rather points to how intersecting forms of inequality have ensured that the criminal justice system concentrates its effects among some social groups, reproducing and amplifying inequality.

blatantly identifiable racism, but instead emerge systematically in practices and implicit biases that reinforce the racial status quo while appearing "colorblind" (for a discussion of implicit bias in the criminal justice system, see also: Staats et al. 2008). Frontline workers, thus, operate in a system of taken-for-granted policies, practices, and norms that reinforce existing inequalities. They inherit this system upon entering it, and it will sustain itself long after they leave (Van Cleve 2016). Hence, the ways in which seemingly neutral logics of due process or crime control are racialized, classed, and gendered often go unnoticed.

Van Cleve (2016) powerfully demonstrates this in her study of an urban court system where race becomes tacitly used by court professionals to evaluate and respond to defendants. Black and Latino/a defendants were systematically labeled the worst kind of criminals, while those who were white and/or from upper-classes were more likely to be perceived as deserving of protection from criminal justice action, often accessing a "privileged pipeline" to less-punitive alternatives like probation (e.g., because their futures seemed more valuable). Scholars have similarly found racialized, classed, and gendered processes across wide-ranging criminal justice and criminal justice adjacent sites (e.g., see: McKim 2008; Gowan and Whetstone 2012; Kaye 2012; McCorkel 2013; Whetstone and Gowan 2017).

Moreover, these processes have significant effects on the subjects of criminal justice intervention – suspects, arrestees, and, in this case, participants. They communicate to specific social groups that: (a) legal institutions are illegitimate, unresponsive, and ill-equipped to meet their needs, generating legal cynicism (see: Kirk and Papachristos 2011), and more importantly: (b) legal institutions will continue to mistreat them as members of a social group that is routinely marginalized and excluded by the law, resulting in "legal estrangement" (Bell 2017).[2] As Clair (2018) and Bell (2016) indicate this has important ramifications for how such individuals interface with agents of the criminal justice system, rooted in distrust. (Although, notably, this kind of analysis also could be extended to the medical system and the mental health system specifically, where disadvantaged groups also confront discrimination and institutional bias that

[2] Researchers have demonstrated that legal cynicism, or distrust of the law and legal authorities, is concentrated among some social groups, especially black Americans, more than others and within particularly disadvantaged neighborhoods (Sampson and Bartusch 1998; Kirk and Papachristos 2011). Bell (2017) recasts this conversation in terms of "legal estrangement." She argues that rather than focusing on the attitudes of individuals, this distrust of the law and legal authorities must be viewed in terms of a set of structural conditions that produce it, specifically legal and institutional exclusion. This exclusion can be directly experienced by individuals in interactions with the legal system, but also becomes part of a collective experience, thus operating "both within and beyond individual perceptions" (p2086).

leads to disparate treatment patterns (for medical system, see: van Ryn and Fu 2003 and Institute of Medicine 2003; for mental health treatment, see: Abreu 1999; U.S. Department of Health and Human Services 2001; McGuire and Miranda 2003; Neighbors et al. 2003) and thus also maintain distrust towards providers (Boulware et al. 2003; Richardson et. al 2012)).

In this study, I more closely examine the kinds of dynamics of the setting that shape how participants are engaging. I show that their orientations toward the court intervention – and thus the strategies they employ – reflect very different kinds of understandings of the institutional setting. Some participants feel comfortable working with the court, viewing institutions as responsive to their needs and thus legitimate. Other participants see the court as a set of constraints that must be strategically navigated (see also: Lareau 2003), often with histories in which they have been poorly served by institutions such as the criminal justice system. Most fall somewhere in between. However, I show that both staff and participants are contending with a punitive logic that fundamentally shapes the kind of engagement that is possible, with all participants experiencing pressures to acquiesce to the court intervention and its goals. For some, doing so can be relatively easy and beneficial. However, many struggle with this task across time, shaped by varied forms of impediments and adversity the court is not designed to address.

Mental health courts and the role of mental illness

I have framed this dissertation in terms of the kinds of processes that can emerge in settings like problem-solving courts. Yet, presumably the focus of the problem-solving court under study here – mental illness – generates a unique set of considerations for this analysis. Hence, it is important to lay out how mental illness will be approached here. Specifically, I address three points below: (a) readers should not devalue interview subjects' responses based on stereotypical understandings of mental illness; (b) mental illness as a biological condition is not a primary variable of interest in this study, which prioritizes social factors; and (c) mental illness is still relevant, especially as a social construct that shapes how staff and participants operate in this context together.

Mental illness has long held a place in the public imagination. For most of history, it has been negatively associated with bizarre conduct and framed in terms such as insanity, lunacy, and madness (Grob 1994; Gamwell and Tomes 1995). Attitudes towards mental illness have

shifted across time alongside sweeping changes in diagnostic practices and treatment. Still, given that mental illness by its definition can impair cognitive and emotive functioning and is often (poorly) characterized in terms of individual deficits (Xie 2013), a social undercurrent of anxiety remains regarding whether those who are labeled mentally ill can be trusted to think rationally, pursue their interests, and behave (see: Hinshaw and Stier 2008). This is particularly of concern within the mental health court context. These courts often specifically target individuals with "serious" mental illness (as is the case of the courts under study here) – i.e., mental illness that in principle "substantially interferes with or limits one or more major life activities" (NIMH 2019). Moreover, court participants arguably have already revealed themselves through their criminal offense(s) to be the kind of severely ill individuals who are discussed as "disruptive to communities" and, even in some cases, "violent." At first glance, it might be easy to imagine that all mental health court participants struggle with severe conditions that fundamentally shape (and impair) their lives, as well as their ability to narrate their experiences.

Yet, this kind of reading misses how diverse participants are and the reality that despite this diversity, participants overall tend to be capable social agents. Those who were interviewed were overwhelmingly coherent and competent narrators of their lived experience. They had knowledge, skills, and resources that allowed them to navigate their social realities and pursue their interests, although they sometimes made the kinds of poor decisions that could contribute to their suffering. Moreover, even a select few with the most severe symptoms tended to have a fair, if somewhat distorted, understanding of their reality that could illuminate the kinds of opportunities and constraints they faced in their daily lives.[3]

Further, it is important to flag that criminal justice involvement is a poor predictor of severe mental illness. Mental health court participants become involved with the criminal justice system for many of the same reasons as their counterparts without mental illness (see: Fisher et

[3] For example, a male participant diagnosed with schizophrenia with a history of hospitalization often alluded to how a scattered network of individuals in the community mysteriously knew information about him much to his frustration. In some ways, he sounded deluded as he explained, for example, of how this network knew about him: "I'm thinking it's like I don't know, you know, we're dealing with a supernatural time here. So I'm thinking its dealing with the supernatural whatever it is." Yet, after encounters with a police officer who hung up a poster the participant had given him in his office, a judge in another court who paid for his lunch every now and then, and others in the legal system who talked about him without being asked about him, it became clear that a network of individuals in the community did know him. While their knowledge was likely rooted in interactions driven in part by his mental illness (i.e., not a supernatural power), ultimately his assessment of reality was not as "crazy" as it initially seemed. In other words, he had a greater understanding of his experience then would be accounted for if such talk was simply attributed to delusion, as often is easy to do in such cases.

al. 2006; Hiday and Burns 2010; Epperson et al. 2014). Additionally, in terms the mental health court specifically, those offenders with severe impairments who cannot function independently in the community are not the primary target population of mental health courts. According to my observations of court proceedings, only a very small minority of participants experience the kind of significant functional disability that impedes their ability to make decisions about their own care and thus fall in a subgroup of those with severe mental illness commonly acknowledged as requiring more comprehensive state interventions (Monahan et al. 2003; Frank and Glied 2006).

Hence, overall, I argue that seeing court participants first and foremost in terms of mental illness misses the reality of their experiences in many ways. Mental illness is variable and episodic; it is not a constant influence on individuals' experiences. Moreover, mental illness is not directly correlated with social functioning. While diagnoses like schizophrenia and bipolar disorder sometimes help explain functional disabilities, they often only explain them in part and they are not predictive of the degree of disability one will experience. Further, many factors influence how illness manifests, such as substance use, trauma, environmental stressors, and social positioning, demanding a more holistic examination of the individual with mental illness.[4]

Additionally, how mental illness manifests as a *label* specifically is a social process. The ways in which participants identify symptoms, understand themselves, experience stigma, and seek help are conditioned by characteristics such as gender, ethnicity, age, and education. In turn, how they are, then, responded to is shaped by available diagnostic categories and potential biases of providers, who must do the sometimes-messy work of translating self-narratives into a diagnosis. Within the criminal justice and social service context, these processes are undoubtedly shaped in part by what such labels can help organizations and individuals achieve, functioning as strategic resources that can provide access to public aid (Watkins-Hayes 2009; Hansen et al. 2014), as well as in the case of the court, avert punishment, resulting at an extreme in some diagnoses that are "transparently incorrect" (Dobransky 2009, p725).

In this dissertation, then, I move away from framing participants first and foremost in terms of mental illness. I report diagnoses because they can shape how participants understand

[4] From this vantage point, some argue that manifestations of mental illness can even be viewed in part as a consequence of social life structured by inequality rather than primarily the product of a diseased brain (for a discussion of how social factors influence mental illness, see: Anshensel and Phelan 1999; Tausig 2007; Horowitz 1999, 2010; Throits 2010). (Moreover, this is far from a unique vantage point; health researchers have long demonstrated that social factors like socioeconomic status and race play a fundamental role in disease outcomes, see: Link and Phelan 1995; Phelan and Link 2015; Williams and Mohammed 2018).

themselves and their problems and the kinds of responses they receive inside and outside of the court (with faith that this will not lead the reader to discount participants' beliefs, aspirations, or interests as the product of confusion or delusion). Still, I generally deprioritize using diagnoses to understand how their internal (neurotransmission) processes contribute to their divergent experiences. Instead, I try to view participants more holistically, thinking about their cumulative exposure to social conditions in which mental illness can play a role, but does not fully define their experiences.

Importantly, this is not to suggest that I treat mental illness as completely relative to the point that it only exists in the eye of the beholder. Mental illness is a condition, that by definition, affects a person's thinking and behavior, with consequences for social relationships and daily functioning. Moreover, while I maintain some critical distance to mental health labels, I recognize that mental illness operates as a very prominent construct in the court. It becomes the central organizing feature of the intervention, shaping the perceptions and interactions of staff and participants. Drawing on dominant biomedical understandings of mental illness, judges often demand that participants prioritize mental health treatment (almost always psychiatric). From the court's vantage point, mental illness is a disease of the brain – or a chemical imbalance – that can be corrected through such treatment (as is common in mental health courts, see: Hughes and Peak 2013). Of course, staff debate how ill different participants really are behind closed doors and recognize some participants as more ill than others (see also: Dobranksy 2009). Moreover, staff might not reinforce this model across all affiliated settings, depending on their professional knowledge and personal beliefs (see: Watkins-Hayes 2009). However, its prominence at court (as well as likely in psychiatric offices and also within popular culture) certainly ensures that participants must contend with it. Many are often wrestling with how ill they really are and what kinds of treatments will change their experiences for the better. Yet, as will be shown treatment compliant participants can still have problems just as those who fail to comply might not. Moreover, treatment compliance itself misses the way in which individuals struggle to manage such conditions and exert control over their lives through their own working knowledge (Conrad 1985; Kleinman 1994).

Ultimately, then, this dissertation tries to present a more nuanced understanding of the diversity of human experience here that falls under the umbrella of mental illness and which then is processed through – and shaped by – mental health courts. Both participants and staff are

working to achieve the best possible outcomes. Facing criminal charges and associated problems, participants often experience significant distress and want help. Court staff regularly grapple with individuals who are caught up in problems – whether in terms of criminal justice involvement or simply behaviors that raise concerns about their wellbeing – and thus are eager to provide aid to participants in their moment of crisis. Within the mental health court context, these groups are channeled towards mandated and supervised mental health treatment. This works for some participants, but not all – and it certainly should not be read as a uniform evaluation of the attributes of all participants here.

Plan of Dissertation

This dissertation proceeds as follows. In Chapter 2, I describe my setting and methods. The study entailed several years of ethnographic observation in two mental health courts, coupled with longitudinal interviewing of participants in one mental health court. This approach provided different vantage points from which to interrogate the key questions guiding this dissertation. Observing staff while they were working and talking to them about their work, I tracked how they evaluated and responded to participants in practice. Simultaneously, observing participants and talking to them about their participation, I documented how they responded to and made sense of the program. While I analyze each group separately, taken together, their perspectives provide a window into how these two sets of actors each engaged with and (re)constituted the institutionally complex site of the mental health court.

In Chapter 3, I examine the experiences and perspectives of staff as they carry out their work. Starting with staff is important for two reasons. First, as frontline workers, they enact the intervention, establishing how program goals are pursued (and enforced) in practice. Second, in so doing, they establish the terrain to which participants are reacting. Building on a growing body of scholarship, I establish key tensions inherent in their work and how they overcome them. Specifically, I show that staff are pressured both to standardize their approach to participants, while also do so in non-standardized (i.e., individualized) ways. I argue that staff resolve the tension between standardization and non-standardization by turning to what I call the "institutional dispositions" – or institutional knowledge, skills, and styles – of participants. It is not staff that choose participant's fates through the complex and ambiguous decisions they are

tasked with making; rather, it is participants who must prove themselves to be ready, willing, and engaged, making them more or less deserving of accommodation and eventual successful completion of (or unsuccessful removal from) the program.

In Chapter 4, I turn to participants to better examine how they are engaging with the program. I show that, responding to staff, participants quickly learn that they must show themselves to be ready, open, and willing to help themselves – or at least begrudgingly go along with the help being provided. That is, they experience pressures and pulls to *perform compliance*. Yet, given the complexity of the setting, they can enact this performance in different ways. I present a typology of three strategies available to them to carry the performance out. I describe how each strategy works and show how they are embedded with unique costs and benefits tied to the complexities of this setting that participants must be equipped to manage as they navigate the program. I argue that while all strategies are possible in this context, they are not equally possible for all participants. Participants will find themselves more predisposed towards one strategy over another given their orientation towards settings like the criminal justice system and the resources at their disposal. Thus, some participants are more equipped than others to work with the program and this variation should be attributed to far more complex factors than staff are forced to ultimately rely upon for their evaluations.

In Chapter 5, I build on the argument developed in the previous chapter by examining how participants are differently equipped to carry out their performances across time. I show that to the degree to which participants face impediments and adversity, performing compliance becomes an increasingly difficult and undesirable feat. Their strategies break down as they face growing contradictions between what they are asked to do and what they have the resources to do. Hence, some participants are particularly likely to struggle in this context because the demands of participation are not easily reconcilable with their needs, desires, and aspirations. This chapter thus further shows how preexisting inequalities between the participant base are more likely to shape their engagement in this context than their willingness by more closely examining the constellation of advantages and disadvantages participants can differently experience in this setting across time.

In Chapter 6, I move beyond examining how participants are reacting to the pressures and pulls to perform compliance to more carefully examine how they are grappling with the outcomes that compliance intends to generate. After all, the program is designed to engage

participants in a set of practices and habits that they will ideally come to value, becoming more self-disciplined or, as I argue building on prior research, "self-controlled" individuals. Participants might only engage with this programmatic focus on self-control strategically to appease staff, but, as I show, many are often wrestling with what self-control means and what it can help them achieve as they confront significant turbulence in their lives in the form of a criminal offense and its collateral effects. For some, this focus on self-control provides them with exactly what they need—it helps them make sense of their problems and provides them with the interpretive tools to overcome it. However, for other participants, a focus on self-control can work to their disadvantage as it serves as a way to delegitimize and marginalize the real problems they face without offering any meaningful redress to them. Of course, most participants fall in between, working to find ways to make this focus work to their benefit, but struggling with the ways in which it does not.

I conclude with some reflections on how the tensions between how the program is intended to work on the books and how participants ultimately experienced it in practice. The result is some troubling issues for both programs, including predominantly what the "right" duration for the program should be and how treatment adherence could be increased after participation. I maintain that though the court provides helpful resources and helps many participants, it suffers from significant institutional and organizational constraints that generate barriers to achieving intended organizational outcomes for all.

Chapter 2
Setting and Methods

Introduction

This chapter lays out my setting and methods. I approached my research from two distinct vantage points: the experience of staff and participants. Staff and participants are differently positioned within the mental health court. On the one side, staff are the gatekeepers of potentially desirable resources as well as agents of social control; on the other, participants are dependent on and under the control of staff as they work to access resources and avoid amplifying punishment and control. Both perspectives are critical to understanding the mental health court and the processes unfolding within it.

These vantage points, however, were approached very differently. To better understand the experiences and perspectives of staff, I conducted ethnographic observation of routine staff decision-making practices in two urban mental health courts. I coupled these observations with in-depth interviews with staff members involved in these decision-making processes. This approach provided insight both into how staff implemented program goals in practice as a group, as well as what they thought about this work individually. Drawing on staff data from two courts allowed me both to qualify unique contingencies of each court, while also identifying shared patterns between them given a similar institutional form. To better understand the experiences and perspectives of participants, I conducted longitudinal, in-depth interviews with 42 participants in one of these courts (with 6 of these participants dropping out of the study after the first interview). These interviews provided insight into participants' experiences inside and outside of the court, although, as will be discussed, they were fundamentally shaped by the context of social control in which participants were likely very wary of the kinds of information they could share.

In this chapter, I explore these methods in greater depth. I begin by describing how I gained entrée to these courts. Second, I discuss the court structures. Third, I discuss staff-based

data collection. Fourth, I discuss participant-based data collection. Finally, I discuss data analysis, concluding by discussing how names and identifying information have been changed to protect anonymity of both participants and staff. This project received ethics approval through the Institutional Review Board.

Entering the fields and data collection timeline

This project began in January of 2012 after I was nudged by a fellow researcher to pursue my interest in mental health courts by simply contacting a court. I identified Kent County online. This court was selected with the expectation that due to its urban location, it would process a more racially diverse participant population in comparison to suburban and rural areas, providing greater variation among the participant population. I contacted the program coordinator and was invited to talk with her in person. I explained my interest in observing the decision-making of the staff and was permitted to do so. Over the course of a year (with the approval of the Institutional Review Board – IRB), I attended meetings whenever I was aware they were being held and I was available, which was approximately half of the meetings held. I also interviewed key staff involved with the decision-making processes and attended various events organized by the court, such as a graduation ceremony for participants.

The following winter, I transitioned away from attending meetings and towards volunteering on occasion with the court as I constructed a more rigorous research project. (Volunteering included primarily doing data entry at the treatment center and court, as well as occasionally participating in a community service project with participants. I also attended further graduation ceremonies and treatment center events.) Across this period, I designed a project focused specifically on ethnographically observing and interviewing participants, working closely with IRB and informally sharing ideas about this project's design with staff. After investing significant time in constructing and vetting this design, I finally was able to coordinate a formal meeting with the judge – Judge Perry – to seek his approval in August 2013. Judge Perry did not approve my proposed data collection methods with participants – including interviews – out of concern for the welfare of participants and my safety. He suggested I could instead survey participants. However, prior to being able to regroup, I experienced a personal setback, and the project stalled.

In the spring and summer of 2014, I regrouped. I participated very briefly in a project evaluating mental health courts approved by a state administrative body (interviewing a very limited number of Kent County participants with an approved interview protocol). The head evaluator of this project referred me to a mental health court (Rapids County) in which she thought the judge might be more amenable to my research goals. I reached out to the judge – Judge Ash – and program coordinator and was welcomed to Rapids County. I visited to discuss the project and gain an understanding of the court structure and processes. My research goals included ethnographically observing a small subset of participants, while also interviewing a larger group of participants. I also intended to observe staff decision-making to provide a comparison to Kent County. Securing the initial approval from Rapid County administrators for the project, I began again working with IRB in constructing a very detailed application given the issues this research posed. In the meantime, with the approval of Judge Perry (and IRB), I had begun systematically following *all* decision-making meetings for a full year in Kent County as a comparison case, as well as continuing to attend other related events such as an administrative meeting and treatment community events.

In the fall of 2014, IRB required me to gain approval from the state department of corrections (DOC) to interview and observe participants in Rapids County. Viewing this as a final hoop to jump through, I was surprised when, after much back and forth, DOC denied my request outright. They would not even approve interviews. This led to a protracted debate with IRB, but IRB ultimately maintained that I could not recruit probationers without the approval of DOC. I was only allowed to observe or interview participants who were not supervised by DOC, which included those participating in the court on a delayed sentence rather than as part of a probation sentence. With this significant restriction, I commenced data collection in Rapids County (January 2015) alongside my ongoing research in Kent County (which wrapped up in August 2015 with a bout of interviews with staff). This included both observing staff decision-making and recruiting participants. All staff members involved in decision-making and participants recruited were engaged in informed consent processes to clarify the research process, including what kind of data was being collected, how it was being stored, and how it would be shared.

While my goal was first and foremost to observe participants, I quickly confronted multiple barriers. Those participants who I felt most comfortable observing, were least hesitant

about my researcher role, and were available (i.e., not going to spaces such as formal employment sites where I could not go) were disproportionately middle-aged white women without employment or familial obligations, creating a significant bias in my study results. Moreover, observing other participants often involved going to sites that required further access, and I was denied access to the first two sites I requested and lost hope in pursuing access to others. I spent some time with a couple of participants who initially agreed to more extensive participation in the form of doing community service but focused my efforts on interviewing participants. I also began volunteering with the local police department and interviewing other legal actors – including judges and a prosecutor – to gain a better understanding of the institutional dynamics that shaped the court.

After I struggled to meet interview enrollment goals for participants, I renewed my efforts to seek approval from the DOC. Having contacted different actors from researchers who interfaced with the DOC to former DOC employees in the meantime, I had a much better sense of how to frame my request. In the fall of 2015, I obtained a statement from DOC saying that their approval was not required to interview probationers (which met IRB's requirement). I thus began enrolling probationers for interviews as well. After meeting my enrollment goals and watching many of my research subjects graduate from the program or be removed from it, I began wrapping up my data collection in Rapids County. I attended staff decision-making meetings and court less frequently. My final day of observation was in May 2017. My final interviews with a few research subjects concluded five months later.

After I completed data collection, I fully engaged in data analysis of both sets of data, as will be described in greater detail below. As I started participant data analysis, I realized I overlooked placing an explicit written request on my interview consent forms to link participant data with staff-based data, reflecting my initial plan to focus predominantly on ethnographic subjects (where the request was made). I consulted IRB to question what steps I should take to make these links in my analysis, some of which were already embedded in my data (for example, often participants and I discussed things staff said or did, having both been present when they happened) and which fundamentally shaped my data (given that I discussed my dual data collection methods with participants in the informed consent process, which as I will contend below, shaped how they participated in the interview process). IRB indicated I would need to recontact all participants to gain their consent to make links between both sets of data in my

analysis. Given that many participants change phone numbers readily and only a select few would be contactable (and likely those who achieved the greatest stability), I decided instead to analyze both datasets separately. Hence, my analysis proceeds along two separate tracks, first examining the experiences of staff and, then, examining those of participants.

Kent County and Rapids County Mental Health Courts

This study draws on data from two urban, midwestern mental health courts. Mental health courts vary significantly in form (see: BJA 2008b; Steadman et al. 2001) and these courts were no exception. As such, studying them together create important points of comparison. In this study, I highlight differences between the courts to qualify some of the findings unique to each, particularly my findings on Rapids County participants. Acknowledging the general diversity of mental health courts, it is important to be cognizant of the ways in which findings in this area are not universally applicable to all mental health courts. However, as I will argue in this dissertation, despite substantive differences between these courts, both share a basic institutional form that generates similar kinds of tensions and processes. My goal is to critically examine this institutional form throughout this dissertation, offering generalizations about the kinds of tensions and processes it produces – and ultimately describing their mixed effects for the mission of the court and institutional forms like it. In this section, I begin to lay the foundation for this argument by describing the basic structures of both courts.

Rapids County and Kent County courts developed only two years apart alongside a wave of mental health courts that have also developed over the past two decades. They both adhere to general guidelines for mental health court programs, receive state funding due to this adherence, and thus appear similar in many key ways. For example, both are run by a single judge who has ultimate decision-making authority and incorporate treatment providers directly into decision-making practices. Both are designed to link their participants – offenders with serious mental illness – to treatment and social services and engage them in activity to keep them busy while aiming to eliminate any illicit substance use. Both retain relatively flexible goals of improving the lives of their diverse participant population through individualized treatment plans. While these courts share such key similarities, they differ significantly.

Kent County is a felony mental health court that focused on nonviolent offenses, rarely accepting violent offenses. Due to their selection criteria, it is unsurprising that many Kent County participants also had histories of illicit substance use, which is prevalent among those with serious mental illness and likely even more so among nonviolent felony offenders with mental illness, many of whom might be charged with drug-related offenses. It was rare for participants to be explicitly described as not having co-occurring substance use issues. During the period of observation, the participant population was mixed gender and included predominantly white and black participants of varying ages. By the court's account, the average age of participants was above thirty, with a re-occurring concern across the observation periods being that they needed to reduce acceptance of younger participants (i.e., participants 25 years and younger) who staff generally perceived as not doing well in the program. Candidates who agreed to participate in the program were sentenced to mental health court probation, supervised both by state corrections and the court program.

Program participation followed a long-term, staged approach to recovery. Participants were required to move through different phases of participation, with each phase generally decreasing in supervision and requirements. Requirements generally included reporting to staff (a court case manager, a probation officer, treatment case managers, and the judge in a monthly court appearance), treatment adherence (reporting to treatment appointments and taking psychiatric medication), drug and alcohol abstinence (with drug testing occurring at regular intervals), stable housing, and "staying busy" (whether through employment, education, community service, or more extensive treatment, frequently for twenty hours per week). Notably, Kent County was particularly focused on linking participants to a range of transitional housing options in the community and often relied on inpatient substance use treatment, with a significant portion of their participants being placed in such facilities while participating in the court program for 90-120 days, sometimes multiple times. Participants generally progressed through phases as they demonstrated adherence to requirements and became more engaged in consistent activity such as community service or employment. Participants who did not follow such requirements could face sanctions such as corrections-based community service, electronic monitoring bracelets, and jail days as well as demotions in phases.

Participants who were consistently noncompliant were terminated from the program and re-sentenced on their initial charge by the mental health court judge, a criminal court judge.

While the judge sentenced some of these participants to prison and could extend sentences based on their noncompliance in the program, in some cases participants were simply transferred to regular probation. Participants who were consistently compliant enough could successfully complete the program and would be requested to attend a graduation ceremony held in the summer. In some cases, participants might complete the program early, but most participants seemed to complete the program following their designated probation period. Participants also could be extended in the program on a case-by-case basis due to noncompliance. The program initially started as a 12-month program, but changed to 18 months and then 32 months, with staff still debating the appropriate length for the program when observations concluded.

Rapids County is a mixed misdemeanor and felony court that accepts violent offenses on a case-by-case basis. Due to their selection criteria, it appeared that Rapids County accepted participants with greater variation in terms of their functional disabilities, including participants with significant functional disabilities (some of which contributed to their offense) with greater frequency. Rapids County participants also commonly had histories of substance use, although marijuana and alcohol seemed to be the most common form, with a smaller proportion of participants engaged in cocaine, heroin, and prescription drug misuse and abuse when compared to Kent County. (Still, such a comparison is in part flawed given variation in court practices that might have increased a focus on such substance use in Kent County.) Rapids County also had a mixed gender participant population that included predominantly white and black participants of varying ages, although they tended to process younger participants with more regularity and did not similarly discuss a need to exclude younger participants.

Rapids County provided two different pathways through the program based on the participant's plea deal with the prosecutor's office. Participants could either participate as a condition of probation, with satisfactory completion of the court program one stipulation of a participant's probation, or participants could participate on a delayed sentence in which the charge would be dismissed upon successful completion of the program. While severity of offense certainly played a role in which pathway participants were offered, participants could participate in the court on a delayed sentence with felony offenses in some cases. Participant's cases generally remained under the jurisdiction of the judge who sentenced them and would be in charge of re-sentencing them if the participant did not successfully complete the program (although Judge Ash re-sentenced participants in some cases).

Program participation included many of the same features—reporting to staff, treatment adherence, drug and alcohol abstinence, stable housing, and "staying busy"—but unfolded differently. The judge and other staff explicitly rejected a stage approach to the program in which participants would have to progress through standardized phases due to how varied their population was. Staff still generally reduced supervision as participants progressed through the program, but this was applied to participants more flexibly and some participants could make it through the program successfully without such reductions. The court also appeared to rely less on inpatient substance use treatment and transitional housing when compared to Kent County. Most participants were not placed in inpatient treatment facilities, and when they were, they could spend much less time there (although, in some cases, Rapids County participants could also spend significant bouts in such facilities). Additionally, Rapids County participants rarely were placed on electronic monitoring bracelets, a standard practice in Kent County, and often only were on them as a stipulation imposed by the judge who held jurisdiction over their case. Supervision was less intensive in Rapids County, although they still relied on jail and corrections-based community service sanctions. Finally, Rapids County did not have rigid guidelines for drug testing participants. They generally drug tested participants at multiple points across their participation but tended to only increase drug testing when substance use emerged as a potential concern.

Participants who were consistently noncompliant were terminated from the program and re-sentenced on their initial charge. These sentencing practices were not observed, but interviews conducted with nine judges suggested sentencing varied from probation to prison time, depending on the criminal charge and the judge's beliefs about alternative rehabilitation strategies. Participants who were consistently compliant could successfully complete the program at a graduation ceremony that occurred at their last required court appearance, and often was held anywhere from a couple of months to a week or two early. The program was a yearlong, although it could be extended on a case-by-case basis, and staff reported being in the process of extending its duration for felony cases to be more competitive with other mental health courts seeking the same grant funding source.

In short, Rapids County and Kent County varied in multiple ways. Particularly, Kent Count offered longer and more extensive supervision. Kent County also focused more on standardizing requirements, although Kent County staff treated some participants with greater

flexibility in terms of meeting these requirements. Of course, the participant population between courts likely varied significantly as did the services available to help participants. Next, I turn to describing staff-based data collection in both courts.

Staff-based data collection: status reviews and hearings

Mental health courts are boundary-spanning organizations (Steadman 1992) that operate to bring together actors from different organizations under one organizational umbrella. Much of the organizational work that the mental health court depends upon, then, is carried out in affiliated organizations like community mental health centers. However, all this organizational work coalesces around the decision-making of key mental health court staff, which occurs in routine intervals in what are called here status or case reviews – deliberations in which criminal justice and treatment staff members determine how to process cases. These reviews are followed by status hearings in the public courtroom where the judge interacts with participants and enacts decisions. These decision-making processes thus serve a critical function in the court. I describe them and how I observed them in greater detail below.

The content of these decision-making processes varied across participants and, to degree, across courts, but was focused around treatment compliance, substance use, and use of time (e.g., whether participants were engaged in meaningful life activity such as community service or employment). Still, staff could expand their discussions into wide-ranging domains from housing and social support to legal problems to odd mannerisms observed and behaviors reported by inpatient counselors, peers, or family members. In both courts, these meetings were generally held on a weekly basis. They focused on participants on the docket for the day, i.e., the participants who were expected to have their progress reviewed by the judge, generally in open court. While staff decision-making occurred at these regular intervals, not all participants had their progress reviewed at the same frequency. In Kent County, a participant's progress was reviewed monthly, with judicial supervision sometimes increased on a case-by-case basis. In Rapids County, a participant's progress was reviewed weekly to monthly, with judicial supervision generally decreasing as they progressed in the program.

The decision-making process in both courts was lengthy, unfolding sequentially across several settings. First, a meeting was held at a treatment center in which treatment providers

(case managers and administrators) provided updates and recommendations for each case on the docket. In Rapids County, this occurred in one community mental health treatment center, but included many different actors, including a direct representative of the court—the program coordinator. The meeting was directed particularly by a key treatment administrator who took notes on case reviews and would later provide reports to the judge. Multiple community mental health centers were represented in this meeting, two by treatment administrators who provided the reports of several treatment case managers and two by treatment case managers who provided direct reports on their participants. These meetings were organized by a docket shared with all staff members in advance of the meeting that the program coordinator produced.

Staff went through the docket, with treatment administrators and case managers providing reports as their cases came up and the program coordinator or treatment administrator asking questions, and in some cases, providing additional details from their own experiences with participants, with other staff members adding advice as deemed necessary. In Kent County, I did not secure permission to collect data on these meetings (having not even realized they were occurring until later in my observations), which involved only treatment providers from the one community mental health center directly affiliated with the court program, although I initially attended a few meetings upon learning of them and could surmise that they served a similar function. These meetings provide a layer of peer review, ensuring that a primary source of information that drives judicial decision-making—case manager reports—is first vetted by other treatment staff, who can help identify the best possible treatment interventions, and condense information into key recommendations to share with the judge.

Second, a meeting was held at court in which case reviews were provided directly to the judge. Again, these meetings unfolded differently across courts. In Rapids County, these meetings were held shortly after the treatment meeting in the judge's quarters (and I did not attend these meetings until later in my observations). They involved limited staff, with most treatment providers not present. The treatment administrator summarized the reports of treatment providers. These meetings were generally short and to the point and could involve tacit information sharing. Key staff, including the judge, often had pre-existing, shared knowledge about participants or the criminal justice and treatment systems that affected how they talked (or did not talk) about cases. In these meetings, the treatment administrator followed the order of the docket, reviewing cases, while the judge took notes on her docket and added input or asked

questions. The program coordinator might make corrections and other staff, such as a defense attorney, might be asked to provide feedback.

In Kent County, these meetings generally did not seem to occur on the same day as the treatment meetings. They were held in a jury deliberation room, which was often packed with staff members, including: the judge, a program coordinator, a treatment administrator, multiple treatment case managers, court case managers (a position constructed in this court to provide an additional layer of supervision), probation officers, a nurse, an employment specialist, and, often, a rotating inpatient substance abuse treatment provider. Public defenders sometimes came to these meetings, but this was not required (as recounted to me by public defenders in interviews) and they often added little to, most commonly, no input. Perhaps unsurprisingly, case reviews could be much longer, potentially engaging at least three staff members who regularly were tasked with directly interacting with participants: a probation officer, a court case manager, and a treatment case manager. However, given that most participants were reporting less frequently to the judge, Kent County staff generally reviewed less cases when compared to Rapids County, providing more time to deliberate over each case. Kent County also relied on a docket to organize the meeting. Case reviews generally began with a court case manager reviewing the participant's case, particularly in terms of key points of compliance they reviewed earlier that day with the participant in their office, including a drug test that court case managers monitored. Other staff members would then add information or opinions, as they collaborated in discussing how to respond to the participant. The judge routinely concluded the review, often enough through articulating a decision regarding the disposition of the participant.

Third, following this meeting, official "status hearings" were held. All participants on the docket came before the judge to discuss their progress in open court. While the judge had already received information on the participant from staff, participants might offer conflicting interpretations of this information or new information altogether. This interaction culminated in the judge enacting a decision, which could involve no change to the participant's current course, or any type of decision that staff had the power to make from rewarding a participant to terminating them from the program altogether. Generally, this decision reflected the consensus in staff-only meetings; however, the decision might also be changed due to new information provided in court or, simply, the judge forgetting to enact a given decision or changing their

mind (particularly in the case of less serious decisions such as failing to mandate a new treatment as requested by staff) (see also: Baker 2013).

Status hearings also varied across courts. In Rapids County, participants came before the judge more frequently and thus more participants appeared at court, often with kin and associates. The gallery, which was relatively large, was generally full, sometimes with individuals standing in the back, and could be quite boisterous. Various staff members, particularly treatment case managers or lawyers, might be pulling participants out of court to talk with them privately prior to their status hearing. On most days, status hearings were preceded by a participant receiving a special honor for doing well and/or a graduation ceremony in which participants in the gallery might be engaged through, for example, the judge asking if anyone wanted to congratulate the graduate. After these more jovial events, status hearings commenced, with the treatment administrator calling participants up one-by-one to interact with the judge. Participants were accompanied by their treatment case manager, who was to both act as an advocate and report on them.

In Kent County, participants generally came before the judge on a monthly basis, with some exceptions, and thus on any given day only a quarter of all participating participants appeared. While some participants brought family, romantic partners, or friends, the gallery was both smaller and never very full by comparison, and during my period of observation, participants were eventually required to sit in the jury box until they were called, separate from anyone attending with them who remained in the gallery. Participants doing well were generally called towards the beginning, but the program did not have the same formalized graduation or special honors appearances to precede hearings (graduations were instead held as one annual ceremony). Further, treatment caseworkers did not stand with participants. Instead, participants stood alone, unless court case managers were called upon to stand to report on a participant's noncompliance or a public defender was called for more formal proceedings.

I collected data on the various components of these decision-making processes (as delineated above) in both courts across two years (2012 and 2014-2015 in Kent County and 2015-2017 in Rapids County). I sat in on meetings and in open court with a laptop. Data collected consisted of notes typed of all components of the decision-making process observed, without editing based on analytic presuppositions or hypotheses. Participant identifiers were not retained, but the professional background of staff reporting information was indicated. I

reviewed and filled in these notes (where shorthand was otherwise used) between and after staff decision-making meetings and into the next day. In both courts, I experienced significant learning curves, slowly gaining a greater understanding of the types of resources, services, and processes being discussed. Hence, while I did not initially intend to spend so much time observing staff decision-making, doing so allowed me to gain a more refined understanding of the experiences and perspectives of staff as they carried out their work.

To further refine this understanding, I also conducted in-depth interviews with all staff members involved in decision-making, excluding those working for DOC in Rapids County for whom I would have had to specifically seek DOC approval (given their involvement in the Rapids County IRB review).[5] This included 19 staff members in Kent County (2 public defenders, 2 probation officers, 6 community mental health treatment providers, 1 program coordinator, 4 court case managers, 2 inpatient substance use counselors, an employment specialist, and the judge) and 9 staff members in Rapids County (2 public defenders, 5 community mental health treatment providers, 1 program coordinator, and the judge), although I also interviewed staff members who had a less direct role in court processes (2 treatment case managers, 1 inpatient counselor, a prosecutor, and 9 judges). Interviews with those directly involved in decision-making were carried out in offices or nearby coffee shops. They tended to last around 1 hour. They included questions about their career trajectories, understanding of program participants and their problems, and their perspective on mental health court practices. These interviews were recorded and transcribed verbatim either by me or a transcription service.[6] Interviews with those less directly involved in Rapids County mental health court were conducted in person, over the phone, or, in the case of one treatment case manager, by email. These interviews tended to be shorter.

Despite spending significant time with staff, ultimately much of this data plays a background role in the dissertation. I condensed my years of fieldwork and interviewing into a single chapter. Still, I detail what these processes were like here because they shaped my orientation towards participant data. Understanding the perspective and experiences of staff in these settings helped to elucidate the environment in which participants operated and to which

[5] I interviewed one staff member working for the county, but could not use this data as it turned out he was an employee of DOC. I ultimately decided not to pursue DOC approval for staff given time constraints.
6 The exception was one court caseworker who requested that his interview not be recorded but allowed me to type notes.

they were responding. It also helped reveal some of the fundamental tensions that shape how the court is constrained in helping participants, as I turn to exploring in the dissertation's conclusion. Still, the data that most shaped this dissertation were derived from participants, which I turn to now.

Participant-based data: longitudinal interviews

To better understand participants' perspectives and experiences in the court context, I ultimately relied on in-depth longitudinal interviews with participants (see: Grinyer and Thomas 2012). Longitudinal interviews are necessary to study fluctuations in participants' experiences as they progress through the program, with the expectation that their relationship to it will change over time as they experience obstacles, setbacks, punishments, and, ideally from the perspective of the program, benefit from and internalize treatment goals. A longitudinal design also provides opportunity to build trust with participants, who in a context of social control, might have plenty to conceal in the interview process.

Interviews were conducted with 18 female and 24 male participants who self-identified as black, white, or mixed race and varied in age from 18 to 57, meeting the recruitment goal of generating variation in court experience across race, gender, and age. (Seven participants rejected participating and ten more agreed to participate, but then failed to show up or a date was never coordinated.) Those interviewed were disproportionately successful, with only 12 participants interviewed terminated from the program. This imbalance was likely generated for several reasons, but two are most notable. Initially, the DOC denied access to probationers, resulting in recruitment of a first wave of participants who were participating as a condition of a delayed sentence, which seemed to correlate with lower levels of prior criminal justice involvement and greater rates of program success when compared to probationers. Access was eventually gained to the probationer population. All but two interview subjects terminated from the program were probationers. More noteworthy, a recruitment bias emerged in which participants were targeted who appeared to have some stability vis-à-vis initial compliance with the program after observing status hearings (where participants were recruited) and thus assumed to have a greater likelihood of showing up for interviews. While I anticipated targeting

participants as they adjusted to the program, this clearly resulted in missing participants who struggled the most in the program.

First interviews were generally conducted within months of participants starting the program. They were compensated with 35 dollars, with all follow-up interviews (which were intended to be shorter) compensated with 20 dollars. The majority of participants were interviewed 1-3 times, which was the initial goal, although 8 female and 5 male participants (who were recruited mostly earlier in the process) were interviewed 4-6 times to better account for fluctuations in the participant experience and build trust. Unintentionally, this resulted in more interviews with 5 white females, 3 black females, and 5 black males (the majority of whom were participating on a delayed sentence). Participants who successfully completed the program were interviewed within weeks of graduating, with the exception of five participants who did not respond to the request and one participant who was interviewed days before graduating. Participants who were terminated from the program were not interviewed after termination due to a lack of access. Interviews lasted approximately one hour and covered the same range of domains across time including: program-related topics such as requirements, sanctions, and court staff, treatment-related topics such as mental health, substance use, and treatment, and support-related topics such as employment, education, housing, income, and social support. Interviews were recorded and transcribed verbatim by a transcriptions service.

The way in which participants were recruited and participated in the interview process produced a dynamic that informs the core analytic insights of this dissertation. Specifically, participants likely related to the interview process in similar ways as they related to the court generally, replicating similar kinds of tensions. Participants had good reason, at least initially, to view me as a potential arm of the court. Participants were alerted to the study through a handout passed out by court staff and regularly saw me in court, where I made my first contact with them. I physically separated myself from court staff in this space, sitting with participants and their kin in the court gallery, but I stood out by regularly typing on a laptop (which required special permission to bring through security into the courthouse), taking notes on court sessions, and interacted with staff informally. To recruit participants, I explained to them the study before or after the participant's appearance in front of the judge, generally immediately outside of the courtroom. If participants agreed to participate, we set a time to meet for the interview. At these meetings, I engaged participants in the informed consent process, explaining how data was being

collected and stored and would be reported. Most importantly for participants, I explained that I also observed staff decision-making, but there would be no information-sharing with either party outside of de-identified official reports.

While I emphasized confidentiality, it is likely that many participants felt a risk that I would share information with staff or otherwise adopt the perspective of staff. In a couple of cases, younger participants seemed to confuse me with court staff. In one case, a participant failed to remove alcohol from his house prior to an interview and later admitted he thought I would reveal this type of information to staff due to reporting requirements despite my emphasis on confidentiality. Only after learning I did not do so and discussing why did he reveal greater information about his departure from program goals. While many participants might talk about how they would depart from program goals in the future, only a minority talked about departures they reported as not detected by court staff. Sharing information about departures increased in later interviews, particularly after participants successfully completed the program. Participants thus indicated that they were aware they needed to be talking in ways that reflected how they wanted these topics portrayed in the court context, particularly towards the beginning of the interview process prior to any level of trust being established. As a result, I did not systematically collect in-depth data on the dynamics that led to participants removal from the program. The minority of participants who were removed from the program tended to present themselves as compliant with its rules in the select number of interviews prior to program removal.

Further, my positioning as a white, female graduate student and the focus of my activity with participants in part replicated a staff-participant dynamic in the interview process and which could create barriers to building rapport. Like staff members, I had considerable social distance to many of the participants. I interviewed participants about key topics—including mental health, substance use, treatment, and criminal offending—that were the focus of the intervention and thus likely key domains covered in their interactions with court staff, particularly treatment staff members who also reviewed such information at length in screenings to determine treatment needs. In this way, I positioned myself in a similar role as a staff member, soliciting information about potentially stigmatized topics for which participants could get in trouble from a position of social distance and potential judgment. Participants thus also likely were conscientious of how they wanted to portray themselves generally in this dynamic and shared in ways that mirrored

how they might share with staff. However, even beyond the staff-participant dynamic, participants might have had an interest in shaping the way in which I saw them as a researcher or might have maintained mistrust towards me due to my social identity and presentation of self.

Additionally, I maintained my own biases and assumptions that shaped the kinds of follow-up questions that I asked as interviews unfolded. In particular, participants often enough made contradictory claims around stigmatizing and punishable conduct such as substance use. Sometimes I attempted to solicit greater detail, but other times I did not out of my own discomfort. Ideally, interviewers find ways to support and empower interviewees to ensure reciprocal interaction resulting in richer data (Lillrank 2012). However, I likely gave off cues as to what I found aberrant or uncomfortable, shaping participant responses and how topics we covered together were explored.

Still, I was not a court staff member. I did not affect participant's access to services or resources and I could not punish them for their beliefs or behavior. I explained to them the purpose of my study and how I maintained confidentiality and I worked to build trust with participants through conducting multiple interviews across time, including purposefully interviewing participants after they completed the program. I tried to remain attentive to the social distance between myself and participants and how participants might differently be reading me across time in ways that affected our conversations. While participants could talk in ways that were contradictory, convoluted, and sometimes seemingly dishonest, they shared significant details about their experiences inside and outside of the court, including in many cases how their beliefs departed from program goals. In fact, how some participants chose to do so was revealing of the ways that participants could engage with the program, with some seemingly better equipped to navigate program goals they might not fully support or support at all. This dissertation then does not comprehensively track what participants fundamentally believe about their problems and the program; instead, it tracks how participants talk within a context of social control and what that says about how they can and will engage with the program here.

Importantly, this talk could be influenced not only by the interviewer's identity or the social control context, but by the interview process itself. Interviews are relational work and given that, in most cases, this relationship was built across the course of multiple interviews, participants might have changed their self-presentations and talk as the interview relationship

changed. As noted, participants tended to disclose more in later interviews as rapport was built. Additionally, the questions asked in initial interviews might have provoked reflection that influenced how participants thought about and experienced the program, shaping responses in later interviews. In this vein, findings could reflect less about how participants' orientations towards the program changed and more about how their relationship to the interview process and interviewer changed. I try to grapple with these dynamics in chapter 5 where I look at change in participant talk. I ultimately cannot fully know the source of change from these interview methods. Most problematically, I anticipate that the degree to which participants increasingly disclosed information varied across the participant base, creating biases in what data I was able to collect (impacting, as noted, what I can say about those cases that were terminated from the program). However, I work to be reflexive about this potential bias in my analysis and attentive to the ways in which changes in talk can be both a reflection of change in perspective and change in relationship to the interview process.

Finally, I also work to be attentive to how the specific dynamics unfolding at the time of the interview differently shape talk. After all, the participant interviewed immediately prior to court when they were concerned that they might be jailed for noncompliance could express a different perspective about the program – and its potential fairness – than the participant nearing graduation who had no reason to fear upcoming jail sanctions and had long since overcome the deleterious effects of past jail sanctions. Likewise, the participant who perceived she was gaining support from staff had a very distinct perspective about the program when compared to later experiences in which she believed staff had retracted this aid. While my goal was to interview most participants near the beginning, middle, and end of their participation, I ultimately interviewed participants for a range of factors in practice, including availability and willingness. Hence, I did not systematically interview all participants at similar points.

As a result, my dissertation is not designed to draw generalizable empirical comparisons across all participant cases, but to document processes unfolding in this context and the possible mechanisms that can explain them. More specifically, I aim to better explain the kinds of demands participants are subject to in contexts like, identify available participant responses, and trace how participants are differently equipped to engage in these responses, a line of inquiry possible to investigate through interviewing a diverse group of participants at different points across their participation.

Data Analysis

Data analysis is rooted in an inductive, comparative method. Analytic categories were developed across time through an iterative process in which I moved between examining the experiences and perspectives of participants and staff. Data derived from each group provided leverage over the kinds of analytic categories that should be investigated across these two groups. Data collection in part followed a grounded theory approach (Glaser and Strauss 1967; Charmaz and Belgrave 2012) in that interview questions for staff and participants were designed as important themes were being noticed in my fieldwork. However, the bulk of analysis that informs this dissertation was carried out when data collection was completed as I increasingly became interested in examining how the varied forms of participant engagement mapped onto staff expectations and requirements.

Data analysis thus proceeded in two, iterative stages (talked about separately here to condense information about each stage). I started by coding and analyzing staff-based data to look for patterns in how staff thought about and processed participant cases. Coding and analysis of these fieldnotes and transcripts was conducted using Atlas TI qualitative software. Initially, coding was open-ended, pursuing wide-ranging themes, but as I coded more of my data, I began refining and revising a coding scheme focused around the kinds of institutional engagement staff privileged. However, for this analysis, I ultimately relied most heavily on interview transcripts where staff talked openly about what made participants successful in the court and the reasons some participants were not successful (belief systems that could sometimes be glossed over in deliberations, particularly in Rapids County where certain kinds of decisions were made more efficiently and sometimes unfolded in part outside of the decision-making setting given how closely staff worked together outside of these meetings).

Second, I also coded and analyzed participant data. Given that my data for each participant could be extensive, I began by working with seven undergraduate research assistants (differently compensated through a research grant or course credit, depending on when they joined the project and available funds) to provide thick descriptions—summaries that relied heavily on direct quotes from participants—of what participants said regarding a range of topics, focusing primarily on beliefs and behaviors regarding criminal offending, mental health, substance use, treatment, and the program, but also histories within the mental health and

criminal justice system and various supports like housing, employment, and income. Research assistants were provided with extensive directions on how summaries were to be completed, along with examples of summaries, and I reviewed their summary work alongside interview transcripts until it was clear they were capturing the appropriate content and level of detail. Summaries on average were between 10 to 20 pages (single-spaced) in length.

The purpose of these summaries was to capture the nuances of what participants said both within and across interviews around specific domains, particularly to layout any changes or shifts in their accounting. Interviews generally can include contradictory and vague data, and this seemed to be particularly true in this setting where participants faced evolving forms of social control and were wary of what they said. In some cases, participants appeared to change their minds across time. For example, some participants were very favorable of the program until they thought they might be jailed or might become more favorable of the program as they gained increasing forms of support. In other cases, participants were clear they had concealed some beliefs initially. For example, a participant initially explained that his involvement with the mental health system stemmed from what he vaguely described as poor behavior in school. In a later interview (as he became increasingly open about multiple topics for which he could face penalties), he reported that his involvement with the mental health system started when he strategically claimed he was suicidal to get out of a bad foster care situation. Hence, these summaries made it easier to gain a comprehensive perspective of what the participant was offering, rather than relying on an isolated statement.

As summaries were completed, I analyzed them to examine the different ways in which participants were engaging with the program and explore factors that might shape this variation. I developed a typology of strategies participants employed in this setting. I initially identified 7 strategies, but increasingly refined these into 3 ideal-typical strategies that could be employed in different ways both at a given point and across time. As I identified the key qualities that characterized these strategies, I reviewed all participant cases to examine how participants were differently employing them, what explained variation across participant cases, and how this variation differently shaped what participants were gaining across their participation in the program. Inductively finding that pre-existing inequalities between the participant base were fundamentally shaping their engagement, I returned to staff-based data to think about the ways in

which staff thought and talked about participant engagement to identify discrepancies between these two groups.

Certainly, identifying and describing the kinds of strategies participants employed and how these strategies were differently privileged by staff requires considerable simplification of complex patterns. Ultimately, a key finding of this analysis is that participants vary considerably, making it difficult to neatly fit them all to a single typology, and staff are grappling with significant complexity in which they regularly employ flexible approaches to a varied participant base. Still, the patterns identified here help delineate key points of distinction that matter for how participants are differently equipped to engage in this setting and how staff are not adequately equipped to attend to this variation among their participants.

Masking Identities

It is important to note that names and identifying information have been changed to protect anonymity of both participants and staff. Yet, masking both groups' identities is an imperfect process. Given the unique structures and process of the courts (which have been assigned pseudonyms), outsiders could potentially identify the courts and thus the staff working in them. However, pseudonyms create an extra barrier such that these results are not immediately associated with either court (for example, in an internet search). The decision to not further conceal characteristics of the courts was made as these findings ultimately should not reflect poorly on the courts or their staff (and thus not have negative repercussions for them). While I am critical of institutional arrangements that reproduce inequality and use these courts to examine how this happens, my overarching point is that these staff provide a best-case scenario of dedicated professionals working to help participants achieve better outcomes.

I take a similar stance towards individual staff. Much of the talk of staff unfolded in front of each other and staff interview data I present is not significantly critical of the court organization or otherwise controversial. Hence, I use the professional background of staff to help situate their commentary, even though this makes them (more – or completely as in the cases of judges, for example –) identifiable, particularly to other staff members.

However, masking participants identities raises another set of issues. In some ways, it is easier to conceal the identity of the participant to the outsider given that their identities are not publicly

linked to the court. Still, staff knew participants' cases intimately and thus could potentially recognize participants by key characteristics. In some cases, this might be less concerning, as participants are clear that they gladly share with staff the same kinds of information they share in interviews largely because their perspectives and experiences are not at odds with the expectations and goals of staff. Yet, in some cases, participants are critical of the court or share information for which they could have been penalized. While staff also expect this in participants (and, in some cases, participants report that they share some of their otherwise undetected noncompliance and frustrations with key staff members as well), in some cases, I alter identifying characteristics of participants to better protect their privacy (e.g., changing a person's gender, age, criminal offense, or employment history)

Chapter 3
Plotting out Diverse and Dynamic Mental Health Court Standards

Introduction

In this chapter, I turn to exploring the – predominantly informal – standards court staff use to assess and respond to participants in their routine decision-making. These standards function as the rules of the game. They establish the parameters for how participants should and can conduct themselves if they are to successfully complete the program. As such, these standards will provide context for later chapters that explore this conduct directly. My primary goal is simply to lay out what these standards are in practice – and how they are applied in discretionary, which is to say non-standardized, ways – to better understand the opportunities and constraints participants must navigate across their participation.

Attending to the informal standards of court staff is critical to an analysis of mental health courts. Court staff function as "frontline workers" – those positioned to work directly with clients at the lower echelons of bureaucratic organizations (see: Lispky 1980; see also: Chiarello 2015). This work is characterized by significant discretion. Policies "on the books" must be interpreted in practice, with frontline workers determining how to allot organizational resources such as public aid, as well as, in the court context, criminal justice sanctions. Such determinations are far from clear-cut; they are shaped by the distinct experiences, beliefs, knowledge, and identities of frontline workers, as well as local cultures of the courts themselves (Watkins-Hayes 2009). In other words, frontline workers play a fundamental role in determining how policy is enacted (and reenacted) on the ground – or in this case, how the mental health court takes form in practice – and these processes can unfold in different ways depending on the staff involved and the local cultures in which they operate.

I draw on ethnographic data of staff deliberation and decision-making routines (as described in my methods chapter) to explore this frontline work. I demonstrate that staff across the courts observed here are highly dedicated to a shared set of goals advanced by mental court

policy and policy guidelines. They translate these goals into rules that they treat as standards all participants can and should meet: i.e., the minimum requirement to successfully progress through the program and, in principle, make life decent and good. Staff promote them as such and turn to enforcement in key moments when participants fail to comply. However, these standards, in fact, are applied in non-standardized ways. This happens most conspicuously between courts as the rules for different courts, even around the same set of goals, materialize with different intensity, revealing no one reliable set of standards for the mental health court.

Most importantly, however, despite differences between courts, staff across courts express a similar tension given the complex institutional terrain in which they operate: they work to find ways of applying their rules in fair and uniform ways, while also responding to participants as individuals with distinct attributes and circumstances. In the process, staff emphasize and enforce standards differently *among* their participants while maintaining a semblance of standardization. I ultimately argue that staff resolve the tension between standardization and non-standardization by turning to their perceptions of what I call the "institutional dispositions" – or orientation towards the institutional setting and its goals – of participants. Staff rely on their perceptions of these dispositions to resolve the complex and ambiguous decisions they are tasked with making. From their vantage point, they are not responsible for participants' fates; participants must prove themselves to staff to be ready, willing, and engaged – and thus deserving of accommodation and eventual successful completion of the program – through their (visible) conduct.

I approach this analysis in four parts. First, I turn to the institutional context to describe what makes staff decision-making so complex: staff are given significant discretion to carry out their work and confront conflicting institutional demands, particularly a need to both standardize and individualize responses. Second, I layout key features of the local structures of the courts that produce differences in how staff approach this work, but, as I will later show, not fundamental differences in how staff approach the primary tensions of this work. Third, I describe the goals staff are engaged in promoting and enforcing as standards, and how staff do so in non-standardized ways across their participant bases. Fourth, I conclude by discussing how staff turn to their perceptions of the institutional dispositions of participants to make sense of the complex decisions they confront.

I. Institutional context: mental health courts on the books

Policy and policy guidelines: transferring discretion to frontline workers

Mental health courts emerged in the late 1990s at the grassroots. They are an offshoot of an innovation in criminal justice practice known as "problem-solving courts" (Berman and Feinblatt 2005). Problem-solving courts, like other innovations in criminal justice, started as an experiment. In the era of mass incarceration, a rising tide of cases was overwhelming court systems across the U.S. A subset of judges, attorneys, and court administrators became increasingly frustrated with the failure of the courts to provide meaningful recourse to the "revolving door" of criminal offenders (often with problems like substance abuse) in and out of the criminal justice system. Due to this frustration, they sought ways to disrupt this cycle through nontraditional practices typified by the problem-solving court. The first problem-solving court was a "drug court" established under the direction of a judge in Dade County, Florida in 1989. With favorable outcomes such as reducing reoffending, court professionals across the country began following suit, stimulated in part by seed money provided by then Attorney General Janet Reno. Drug courts quickly expanded under the direction of local administration, followed by other kinds of problem-solving courts such as mental health courts, first implemented in Broward County, Florida in 1997.

Given these grassroots antecedents, formal policies have followed – rather than directed – experimental designs. It was not until 1996 that drug court stakeholders convened to develop "key components" of the drug court model (NADCP 1997) – a set of integrated principles and practices for drug courts that continue to be used to shape their design and implementation today. In 2000 and 2004, the policy leaders of the state court systems in the U.S. (Conference of Chief Justices and of State Court Administrators) passed resolutions in support of problem-solving courts, encouraging further evaluation and integration of principles of these courts (Casey and Rottman 2005). Around the same time, in 2000, after several mental health courts were already in operation, federal legislation – the Law Enforcement and Mental Health Project – was implemented to trigger development of one hundred "pilot" mental health courts. This legislation provided some guidance for what a mental health court should be, but guidelines remained very general (including, for example, ensuring ongoing judicial supervision and the coordination of mental health services). In 2002, the Council for State Governments, in coordination with the Bureau of Justice Administration, began producing formal mental health court policy

recommendations. These recommendations culminated in the "essential elements" of a mental health court, which like (and based on) the "key components" of drug courts, continue to guide mental health court design and implementation across the country (BJA 2005; BJA 2008a).[7]

These elements were largely founded on drug court research, experience of mental health court practitioners, and evidence-based practices promoted in the community mental health field.[8] They address wide-ranging issues, including: planning, administration, and program maintenance, eligibility criteria, terms of participation and treatment requirements, staff composition, as well as how to support informed choice and maintain confidentiality. Most importantly for understanding the standards discussed in this chapter, they promote a relatively comprehensive approach to the mental health court participant. While focusing on mental health and mental health treatment, they recommend participants receive an array of services and supports, including medications, counseling, substance use treatment, benefits, housing, crisis intervention services, peer supports, and case management, in addition to transportation, supportive employment, and family psychoeducation.[9]

Serving as general guidelines, these elements remain abstract, however, providing significant room for court professionals to determine how they are implemented. Each "element" consists of a short statement describing criteria mental health courts should meet and how courts can adhere to them. For example, criteria around the "target population" (element 2) are as follows:

> Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered.

Such criteria do not dictate the kinds of disorders or criminal charges that would make participants eligible or ineligible, transferring authority for such decision-making to courts

[7] These are guidelines. There are not nationally accepted, specific criteria for what constitutes a mental health court (BJAb 2008). Still, these guidelines are used to shape funding decisions.
[8] They were constructed through interviews with court staff, on-site visits to courts, a stakeholder conference, and a review of the scholarly literature, with anticipation that they would continue to be substantiated or adapted with greater research (which was very limited at the time of their creation).
[9] Further, they recommend when participants relapse, "the first response should be to review treatment plans, including medications, *living situations, and other service needs* [emphasis added]."

themselves. Similarly, as another example, the criteria for "terms of participation" (element 4) are as follows:

> Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

What this means is that each court has significant discretion in terms of program parameters for plea agreements, program duration, supervision conditions, and treatment requirements, as well as when and how participants successfully complete or are removed from the program.[10] Hence, ultimately, while such elements provide a general framework for what a mental health court should look and act like, they do not heavily constrain the way courts are designed and implemented specifically.

Moreover, as already indicated, these guidelines explicitly emphasize the need for staff discretion when it comes to monitoring and responding to participant cases. Mental health courts were designed under the premise that mental illness posed unique issues that often require individualized responses and leniency (as reflective of the logic of the community mental health system discussed below).[11] Thus, while the more prevalent drug court model relies on a standardized behavior management grid to apply incentives and sanctions, the Bureau of Justice Assistance specifically advocates that mental health courts cannot treat participant behavior uniformly. Instead, court staff should use their discretion, while relying more heavily on incentives and use sanctions (which have "clinical implications" and should be imposed "with great care and with input from mental health professionals") less frequently when compared to how these decisions are made in drug courts (BJA 2005). Further, the Bureau of Justice Assistance recommends that even those in recovery might be unable to meet the standard expectations upheld in drug court, such as taking classes, working, and paying court fees (BJA 2005). Court staff, thus, must determine how to implement general guidelines on a case-by-case basis.

[10] The essential elements indicate that participants should be able to withdraw from these programs without it impacting their criminal case and should receive positive legal outcomes when they complete the program. However, they do not indicate how staff should make decisions about when and how participants should successfully complete the program or be removed from it.
[11] For example: "Treatment plans must be highly individualized, and therefore, general standards are not particularly useful. In addition, treatment plans often change, sometimes multiple times, based on a participant's response to treatment" (BJA 2005).

At the regional level, in the state where I conducted research, these national guidelines were promoted as the primary resources that courts should use to develop and implement mental health courts. State-specific guidelines were produced more recently – both in the form of legislation allowing for the development of mental health courts in district and circuit courts (2013) and policy directives and recommendations provided through the state's court administrative office (2016 and 2018). Both courts were already in operation for several years before this legislation was implemented, and thus close to a decade by the time these policy directives and recommendations were produced (with ethnographic data collection completed before 2018).

Still, these newer state-specific guidelines provide further insight into the way in which discretion was also enhanced at the regional level by the state court administrative office that produced them. They include a set of binding standards (which courts must follow), best practices (recommended with the support of scientific research), and promising practices (encouraged for consideration as they are supported by anecdotal evidence and experience).[12] They emphasize the importance of adhering to the "essential elements," but extend far beyond them, offering more comprehensive and specific guidance on court practice. However, even these guidelines often remain open-ended. For example, a binding standard on services includes:

> A mental health court shall provide a mental health court participant with all of the following: mental health services, substance use disorder services, educational and vocational opportunities *as appropriate and practical* [emphasis added].

The frequency and intensity of these services is not specified. Thus, whereas one court might rely heavily on mental health treatment, another might focus more on substance use treatment – and the degree to which educational and vocational services are incorporated is at the court's discretion. Similarly, as another example, a binding standard on drug testing is as follows:

> A mental health court shall provide…the following: *If determined by the mental health court to be necessary or appropriate* [emphasis added], periodic or random testing for the presence of any nonprescribed controlled substance or alcohol in a participant's blood, urine, or breath...

Under this standard, courts can use drug testing, but are not required to do so and maintain discretion about the extent to which they drug test their participants.

[12] Notably, they continue to rely heavily on more abundant *drug* court research (with the caveat that they will continue to be adapted with the production of more *mental health* court research).

Perhaps most notably, these binding standards also remain open-ended in terms of directions for responding to participant progress and setbacks. Participants must be provided with the following:

> A regimen or strategy of appropriate and graduated but immediate rewards for compliance and sanctions for noncompliance including, but not limited to, the possibility of incarceration or confinement.

Following the essential elements, obstacles and setbacks are expected and must be responded to with individualized and graduated (i.e., open-ended) responses. However, the primary binding standard on phase promotion and graduation[13] is as follows:

> In order to continue to participate in and successfully complete a mental health court program, an individual shall comply with *all* [emphasis added] court orders, violations of which may be sanctioned at the court's discretion.

Given that participants rarely comply with *all* court orders in practice, such a standard in practice means that all noncompliance is open to the interpretation of staff, who can determine when and how it matters to a participant's progression. This discretion is further compounded by a lack of guidance on termination, with the only binding standard provided:

> If the participant is accused of a new crime, the judge shall have the discretion to terminate the participant's participation in the mental health court program.

In fact, no best or promising practices are provided to direct when and how staff should terminate participants from the program, although a best practice around graduating participants includes ensuring a period of greater than 90 continuous days of negative drug tests (albeit, a goal that could be met through the discretionary choice not to drug test participants).

In sum, mental health courts emerged as an experimental design, with policy and policy guidelines following practice. Moreover, even when policy and policy guidelines developed at the national and regional level, they provided space for court professionals to use their discretion to determine how to design and implement their courts. Still, mental health courts did not emerge in a vacuum. Even when preceding formal policy guidelines, they drew on knowledge, expertise, and resources from the community mental health and criminal justice systems. Hence, it is important to briefly outline how they provided a foundation for the work of the mental health court staff studied here, as well as the tensions they generate.

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[13] Other binding standards under this substantive domain focus on court fees.

Dominant logics core to mental health courts: conflicting demands

Organizations like mental health courts are not only organized around formal rules, but also the logics of the institutional fields in which they operate. These "institutional logics" function as macro-level belief systems that provide templates guiding how to think and act within an institutional field (Friedland and Alford 1991; Thornton et al. 2012). They condition the assumptions, values, and beliefs of those who inhabit the field, frequently operating as taken-for-granted prescriptions for how things are done. In the context of the mental health court, such macro-level logics provide a shared understanding for what constitutes legitimate program goals and how they should be pursued among diverse court staff. Yet, importantly, like most organizations, mental health courts operate under the direction of multiple logics and each can impose different, and potentially conflicting, prescriptions (Greenwood et al. 2011). Hence, while providing a shared vision and basis for action, institutional logics also generate tensions that staff must resolve in practice as they choose (consciously or not) between conflicting demands.

As "hybrid organizations" (Battilana and Dorado 2010), mental health courts specifically integrate two institutional fields and their accompanying logics under the mental health court umbrella: (1) the community mental health system, which provides the primary expertise to guide the court intervention, and (2) the criminal justice system, which (as the home institution of the mental health court) constrains and shapes how this expertise can be applied. This expertise is grounded in the logic of "recovery," around which the community mental health system increasingly converged in the 1990s. Recovery was promoted as breaking from a past logic in which individuals with severe mental illness were perceived as defined by their illness (Anthony 1992, 2003). Given both a supposed lack of appropriate rationality and knowledge, these individuals were expected to defer entirely to psychiatrists. Their conditions were projected to be deteriorative, or at best, be maintained without improvement, leading to life-long dependency on the mental health system and practices such as keeping individuals incarcerated in psychiatric hospitals.

Recovery, in ideal, offered a new vision for mental health treatment and the mentally ill individual. While the meaning of recovery varies, it generally refers to the process through which individuals with mental and/or substance use disorders learn to manage their condition and live

self-directed, multidimensional lives (New Freedom Commission 2003; SAMHSA 2006). Recovery thus redirects attention away from intervening solely on a mental health condition to the management of and potential recovery from that condition alongside (and through) living a well-rounded life. More specifically, this involves promoting meaningful life activity (e.g., employment and education), stable and safe housing, community (i.e., social supports), and physical wellbeing (SAMHSA 2012; see also: Drake et al. 2001; Drake et al. 2004).

Further, recovery, in its ideal form, recognizes the individual with mental illness as a source of expertise and authority. This individual, in the parlance of the logic, is a "consumer" of treatment services who is given the information needed to evaluate available treatments and make choices in how treatment unfolds. The individual, after all, is ultimately responsible for managing his or her condition and thus must be given the tools to do so. The primary goal is to help the individual develop the personal motivation and capacity (i.e., skills and supports) to engage in this management process, learning how to proactively participate in treatment consistently and effectively. In this vein, there is no one uniform recovery process; recovery must be adapted to the specific needs, desires, and capacities of each person, who experiences unique kinds of setbacks and obstacles and inevitably progresses in individually-contingent ways.

This kind of logic is embedded in mental health courts, as might be clear though the former discussion of policy guidelines. Mental health courts are designed to be both comprehensive, extending across many domains of the court participant's life, and flexible, adapting to the unique capacities of participants on a case-by-case basis (flexibility further heightened by the overarching medical framing of participants in part as "ill" and thus deserving of care, compassion, and open-ended clinical – not standardized punitive – interventions, see: Conrad and Schneider 1980). Moreover, while mental health courts certainly do not place authority in the hands of participants, the courts are designed to intervene upon their motivations. Participants are routinely asked about their conduct, beliefs, and aspirations by treatment and criminal justice professionals to engage them personally in the intervention, with a series of graduated incentives and sanctions used to further shape this engagement. Ultimately, participants should exit the mental health court engaged and positively motivated. More specifically, they should understand, value, and independently pursue the benefits of living in recovery and thus no longer reoffend. In this vein, recovery resonates with the goals of the

criminal justice system: in principle, it offers the expertise to channel offenders out of this system, reducing associated costs of incarceration, through breaking the cycle of behaviors that led them into it.[14]

Yet, within the criminal justice system, recovery is certain to take on new forms given that this system differs markedly from recovery's home institution (i.e., the community mental health system). The criminal justice system, after all, is the first and last resort institution to uphold the law. As such, it does not promote the kind of flexibility heralded by the community mental health system. Within the criminal justice system, formal rules are of grave import. They are to be enforced, serving as the minimum obligation individuals owe society as opposed to a set of guideposts individuals should pursue to their personal benefit. Hence, for example, certain types of substance use are not just negative behaviors to work on modifying across time with therapy; they are violations of criminal law (and/or probation and parole orders). Individuals are not softly encouraged to develop the skills and supports to abstain, with the authority to chart the course of their recovery; they *must* comply or face criminal sanction. Authority resides with the law and those charged with upholding it. Moreover, with this authority, those charged with upholding the law must adhere to certain rules themselves. Punishment cannot be arbitrary; it is to be applied in a just and evenhanded manner. Under this logic, (legal) standards must be in place and uniformly applied to ensure fairness of process and thus fairness of outcomes.

Given this contrasting logic, the criminal justice system reorients how recovery can and should be pursued by mental health court staff. Staff are not simply expected to provide open-ended aid; they must ensure certain kinds of rules are met. While the treatment recipient can continue to access services in the community mental health system regardless of whether they adhere to the goals of recovery, court staff can impose jail sanctions or remove the court participant from the program for non-adherence. Coercion and punishment are part and parcel of the mental health court process – normalized responses to meet the bare minimum established by the court. Yet, as court staff take on the role of upholding the law, they also are likely to experience its accompanying burdens. This includes ensuring they can fairly evaluate whether

[14] This also converges with wider cultural logics about personal choice, responsibility, and self-management. Afterall, recovery signals a break with a much-feared dependency on the state (Braslow 2013). As Braslow argues, most individuals in recovery will not need intensive services indefinitely; rather, they will develop the skills and capacity to meet their needs and make "good choices" independently. The ideal individual in recovery will be able to use (underfunded and sparse) state resources as needed and otherwise become economically independent, causing no further social disruption (i.e., crime or expensive hospitalizations).

participants violate rules, as well as safeguarding against arbitrary or biased decisions. Therefore, even as staff are guided to individualize their responses to participants under the logic of recovery, staff are likely to face significant pressure to identify standards by which they can make decisions consistently in ways that are at odds with this push to individualize responses.

In short, recovery provides a set of beliefs, values, and assumptions to organize the work that unfolds within mental health courts. Yet, transplanted to a foreign institution – the criminal justice system – with its own logic, staff are tasked with determining when and how to apply recovery in the face of tensions that emerge. Before examining how these tensions play out, it is important to briefly outline the distinct structures of the mental health courts observed here, which could refract the responses of staff in different ways.

II. Organizational structures of frontline work

Organizations like mental health courts are not just shaped and constrained at the macro-level, by institutional regulations and logics, or micro-level, through the thoughts and actions of frontline workers, but also by the structure of the organizations themselves. This is important to recognize in the mental health court field given that mental health courts vary considerably in form (see: BJA 2008b; Steadman et al. 2001). For example, in the state where I conducted research, a study of operating programs released in 2012 showed that these programs differed in terms of their legal and clinical eligibility (e.g., the types of offenses they accepted and their mental health diagnostic criteria), staff decision-making composition (e.g., whether treatment providers participate on the decision-making team), decision-making processes (e.g., whether there was a private meeting with staff before the judge interacted with the participant), services utilized (e.g., inpatient substance use treatment, therapy, and housing), phase structure of participation, program length, and discharge requirements (e.g., whether participants could reoffend and what services they were required to complete). Recognizing such variability, I briefly outline key features of the structures of the courts I researched. I describe the structures and processes of these courts in further detail in my methods chapter (chapter 2). Here my goal is to emphasize key idiosyncrasies that help explain divergences in interventions between courts, while also (re)stressing similarities between courts that ultimately lead to a degree of convergence in how staff intervene.

Emerging in different regions of a Midwestern state at different times, both courts were designed and implemented in different ways. It is important to note that this, at least in part, reflected differences between participant populations, as courts did not share the same eligibility criteria. Kent County accepted nonviolent, felony-level offenses (only accepting participants with violent offenses rarely on a case-by-case basis), increasing the likelihood of accepting participants with drug-related offenses and problems (e.g., felony-level possession or distribution charges). Rapids County accepted both misdemeanor and felony-level offenses, as well as violent offenses, increasing the likelihood of accepting participants with offenses more commonly charged among those with severe mental illness such as trespassing and misdemeanor assault. Both courts also varied in their mental health criteria, with Kent County requiring a "serious and persistent mental illness" and Rapids County restricting entry to those with schizophrenia or bipolar diagnoses, although it is unclear the degree to which this further differentiated participant populations in practice. Moreover, both courts varied in terms of informal eligibility criteria. For example, Kent County staff reported being hesitant to accept participants under the age of 25 (although they sometimes accepted these cases across my observations); Rapids County staff reported no such hesitance, routinely accepting participants as young as 17. These eligibility criteria reflect the different priorities and capacities of the courts, but also certainly shape them, as courts must be responsive to what ultimately are likely varied needs between participant bases.

Regardless, both courts diverged in how they were structured to intervene upon the participant. As mental health courts, both maintained formal relationships with mental health treatment providers to foster greater treatment compliance and incorporated these providers directly into decision-making. However, comparatively, Kent County, housed in a criminal court, was much more structured around regulating substance use, as well as regulating housing (commonly related to regulating substance use) and activity. In Kent County, drug testing was central to supervision (and occurred at the drug testing center located in the courthouse), with participants regularly tested throughout their participation and these results directly monitored by court case managers (who reported these results as part of their routine updates on

participants).[15] Kent County also compelled participants unilaterally to participate in substance use treatment programming (relapse prevention) unless they could prove it was not needed and commonly placed participants in inpatient substance use treatment facilities for 90-120 days at some point – if not multiple points – across their participation, as well as transitional housing where drug use could be monitored. Kent County also remained focused on managing participant's activity. It included an employment specialist directly on the decision-making team to foster greater engagement with employment (and monitor this engagement), as well as rewarded participants with fee reductions for activities like completing high school equivalency and community service (urban gardening) programming.

Rapids County, housed in a probate court, was not structured to regulate drug use, housing, and activity in the same ways. Drug testing was not routinized; it was conducted as staff deemed necessary (by court staff or deputies in bathrooms outside the courtroom). Mandated inpatient substance use treatment and transitional housing were used less frequently and often for shorter durations and, unlike Kent County, Rapids County included no unilateral substance use treatment requirement for all participants, although participants were referred to self-help recovery groups and other kinds of outpatient treatment, as well as transitional housing, as deemed necessary. Further, social service providers like employment specialists were relied upon, but not directly incorporated in decision-making and sometimes described by staff as being dishearteningly inadequate.

These courts also differed in terms of their supervision requirements and staff composition and roles. Kent County was structured to provide longer and, in some ways, more intensive supervision. Participants were supervised for 18 months, and later up to 30 months. Kent County regimented participant progress around four, and later five, phases with specified benchmarks and supervision practices. All participants were on probation and supervised by probation officers who directly participated in decision-making. Kent County also relied on a unique position – court case manager – housed immediately next to the drug testing center to serve as a further layer of supervision, interacting with both other staff members and participants (in significant part around drug testing) to summarize the participant's progress and report

[15] During my observations, the court moved to a random drug testing model in which participants would have to appear when they were called to test. Regardless, throughout my observations, participants were routinely drug tested as part of their participation (starting at weekly and sometimes increased to multiple times per week).

directly to the judge if, for example, bench warrants for arrest needed to be written outside of the routine decision-making process. Treatment case managers contributed to decision-making but were neither the primary reporters on participants (given that this was carried out by court case managers) nor stood with participants in court. Participants, however, generally only came to court once per month to appear in front of the judge.

Rapids County differed significantly. Supervision lasted a year and was not organized around specified phases through which all participants were required to progress, although supervision was generally reduced as participants progressed. Participants started by meeting with the judge more frequently when compared to Kent County (i.e., weekly), but this could be decreased to monthly across their participation (along with accompanying requirements like case management appointments). Not all participants were on probation or supervised by the same probation officer given more varied legal statuses, although the probation officer who supervised the most participants eventually joined the decision-making team later in my observations. Treatment staff served as the primary supervisors of participants' cases and even stood in court with participants in front of the judge to advocate for and report on participants. No court case manager position existed, although the program coordinator, treatment administrator, and judge worked very closely to monitor and respond to cases inside and outside of formal decision-making processes (e.g., texting on the weekend and discussing cases during the week outside of formal meetings).

Finally, the courts also varied in terms of the unique orientations and expertise of the two judges. This is important as judges served as the highest-ranking staff member, with the ultimate responsibility to make decisions in individual cases as well as administrative decisions about the direction of programs overall. Judges, thus, set the tone for these programs. Judge Perry, a former drug court judge, was very focused on regulating substance use and activity of his participants. He often employed discourse that revolved around ending dependencies on the state and making participants more self-sufficient. For example, from his perspective, some participants were products of the "nanny state" and the "tragedy of low expectations…[that] they live down to." They needed to learn how to "take ownership of their own wellbeing." Judge Ash, a probate court judge with significant experience in the mental health field, was very focused on managing problems associated with mental health given what she viewed as a broken system of mental health laws. She also expected participants to work on becoming self-sufficient but was

much more likely to frame them in terms of a biomedical model in which their problems could be tied to a chemical imbalance in the brain. For example, she described of why participants sometimes lied:

> "The depth and complication of their disease just makes them do things that make no sense. But it does to them somewhere. Oh god, how'd you like to have all that going on in your brain? Oh, I'd hate it. Wouldn't you?"

Further, compared to Judge Perry, Judge Ash more readily used her authority to regulate mental health treatment (e.g., mandating certain participants talk to psychiatrists about injections) and also was more likely to express a need to cater interventions to participants based on perceived functional impairment. Again, in both cases, these orientations could both reflect differences in participant bases, as well as shape which participants were ultimately deemed eligible for program participation and what kinds of interventions gained legitimacy.

Still, these courts also converged in important ways. As noted, they both incorporated mental health treatment providers directly on the decision-making team, ensuring they influenced decision-making. These decision-makers met privately without the judge and then again with the judge, to inform judicial decisions. Further, both judges joined the courts out of a desire to break from traditional court practice and pursue treatment goals, further amplifying the influence of the recovery logic. Moreover, this was not just aspirational; both courts relied heavily on a range of service providers in their communities and worked to provide the kind of comprehensive interventions that stem from a recovery model. Perhaps most importantly, both courts operated in the institutional context described above, which encouraged them to individualize interventions (*even with* Kent County's phase-based benchmarks), while also making difficult decisions around incentives, sanctions, program graduation, and program removal. Thus, while I point to differences in how court staff promoted and enforced certain goals given these organizational structures and participant bases, I show that these differences ultimately do not result in entirely divergent approaches to the work of standardizing and individualizing the intervention, as I turn to next.

III. Mental health courts in practice

In practice, staff across courts coalesce around a shared set of goals that are reflective of the institutional context in which they operate. Sometimes these goals function very visibly as

standards. As I will show, judges make clear that they are fundamental to participation as the minimum requirements participants must meet and which will make their lives better – messaging important both as a public statement about how the court acts and as a coercive command to participants undergirded by the reality that judges *could* act (e.g., jailing participants). Further, beyond this public messaging, staff also signal in their routine deliberations that these goals serve as rules they expect their participant base to meet, perhaps most importantly by acting on them.[16] They reference participant conduct vis-à-vis these goals to justify a series of graduated rewards and sanctions. Hence, in multiple ways, staff demonstrate that they hold their participants base to well-established standards, providing a basis of certainty and legitimacy for what otherwise could be potentially ambiguous and difficult decisions.

Yet, while benefitting from the legitimacy conferred by a semblance of standardization, staff also commonly applied rules in non-standardized ways. They did so both between courts and, most importantly here, among their participants as they worked to generate tailored responses to participants with diverse attributes and circumstances. In the process, they produced tensions between what they said and what they did. I layout this tension across the five primary substantive goals around which staff crafted, promoted, and enforced standards in both courts: mental illness and mental health treatment, substance use and abstinence, activity, tertiary domains such as housing, and supervision and criminal justice requirements.

Mental illness and mental health treatment

Across both courts, staff promote a set of goals oriented around mental illness and mental health treatment. This includes working to ensure participants: (a) acknowledge and identify with the serious mental illness with which they were diagnosed, (b) regularly meet with mental health treatment providers (e.g., a psychiatrist and treatment case manager), and (c) follow prescription regimens and any other advice of mental health treatment practitioners.[17]

[16] Staff interactions with participants outside of the courtroom were not observed. It is likely that staff varied in the intensity with which they promoted these standards individually with participants, but given its importance to the court process, it is hard to imagine staff not focusing on it at all.
[17] This set of goals is rooted in the logic that participants can resolve their problems in part through gaining greater internal control – fixing a chemical imbalance in the brain. In more severe cases, participants also are required to supplement internal controls with external controls including, for example, legal guardians and supervised housing arrangements.

This set of goals manifested in part through official rules. Both courts employed eligibility criteria that involved a mental health diagnosis (although they varied slightly in type across the courts as described above). Participants who were not diagnosed with a mental illness could not gain entry to the program and participants who lost a diagnosis (through later psychiatric evaluations) after program entry could be removed from the program, no longer meeting its criteria. Both courts also maintained official rules that participants must meet regularly with treatment practitioners (e.g., case managers, who directly participated in decision-making, and psychiatrists), as well as fill, receive, and take prescriptions prescribed by treatment practitioners. Participants who failed to follow these treatment mandates could be removed from the program, as well as face graduated sanctions such as increasing supervision or jail time.

Yet, these rules did not just exist "on the books," staff actively promoted and enforced them as a set of standards they expected their participant base to meet. Most prominently, they were promoted as such publicly at court by judges. Very frequently, judges reminded participants of the importance of mental health treatment, particularly as issues with treatment noncompliance emerged (as it commonly did on any given day at court). For example, Judge Perry, explained to a participant of the importance of attending a mental health treatment appointment:

> "[I am not having you go to treatment as a punishment. If I want to punish people, I know where the jails are, I know where the prisons are. If I'm saying I want you to get help, I want you to get help.]"

In this vein, Judge Perry signaled that treatment was a baseline good from which participants could and should benefit – or otherwise face consequences in the program. When participants contested their treatment regimens, he suggested they could seek out second opinions – "that's a medical issue, not my issue." However, he made clear participants must attend treatment appointments and follow the advice of psychiatrists. It was "essential," "very important," and "could affect your future in the program."

Judge Ash similarly reinforced the importance of treatment compliance, but she was even more emphatic in her public messaging about these goals in ways that was certain to convey their import as standards participants were expected to meet. She more frequently alluded to jail as an alternative to mental health treatment compliance and made clear participants were expected to comply. For example, she asked a participant who had recently forgotten to attend her

psychiatric injection appointment: "[Wouldn't it be a shame to go to jail for not taking your shot?]" and another who had an upcoming medication review but had missed an appointment wit his case manager: "[Under no circumstances can you miss that appointment.]" She introduced participants to the program by explicitly talking about their mental illness (e.g., "[You have the same problem as everyone else here, you're mentally ill]"). She routinely checked in about mental health treatment independently of whether treatment staff noted concerns (e.g., "[Still taking your meds?]") and offered advice about when to return to psychiatrists and whether participants should try injections.[18] Moreover, she occasionally volunteered to attend (and attended some) psychiatric appointments with participants and visited participants when they were hospitalized for mental health problems.

Further, across both courts, this did not boil down to just rhetoric. It is unlikely that a participant could progress through either program successfully without meeting these treatment compliance goals with some consistency. No such case was observed. In deliberations, staff made clear that they expected participants to abide by them as standards central to participation. Staff routinely cited mental health treatment compliance as a reason to reward participants (e.g., with supervision reductions) and, conversely, treatment noncompliance as a reason *not* to reward participants who were otherwise doing well. Further, as indicated, when a participant failed to comply with treatment mandates, staff informed judges so that they would remind participants of the importance of doing so at court. When participants repeatedly failed to comply, judges sometimes imposed intermediate sanctions such as corrections-based community service or, in Rapids County, also a short jail sanction. In very rare cases, participants could fail to gain entry or be removed from the program based on their conduct vis-à-vis these goals.[19]

[18] She offered advice about how to talk to psychiatrists and when to consider returning to psychiatrists to adjust medications, as well as whether participants should try injections (and she also occasionally asked specific participants to talk with other participants about their treatment experiences, commonly around injections). In Kent County, by comparison, injections were rarely encouraged at court. For example, when treatment staff suggested them as a possibility in a case where they perceived a participant as taking medication inconsistently, the judge said he would have the participant talk to the public defender. "[I want to make sure he knows he is not being forced to do this. And we can kind of go from there.]" The participant at court rejected a need for injections. Judge Ash harbored no such reservations. She often told participants to talk to psychiatrists about injections, signaling that it was important to their program participation. Further, when participants reported struggling, she readily turned to asking about the role of mental health symptoms and advised case managers to schedule medication review appointments sooner. When participants were doing well, she frequently connected this to improvements in their mental health. She further emphasized such linkages in individual graduation ceremonies held in front of other participants, with court staff typically – and even participants – following suit.

[19] Judge Ash sentenced a participant to jail rather than have him join the program (despite his protests) after the treatment administrator reported that the participant repeatedly missed psychiatric evaluations and did not follow-up

Additionally, across both courts, a handful of participants were extended in the program on a case-by case basis to ensure connection to treatment services and Judge Perry eventually unilaterally extended his program from 18 to 30 months under the premise that it would increase post-treatment connection. He explicitly explained (to a visiting group of court professionals) that he extended the program under the condition that participants attended their mental health appointments as supervision was reduced:

> "[We just want them [participants] to build good habits in terms of maintaining the connection with mental health providers. No one would view it as successful if right after they complete the program, they go out and commit a crime.]"

Judge Perry was clear: adherence to mental health treatment was the minimum obligation participants needed to meet to be law-abiding citizens. In such moments, staff treated these goals as a set of baseline standards around which they could and did intervene.

Still, staff also applied these rules in non-standardized ways for several reasons. Most fundamentally, staff viewed participants as diverging in their mental health treatment needs. At one extreme, participants were perceived by staff as not needing intensive mental health services or, in rare cases, psychiatric medication. Thus, if they missed an appointment with a treatment provider, staff simply offered gentle reminders to the participant to reconnect with services. At the other extreme, some participants were perceived as desperately in need of psychiatric intervention. In cases when this type of participant failed to attend court, for example, Judge Ash told case managers to tell the participant she would *not* write a bench warrant for their arrest if they received their medication injection (signaling its extreme importance). Even more starkly, Kent County staff deemed it appropriate to incarcerate several such participants for their safety and the safety of others when they could not otherwise determine how to psychiatrically stabilize these participants in the community (although commonly in tandem with drug use).

Moreover, staff responded differently to participants in terms of distinct setbacks and obstacles they were perceived as facing (although, importantly, even when leniently responding to noncompliance behind closed doors, judges often still reinforced to participants the importance of meeting their mental health standards in public court). For example, staff

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with his case manager as required to gain entry. In equally extreme cases in Kent County, program removal unfolded when two participants experienced a diagnosis change and one who was suspected of lacking a diagnosis (all transferred to regular probation), as well as when three participants presented as noncompliant with psychiatric treatment and symptomatic in ways that posed concerns for themselves or public safety (who the judge indicated would be sent to prison).

occasionally expressed concern about whether treatment staff were appropriately engaging participants given potential stigma around mental illness and distrust of professionals. Thus, in one case, Rapids County staff did not remove a participant from the program despite him *repeatedly* failing to show up for treatment appointments due to a concern that he was experiencing a serious emotional disconnect with his treatment provider that they had some responsibility in remedying. As another example, staff also recognized transportation or employment barriers that might lead participants to miss treatment appointments. For example, in Kent County, staff reported a participant missed both a therapy appointment and medication review appointment due to work. Rather than criticizing such conduct, the judge noted (in reference to her employment): "[Whatever she is doing, I wish it was contagious. … On balance I think she is really doing great.]"

Further, staff might not be able to effectively pinpoint noncompliance – relying on self-reports of participants in terms of whether medication was taken and, in some cases, whether a mandate was communicated to them at all. Staff sometimes maintained hunches that participants were not taking medications as they should but could not be certain without (uncommon) blood tests and/or access to pill bottles that revealed a surplus of medication (or participants reporting leftover medication when they should not have medication). Moreover, a lack of adherence to medication might be motivated by legitimate obstacles, such as undesirable side effects or a lack of understanding of appropriate dose. Thus, for example, staff in Rapids County explicitly discussed behind closed doors how a participant was *not* "noncompliant" with his medications; he was "[just not taking them as prescribed. He needs a reminder from the judge; he does not need to be in trouble.]" According to their discussion, he was not purposively failing to follow his prescription; instead, it was likely he was unaware of what he was doing incorrectly.

Finally, staff generally expressed a pull to respond to participant conduct vis-à-vis these goals with leniency, perhaps due to the special moral status of mental illness and/or the program's focus on addressing it. Despite the reality that many participants failed to comply at some point – if not multiple points – across their participation with these goals (especially missing an appointment or failing to take a medication as prescribed), criminal sanctions were rare. They were only used in the small minority of cases referred to above in which participants were reported as failing to follow these rules in ways that signaled to staff not just a failure to

adhere to treatment, but also to abide by the authority of the court.[20] In such cases, staff sometimes described mental health nonadherence in part as a "game" or "scam" for participants, with participants testing what they could get away with. Judges felt obligated to signal to participants the importance of following the rules, because otherwise their mandates seemed "like an empty threat."[21] In fact, commonly, staff responded to treatment noncompliance with criminal sanctions not in isolation but when it manifested repeatedly or as part of a package of behavioral problems (e.g., relapse, not completing community service hours, failing to appear at court, and/or being caught in a lie) that signaled the participant was not progressing appropriately in the program – or, as Judge Perry colorfully described, had "one foot on the banana peel, that's for sure." (Relatedly, in some cases, these other behavior problems could overwhelm staff attention. For example, when a treatment case manager in Kent County reported that a participant who was jailed after a relapse was out of medication, such commentary slipped under the radar of the deliberation as staff focused instead on where to house and treat the participant for substance use (although, importantly, treatment staff still likely addressed these issues independently of group consensus).)

In sum, staff treated goals around mental and mental health treatment as standards that must be met and flexible benchmarks to which participants should be encouraged to aspire. Given the focus of later chapters on Rapids County, it is important to note that this tension in some ways was heightened there given that Judge Ash was more emphatic about presenting them as standards participants must meet, but Rapids County staff also exhibited significant leniency towards participants in many cases despite this emphasis.

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[20] Thus, for example, in one such case, Judge Perry concluded of a participant's failure to attend a therapy appointment: ["Well I did speak to her about it the last time and it obviously didn't register. I'm inclined to give her a day on [corrections-based community service] because otherwise it seems like an empty threat. …I don't want to let it slide. She will have to do it in a week. If that means she misses a couple of classes, so be it. Learn to manage your time a little better. How many appointments did she miss?" The treatment case manager says, "Just once." Judge Perry says, "One too many after the warning."] Similarly, in Rapids County, a treatment administrator noted in a case when a participant missed a psychiatric evaluation: "[The judge might be done with him. He's been through this before.]" She further described that "part of it is a game" to him and briefly suggested jailing him until his rescheduled evaluation, quickly adding, "That might be overkill." In such cases, enforcement did not only target treatment compliance, but a more fundamental concern about a perceived pattern of conduct.

[21] In Rapids County, participants were sanctioned and/or removed from the program when missing treatment appointments alongside other forms of noncompliance or, simply, were removed from the program when they stopped showing up altogether after repeated attempts to connect them to treatment (i.e., absconding). Similarly, in Kent County, treatment noncompliance factored into decisions around program removal in a couple of cases and, more commonly, decisions to sanction participants that revolved more heavily around substance use or a failure to complete required community service or employment hours.

Standards around substance use and abstinence

In this context, staff also promote a set of goals oriented around a logic that drugs and alcohol – excluding drugs prescribed by court-approved treatment practitioners – are by default a problem and thus abstinence is the most appropriate solution. More specifically, staff expect participants to: (a) agree not to use drugs and alcohol while in the program; (b) engage in activities as required that contribute to abstinence such as treatment (inpatient and/or outpatient); and (c) avoid things as required that lead to substance use (e.g., staying away from certain people and places).

In some ways, these goals were not central to official court rules. Program eligibility was not tied to substance use and participants by default were not required to engage in interventions oriented around substance abuse if they were perceived as not having current issues around use. Still, substance use was formally integrated into the program given a recognition of the prevalence of co-occurring disorders. All participants were asked about their substance use histories upon program entry, informed of the abstinence policy, and assigned substance use treatment plans accordingly, which could be later adapted. All participants were required to participate in drug testing (albeit more regularly in Kent County). Following policy guidelines, participants were not supposed to graduate from the program if they recently tested positive for drugs and/or alcohol. Moreover, like treatment noncompliance, detected substance use or a failure to comply with substance use treatment regimens could result in program removal, as well as graduated sanctions.

In public court, judges made clear that these goals functioned as a set of standards participants must meet in their routine interactions with participants. Judge Perry often talked about negative drug tests as a kind of "measurable achievement" that could be rewarded and detected substance use as a sanctionable offense. For example, he told a participant recently caught relapsing on cocaine:

> "[I will do everything I can to provide you with resources to help you get better. But when we start out in the program and you keep using drugs and don't take the help being provided, I need to let you know a clear message: You can be in our program or prison.]"

Through such rhetoric, Judge Perry made clear that ongoing participation was tied to pursuing abstinence – rhetoric he also applied in discussing substance use treatment. Drawing on a trope

he commonly employed, he explained the purpose of inpatient treatment to a participant who described it as a form of punishment:

> "[I have been a judge a long time. I know where all the prisons are. If I wanted to punish you, you would be on the bus. There would be no detour to [the specified inpatient facility]. That is not the first step. I sent you there because they can help you. It's kind of like having children who are sick and you need to give them cough syrup. The cough syrup tastes crappy, but they need to take it whether they like it or not, because, on balance, it's for their good.]"

Judge Perry rarely left room for doubt: abstinence – and, in many cases, substance use treatment – were standards fundamental to program participation.

Judge Ash employed different rhetoric (and frequently was less focused on inpatient treatment as it was not as frequently used in Rapids County), but also clearly promoted these goals as standards. Upon program entry, she informed participants of the abstinence policy. Given that participants were not always drug tested prior to their court appearance, she commonly asked participants about their substance use – often following or preceding questions around mental health treatment. For example: "[Still taking your meds? No drugs, no alcohol, right?]" She emphasized the importance of self-reporting substance use and asked for drug tests on occasion to validate (or invalidate) participant's self-reports. Further, she regularly engaged participants in discussions around substance use. She asked how long they had been sober, whether maintaining sobriety was difficult, how they were maintaining sobriety, and how they could continue to do so moving forward (often in connection to a set of upcoming challenges). When participants provided negative results, she praised them, e.g.: "[You know the way to my heart.]" Conversely, she was clear that positive results (that revealed use) would be met with consequences, e.g.: "[If it is dirty, there is going to be a problem.]" Moreover, sometimes independently of staff recommendations, she mandated that participants attend self-help recovery groups or connect with sponsors, occasionally offering to help them secure a sponsor.

Beyond this routine public messaging, staff made clear that these goals functioned as a set of standards behind closed doors in their deliberations and also through the kinds of actions they advocated. In both courts, substance use and concern over potential use regularly featured in how staff evaluated participant's cases. Staff treated positive drug tests (a sign of substance use) as sanctionable behavior. In comparison to treatment compliance, participants were much more readily punished for positive drug tests. Jail sanctions were commonly tied to positive drug tests

and participants also commonly were removed from the program for repeated positive drug tests or behavior associated with drug use (such as absconding from inpatient treatment facilities, which was particularly common in Kent County). Participants also could face intermediate sanctions such as corrections-based community service and, as noted, be incarcerated in treatment facilities – facilities that were intended to be beneficial but also could be described as highly undesirable by participants (as reported by staff).[22] Further, both courts extended participants individually in the program due to substance use.

Still, even here, staff applied rules around substance use in non-standardized ways. Early and first-time (or rare) use were punished less harshly than later and repeated use (in principle, when participants should "know better"). Moreover, some participants were perceived as engaged in potentially deadly addictions requiring serious interventions such as incarceration (to "clean out" and "stabilize"), while others used less harmful substances recreationally, requiring warnings or outpatient treatment. Additionally, staff recognized unique obstacles and setbacks that could shape how they responded to substance use. For example, when a participant was reported as having a couple of positive drug tests for marijuana, but also – as a lower functioning individual – recently placed in adult foster care, Judge Perry asked about how the housing was working out and added, "[I'm not going to be too concerned about a little weed; I'm more concerned about him landing in the right place.]" Similarly, when a lower functioning participant self-reported drinking alcohol recently among other forms of noncompliance, Judge Perry suggested he might need to be jailed (i.e., "to sit"). Staff, however, convinced him otherwise as they deliberated the degree to which he understood their rules:

> The program coordinator summarized a viewpoint being expressed by different staff: "The problem is we don't know if he understands fully. I'm sure he knows he is not supposed to be drinking…" A treatment case manager added that the participant doesn't realize what the consequences could be. The program coordinator confirmed, saying to the judge, "Yeah, I don't know that he realizes what you can do, what you will do."

Staff decided to hold a special meeting with the participant and his legal guardian to discuss their abstinence rule and Judge Perry did not even mention his drinking at court. (Similar processes unfolded in Rapids County, where, for example, a lower functioning participant admitted to

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[22] Judge Perry applied a common trope in explaining why he thought a participant close to graduating who had recently relapsed should be connected to further treatment: "[I don't think any of us are happy about the notion of somebody successfully completing the program and 90 days later using and having some meltdown that brings him back in the system. That's not exactly a success measure. We want to eliminate recidivism if we can.]"

drinking half a pint of alcohol and a beer prior to appearing at court. Judge Ash was clear with him that he could not drink alcohol and would face jail time if he continued to do so, but – in rare form – did not jail him even though he was, by her account, "reeking of booze.")

Moreover, in Rapids County, it was not uncommon for staff to indicate substance use (particularly marijuana and alcohol use) would not be regulated until participants were stabilized on psychiatric medication. For example, after a case manager reported a participant admitted to smoking marijuana, the treatment administrator said they would wait for the participant to receive his second psychiatric injection and then go to "no tolerance." Beyond this initial adjustment period, across both courts, staff sometimes described seemingly legitimate reasons participants used substances or would not be drug tested. Even though Kent Count court case managers regularly ensured participants drug tested, occasionally they would note that a participant had not been drug tested due to a work schedule, with plans to drug test the participant soon. This kind of leniency was even more likely in Rapids County, where participants were not always drug tested (and they also did things like explicitly not drug testing a participant who had recently relapsed on crack cocaine but was otherwise doing well around the holiday, as Judge Ash said: "Let him be home for the holidays.")

Often rationales for substance use did not fully excuse behavior but could provide context to mitigate how staff responded to it. Thus, in an extreme case, Rapids County staff graduated an older male participant who they reported as recently producing positive drug screens and verbalizing that he did not want to quit using crack cocaine. According to staff, however, the participant was clearly dying of cancer (with the judge telling him in open court she knew he was not clean, but he had "kept his promises" to them most of the time). More commonly in both courts, participants reported struggling with grief, anxiety, and physical and dental health in ways that led them to use substances (including pain medications), which complicated how staff decided to punish and/or treat them.

Moreover, staff confronted the ambiguity of their measures – ambiguity heightened by the dynamics of the setting: (a) substance use could be heavily penalized (and stigmatized), leading staff to perceive – but not know for sure – that participants concealed use, and (b) substance use was not as easy to measure as a requirement like attendance at appointments, providing opportunities for participants to shape and contest results. For example, staff confronted suspect results (cool or diluted samples that signaled tampering), ambiguous results

(neither clear cut positives or negatives), partially explainable results (positives that could result from prescribed medication, as referenced above), and missing results (participants not completing drug testing, often due to not showing up as required, although also, in very rare cases by claiming to be unable to produce a specimen). For example, in Kent County, staff often reported "faint line" drug tests that they did not punish without a confirmation of use from an additional lab test.

Finally, given the ambiguity of these measures and the desire to engage participants proactively in their recovery, participants could be praised and rewarded for "owning up" or "confessing" to substance use. Thus, Judge Ash told participants in some cases, for example, she was "really proud" of them when they reported substance use to case managers or court-affiliated staff and tried to identify treatment strategies with the participant to not repeat this substance use moving forward (rather than penalizing them for their use). Similarly, behind closed doors, staff highlighted such confessional work as important to the participant's progress. For example, in Kent County, staff discussed how to handle a participant who briefly absconded from an inpatient facility. A treatment provider signaled he was going to be difficult to work with as a "scary guy" who was "sneaky" – "[Something is always going on but he covers it real well.]" A probation officer, however, countered: "[Now that he admitted to the crack use, he will be willing to work on it. He has never worked on his drug issues before. Now that he has opened up about them, he will work on them.]" Rather than removing from the program for noncompliance, staff placed the participant back in inpatient treatment. (Conversely, participants could be chastised and punished for a failure to adequately reveal or own up to their substance use. For example, in Rapids County staff were determining what to do with a participant who had recently tested positive for drugs upon his release from jail. The program coordinator, however, questioned whether he should even be released, noting: "[He hasn't admitted to anything. He hasn't said anything like: 'I screwed up, I need help.' Instead, it is more like: 'I ate a brownie, I didn't know.']")

Standards around engaging in legitimate activity

In this context, staff also work to ensure participants are engaged in activity that can be beneficial to their wellbeing.[23] Specifically, in both courts, participants must engage in an established amount of time (generally 20 hours per week) of what will be called here "legitimate activity." "Legitimate" is not used to refer to an objective quality of the activity, but staff perception of the quality, which is rooted in two key dimensions: (1) whether it perceivably leads to the participant's betterment, often – but not always – in terms of economic independence, and (2) whether it is verifiable through trustworthy third parties (e.g., employers). Typically, legitimate activity includes community service, education and training, and/or employment, and, in some cases, intensive treatment.

At first glance to the outsider, legitimate activity might not appear as significant as addressing mental health and co-occurring substance use. However, across both courts, this goal was also core to the intervention. According to staff, following the recovery logic, engaging participants in legitimate activity was beneficial in many ways. From their vantage point, it helped "get the energy level up", filled the day "in a constructive way," provided "regular social contact," kept participants from "sitting around thinking about getting high" (or "being depressed"), and helped overall with confidence. Moreover, it could provide some economic independence, concomitantly ending or curbing problematic dependencies on family members that could otherwise be a source of stress and turmoil. Further, it transformed participants into "productive citizens" – individuals not sitting at home playing video games waiting for the "nanny state" to care for them, for example, but active participants in the labor force.

Upon program entry, participants were told by staff that they would be required to "get busy" doing activity as part of their participation. Both judges told participants that they needed to come up with a "game plan" for what they would do with their time. In following court appearances, if participants did not independently engage in activity or were not otherwise engaged in intensive treatment (particularly in Kent County where such treatment was common), they were mandated by judges to participate in certain kinds of community service. Participants who engaged in legitimate activity, were frequently praised and rewarded by judges for their "good choices" and "great progress." (Staff generally, too, expressed pride and admiration

[23] In principle, following the logic of the community mental health and criminal justice systems, this type of activity can provide meaning, prosocial relationships, and independence, as well as shift individuals away from antisocial relationships and criminal behavior patterns.

behind closed doors for participants who started and maintained different forms of legitimate activity.) Conversely, a failure to engage in legitimate activity could result in graduated sanctions. Participants could be mandated to do corrections-based community service rather than simply community service (which had the added benefit for staff of being easier to document and supervise), as well as face jail sanctions.

Moreover, in rare cases, such a failure could even result in program removal. For example, in Kent County, staff members remained very focused on trying to engage a younger male participant in educational programming, which he repeatedly failed to do (not showing up and not completing work when he showed up). In what became his final case review, staff discussed his lack of engagement at length, with the judge describing him as:

> "[…the poster child for why we should not take anyone under 25. He's not interested in school. He's interested in what he's interested in [*implicitly, music*] and he's not going to do anything he doesn't want to do. …I feel like I'm spitting into the wind with this gentleman.]"

After further deliberation, a treatment case manager noted that "[one of the good things]" was he seemed mentally stable and was following up with his treatment, which was "[important for a young man who has early onset schizophrenia.]" Another staff member further reported he had not tested positive for marijuana for the past month. Staff, however, continued to discuss his lack of progress in terms of schooling. The judge stated clearly, "[I'm not interested in punishing him per se.]" However, he concluded of the participant's focus on a music career:

> "[You know if that's all he ends up doing, his parents are going to carry him along forever and ever. I can't change that. But what I can have an impact on is the number of hours members of this treatment team invest in someone who isn't willing to get off the dime.]"

The participant was transferred to regular probation with a requirement to continue with his mental health treatment.[24] In Rapids County, too, staff removed participants from the program after repeated failure to engage in such activity (and often perceived lying about activity

[24] Similarly, a Kent County participant was transferred out of the program when he was required to do 10 hours of community service and became very upset in response. Described as a lower-functioning participant with a closed-head injury, the 10 hours was intended as a minimal requirement to provide him with something to do other than sitting at home. As Judge Perry said, "[Ten hours per week is hardly onerous.]" Given the participant's strong reaction, however, Judge Perry asked the team whether they should transfer him out of the program, noting that other than moving him into a safe environment with his brother – which the judge viewed very positively and hoped to sustain – the participant had not "[advanced the ball.]" The team agreed with the decision to transfer him.

engagement). Hence, at key moments, staff were clear that engaging in legitimate activity was a standard they expected their participant base to meet.

However, in practice, this requirement was enforced in non-standardized ways, many of which reflected dynamics unique to this type of goal. First, as noted, participants were given some time to adjust to the program and new treatment regimens – time that was in part individually contingent – before staff required activity engagement. Court staff initially provided participants with the option to choose what to do, but at some point, staff mandated community service if engagement was not otherwise demonstrated. Second, participants could engage in activity partially (e.g., completing some but not all hours or substituting in different kinds of activities than initially planned). Thus, for example, a participant in Rapids County was not outright chastised or punished when he failed to complete previously mandated corrections-based community service, but also reported supporting his brother's deejaying business while trying to secure hours (mostly unsuccessfully) at a local business. He was further not punished when it was reported that he was arriving late and leaving early to complete community service, even if he was mostly going.

Third, participants might have other commitments (such as childcare), acute problems (such as a medical need), and disabilities that staff determined constrained how they could engage in activity during any given week. At an extreme, particularly in Rapids County, some participants were deemed so impaired that the primary goal was to ensure they were housed, took their medication, and (mostly) appeared at court and with treatment providers; activity was not prioritized. Fourth, activity was more difficult to measure (relying, in part, on third parties not directly affiliated with the court).

Finally, as signaled, certain kinds of activities such as playing video games (even socially interactive video games), working on music careers (viewed as promoting a pipe dream), or prostitution and participating in drug related activities such as trimming marijuana plants (viewed as harmful as well as illegal) tend to be perceived as illegitimate. Other kinds of activity, such as engaging in construction work off the books (which is difficult to verify) or providing informal childcare (which typically is perceived as not leading to economic independence), gain or lose legitimacy on a case-by-case basis – sometimes viewed as an "excuse" not to fulfil the requirement and other times viewed as a legitimate way to fulfil the requirement.

Standards around tertiary improvement

Staff consistently focused intervention efforts around the three domains described above – mental health, substance use and activity. However, they also pursued goals above and beyond these domains given the expansive framework of the recovery model. More specifically, staff could intervene upon wide-ranging domains such as housing, income, social support, and physical health.

In some ways, staff treated their extensions into these domains as a process of promoting and enforcing standards. That is, they not only were extending open-ended aid, but also establishing baseline criterion participants should meet. Judge Perry, for example, described past attempts and future aspirations of ensuring all participants received physical health exams to maintain their health. Further, both judges discussed the importance of ensuring participants lived in stable housing environments and often made stable housing a primary pillar of the court's intervention when participants were perceived as lacking it. To staff, such interventions helped participants fulfil bare minimum needs to make life good and decent, as well as make adherence to other requirements possible. Exhibiting this kind of viewpoint, a program coordinator explained of whether participants shared the court's goals, "I think overall they probably want it. I mean, everyone wants a nice place to live, money, you know, out of jail, and I don't think we ever ask anything too ridiculous." Commonly from the vantage point of staff, tertiary requirements like housing (along with other program requirements) were standards participants should meet, first and foremost for their own wellbeing.

Importantly, however, compared to other standards already discussed, participants were less routinely sanctioned for a failure to meet a tertiary requirement. Still, tertiary domains could shape decision-making. For example, a failure to reside where required or interpersonal conflict (particularly after a No Contact Order was already imposed) could contribute to a negative evaluation of the participant's compliance generally. Hence, after reporting that a participant recently was in a violent domestic dispute with his romantic partner that resulted in his arrest, Judge Perry concluded, "[Thing's aren't terribly hopeful with him.]" Two staff members, seemingly in support, noted how he already was kicked out of two inpatient facilities and exhibited a negative attitude towards them. Judge Perry continued, "[For sure, we are done with that. There are only so many times we can inject ourselves into the girlfriend-boyfriend drama where there clearly is no compliance with that.]" Judge Perry reported he would remove the

participant from the program and sentence him. While noncompliance around treatment (i.e., being kicked out of inpatient facilities) and a new offense (i.e., arrested by police) justified such an action, in such cases staff could draw on tertiary domains to further legitimize their decision-making (i.e., an inability to regulate a social relationship that would lead to further noncompliance). Moreover, on rare occasion, participants were punished more directly for their failure to comply with tertiary requirements. Thus, for example, in Rapids County, staff removed a participant from the program after multiple forms of noncompliance across time that ultimately culminated in a court appearance in which the participant appeared to lie about collecting his Social Security Income (which the court mandated to be managed by a state payee service rather than the participant) and he repeatedly failed to stay at his court-mandated housing arrangement.

Additionally, regardless of how staff ultimately acted, frequently enough they communicated to participants that they had the power to act. Judges could impose legal orders (e.g., No Contact Orders) or judicial mandates. For example, participants were frequently ordered to live in specified residences such as transitional housing, with judges making clear that they could not disobey this order (with the implicit alternative being program removal and resentencing). As another example, Judge Perry became interested in regulating participant receipt of student loans. Judge Perry explained this in one case where a participant was requesting student loans:

> "[I will tell her the notion of—for those who have been away from school a long time: you take one class. You do well, no incompletes, no Ds, then we'll see about you taking two or three classes the next semester. A few years ago, it became contagious to sign up for 18 or 20 credit hours and have individuals become overwhelmed by the work and drop out. Soon as that check is in the account, throw them books out the window. Don't need them anymore.]"

In court, Judge Perry reaffirmed this with the participant, telling her she could only take one class. No participants were reported by staff as disobeying this order, despite multiple being reported as protesting it.

Yet, these tertiary goals manifested in non-standardized ways. Most notably, they were not applied by the court to all participants. Participants could advance through the court without staff intervening in any of these domains because they were perceived as meeting these standards

by default (e.g., appropriately housed and engaged in "supportive" relationships).[25] Moreover, staff did not have equal access to whether participants were meeting these standards, resulting in them regulating them only when concern was raised about them. This happened in a few ways. First, staff could independently determine that they needed to address some tertiary domain, often due to an impending change in the participant's circumstances. For example, a looming eviction or exit from an inpatient facility led staff to work to identify new housing. In other cases, staff could newly decide a participant's circumstance was inappropriate, either because the participant raised a concern, or the staff observed something problematic.

Second, third parties could shape how staff viewed a participant's circumstances. This could include other participants, those in the participant's social network, service providers not directly involved in court decision-making, and agents of the criminal justice system such as police officers. For example, an official police report could document interpersonal conflict that led staff to impose a No Contact Order, or parents could report a participant's social behavior as inappropriate, requiring staff intervention.

Third, a tertiary issue could impact a participant's compliance across other domains. For example, a participant could self-report using (otherwise unpermitted) pain medication to address dental problems, leading staff to mandate follow-up with dental care. Or Kent county staff members commented at length on the quality of a participant's housing (a trailer shared by "fifty-eleven people" and dogs – "it's special in there"), which was ultimately deemed inappropriate when the participant repeatedly linked ambiguous drug test results for marijuana ("faint lines") to this housing arrangement (which further led staff to contact Child Protective Services, since a minor lived in the trailer).

Fourth, these details often slipped into staff deliberations, in the form of empathy, judgment, and, in some cases, simply humor.[26] For example, a Kent County staff member briefly noted that a participant had successfully obtained a food voucher from a local soup kitchen. Not a primary focus of the staff member's report (or the court intervention), the judge picked up on it

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[25] These participants tended to be viewed favorably. They "just got it immediately," "charged through the doors" opened by court staff, and "made it through the program without a hiccup."

[26] As a Kent Count staff member noted, she liked to share a "history or story" of the participant "because it humanizes them a bit and the judge gets to know them and their personality. And they're funny. Our people are hilarious. So sometimes I just have to share their hilariousness."

and questioned why the participant had sought out the voucher given a supportive family. In responding, staff members digressed into discussing the participant's family:

> A treatment case manager reports: "[They are supportive. She lives with her son. But they are all in financial straits. No one is missing any meals, but the whole family is low income. She has to use other resources at times just to make sure no one is stressing where their meals come from. They are very supportive, but low income.]" A probation officer adds, "Kind of a family that lives in a small house with fifty people, nothing is fixed up, and they all drive nice cars. Her son drives an Escalade. Her other son drives [another nice care]. And they live in a bungalow with about five people." The probation officer explains more about the housing situation, continuing: "[So we show big when we are in the streets, but we live in [a not very nice place]. They have fifty eleven cats all around and she says she feeds them. They live low but they drive high…]"

Such commentary did not necessarily shape staff action. In this case, a nurse shifted the conversation to talking about the participant's health, which the judge focused on in his interaction with the participant. However, commentary like it became a common feature of staff deliberations and *could* shape how staff acted.[27]

Of course, frequently, these processes occurred in tandem, as for example, staff decided a participant's housing arrangements could influence *future* compliance or a participant reported on interpersonal conflict that was also documented by the police or informally reported by a service provider. Regardless, the general outcome was the same: staff made clear that participants must meet their tertiary standards as they emerged as relevant.

Standards around supervision and criminal justice

Staff also promoted and enforced a set of program requirements that were primary to the demands of the criminal justice system as opposed to the mission of recovery alone. This included most fundamentally supervision requirements: meeting with key staff members (e.g., treatment case managers[28], court case managers, and/or probation officers) and appearing in front of the judge. Further, particularly in Kent County, this could include electronic monitoring

[27] In another case, Judge Perry did not act, but verbally chastised a participant: [Judge Perry moves into talking about how he has been receiving reports—from "a number of people in the treatment team"—that they are worried about her behavior with men. Perry says when one person brings such an issue to his attention he could think it is a matter of misinterpretation, "but when three different people tell me" he "puts up an antenna." Perry cautions the participant to focus on herself. This program is "not like [how it is] at a bar."]

[28] Treatment case managers serve a dual role of treatment provider and supervision staff in this context, making them fit between categories in this analysis.

bracelets, as well as (often associated) curfews and geographic restrictions. Additionally, staff maintained a role in promoting and enforcing desistance: participants were expected to remain crimefree. Finally, in Kent County, Judge Perry worked to ensure participants paid fines and fees associated with the criminal case and supervision (sometimes tying later phase promotions or graduation to payments on fines and fees).

Supervision standards were promoted by staff as the most fundamental baseline of what participants must do. Hence, participants were rarely rewarded for meeting them alone, although in Rapids County, participants perceived as having the most severe functional disabilities could receive gift cards (for food) simply for appearing at court. More basically, reducing these requirements – e.g., removing electronic monitoring bracelets or lessening the frequency of court appearances – was perceived as a reward in and of itself that could be attached to participants being generally compliant with supervision requirements – e.g., consistently meeting curfews linked to electronic monitoring bracelets and meeting with probation officers. (However, in the vast majority of these cases, participants were rewarded for multiple forms of compliance, including with treatment, substance use, and/or activity requirements as well as supervision requirements.)

As the most fundamental baseline of what participants must do, frequently when participants were failing to meet supervision requirements, they either presented an excuse (e.g., hospitalization) or absconded from the program outright (e.g., cutting off their electronic monitoring bracelets and failing to appear at court). In the former case, staff were tasked with determining the legitimacy of excuses, which certainly provided an opportunity for staff to enforce these standards in non-standard ways. In the latter case, staff debated whether to keep participants in the program at all – a decision shaped by the perceived severity and frequency of noncompliance. Participants could remain in the program even when they failed to comply with supervision requirements, but generally – according to staff reports – participants seemed to meet them with regularity.

Likewise, participants could remain in the program despite reoffending, although staff were concerned about reoffending and criminality. On occasion, for example, they noted the "criminal thinking patterns" of participants that were being or needed to be addressed in treatment. Moreover, staff sometimes signaled negatively that participants were behaving as criminals in ways that needed to be rectified. For example, Judge Perry concluded a case review

in which staff members claimed a female participant had manipulated them by going to an inpatient treatment facility, rather than reporting directly to them (seemingly trying to avoid time in jail):

> "[I think we acknowledge the fact that she does need treatment, but for her to dictate the circumstances under which she finds herself… I think she is one that I have to remind today that we are not running a free mental health walk in clinic. This is a court program. This is an alternative sentence to your going to prison. So you can do what we tell you to do or if you want to act like a criminal than I can deal with you as a criminal.]"

(Conversely, select participants were viewed favorably for not exhibiting a criminal disposition. For example, the Kent County program coordinator noted of a participant staff were considering promoting (and did promote) to the final phase of the program: "[He doesn't seem to be criminally oriented. His conviction was just copying videos.]" The judge responded: "[I'm not too worried about that. Selling bootleg things out of a shopping cart—I'm not going to get too worked up about that.]" Likewise, a Kent County case manager described of a participant staff tended to view very sympathetically: "His case was different—stealing a bible and food" – a point she reiterated across multiple case reviews as staff focused primarily on identifying a supportive housing environment for him.)

Perhaps most importantly, staff sometimes acted on perceptions of criminality. In several cases in which participants were terminated from the program, the specter of both drug dealing and prescription fraud was noted as a significant problem, providing impetus for termination. Similarly, as noted above, the specter of potential public safety risks could contribute to termination from the program in Kent County – whether due to participants endangering others through substance use and ties to drug dealers (such as in the case when a drug dealer purportedly threatened those residing in an inpatient facility after a participant failed to pay his debts incurred while in the program) or being symptomatic in ways that could lead to violence.

Yet, despite a focus on eliminating criminal behavior, court staff (specifically, judges) had considerable discretion in terms of how they responded to actual criminal charges and convictions. Per policy guidelines, participants did not have to be terminated from the program due to new criminal offenses and often were not terminated unless external criminal justice agents (e.g., prosecutors and other judges) incarcerated them and/or charges represented serious criminal offenses to court staff including, in one case, kidnapping and abusing a romantic partner and, in another, a series of home invasions (although even here, seriousness was not a uniform

criterion). Moreover, participants often were confronting low-level offenses that occurred prior to entry in the court program but were left unresolved, which was not observed affecting how staff explicitly intervened upon them in the program. Thus, ultimately, criminality remained a very flexible standard in practice.

IV. Looking for the right institutional disposition: Do you want help or not?

At the frontlines of criminal justice and social service work, mental health court staff are engaged in a form of gatekeeping with high stakes. Their decisions impact the social services participants' access, their legal status, and whether they end up behind bars. Deeply committed to helping participants with whom they work closely, they do not make decisions lightly. They are emotionally invested in their work. They want participants to do well. They want to identify the structure that will help participants thrive, often contemplating whether some intervention not yet tried – or not yet tried for the third or fourth time – will do the trick.

Yet, as gatekeepers at the nexus of the criminal justice and community mental health system, court staff are not simply providing treatment services for treatment's sake. They are charged with providing treatment services in efficient ways to those who most benefit from them and sorting out those who do not benefit and/or otherwise prove to be deserving of punishment. In the process, they routinely confront participants who are not thriving according to their treatement goals. They fail to take medications. They relapse. They do not do gain employment or move housing as directed. Often enough, they are engaged in multiple and/or repeated forms of noncompliance – or they simply stop showing up altogether. Thus, just as staff are emotionally invested in participant success, they also routinely confront feelings of disappointment and frustration, compelled to make difficult decisions of determining when and how to cut off aid and punish participants.

Certainly, some decisions are more clear cut, as in cases when participants "blow the doors off" the program, as Judge Perry described, in terms of flagrant and repeated noncompliance or, conversely, when participants are progressing as desired by staff. However, the decisions they must make can be ambiguous and complex for multiple reasons. Working closely with participants, staff see them as multidimensional beings with unqiue obstacles and setbacks for which they cannot offer boilerplate remedies. Further, staff often lack information,

are presented with conflicting information, or simply are inundated with information in ways that make it difficult to identify the true nature of a problem and/or determine how to prioritize between problems. They also lack certainty and predictability about the outcome of any given intervention (as well as formal rules about when and how to apply interventions) in ways that make it very challenging to choose between them (see Hasenfeld 2010). Moreover, they know that many of their interventions fall short given very real resource constraints (e.g., a lack of availability of adequate housing and jobs and no ready-made solution to disrupt harmful social networks).

More fundamentally, as I argued at the beginning of this chapter, staff can access different institutional models legitimized in this setting with potentially conflicting interpretations of what counts as an appropriate problem and solution. Thus, for example, a participant might be someone engaged in repeated illicit substance use deserving of punishment or, alternatively, someone with so much psychological pain in their life that their substance use is a rational response deserving a therapeutic intervention. Staff certainly present both frameworks in their private interviews and group deliberations. Following conflicting logics at their disposal, they must decide when and how to standardize and individualize responses.

Despite this complexity, decisions must be made expeditiously. With significant discretion, staff are tasked with deciding the fate of participants' cases one after another in routine deliberations and court hearings. I have shown that staff confront this decision-making process with a mixture of upholding goals as standards all participants must meet and, yet also, applying rules around these goals in non-standardized ways. Up until this point, I have simply tried to establish this phenomenon to demonstrate how the mental health court operates in practice as a framework for understanding the experiences of participants explored in later chapters. My point is that given key tensions generated in this setting, staff create a flexible set of paramaters for participant conduct. As a result, (as I will show) participants have agency in navigating these parameters in diverse ways (agency further heightened by the reality that staff are only regulating conduct they can detect).

However, I want to conclude by better describing a primary contributor to the variation in non-standardized outcomes that will further help illuminate the pathways available to participants in this context: staff perceptions of the institutional disposition of the participant. By institutional disposition, I refer to the participant's orientation to this institutional setting and its

goals. I will explore how these dispositions are a product of a complex interplay of factors in later chapters. Here I want to show how these dispositions are read by staff as indicators of who the participant fundamentally "is" and, more specifically, the participant's "true self" in relationship to the program and its goals. Believing in the mission of the court, staff want participants to strive to take charge of their recovery. Yet, without access to the inner workings of the participant's mind or total surveillance, they ultimately must turn to what is rendered visible to them: a presentation of self that appears more or less incongrous with the program's objectives. They rely on this presentation to help determine whether a participant's case is workable or not (see also: Burns and Peyrot 2003; Paik 2011).

On one end of a continuum, staff see participants as deserving of accommodation and eventual graduation from the program *regardless of* obstacles and setbacks they face. According to staff, these participants buy into – or at least are amenable to – the objective of working on themselves and their recovery (and, in some cases, clearly reveal themselves to have the problems program staff aim to tackle such as serious functional impairments due to mental illness and disability). Participants cue this kind of interpretation in several ways. Most conspiciously, participants can show it to staff through their behavior, (presenting as) behaving in ways that align with program goals (e.g., appearing to staff to take medication, showing up to appointments as directed, and providing negative drug tests). Participants who do so frequently or increasingly across time signal not just that their behavior aligns with program goals, but that they – as moral selves – are working towards alignment.

Yet, commonly, participants also manifest this dispostion in how they present their *noncompliance*, demonstrating that even when their behavior is not in perfect alignment with program goals, they are working towards alignment. For example, they proactively confess noncompliance before it is detected and/or accept personal responsibility for noncompliance, promising to follow corrective pathways recommended by staff. Further, and more generally, participants also talk about their buy-in and/or amenability to the program with staff. They describe desiring and benefitting from the program, or at least showing a nascent curiousity and openness to its goals (even if they are not outright invested in them). More basically, according to staff, participants share their beliefs, behaviors, and aspirations, providing an opportunity to know – and thus address – their real needs.

Thus, in the words of staff, some participants show themselves to be "open to changing their life," "willing to accept the help," "working the program," have a "positive attitude," and "take ownership for their wellbeing." Or as one case manager described favorably of a participant progressing unsteadily: "[She kind of gets it. She is not making perfect decisions all of the time, but she gets the bigger picture.]" Some participants could present themselves to be aspiring to achieve – and understanding the value of – program goals.[29] As such, staff worked to extend aid to them. They advocated to increase their treatment appointments rather than jailing them for a bout of noncompliance. They recommended trying inpatient substance use treatment one more time rather than removing them from the program after ongoing substance use. Moreover, they only briefly acknowledged the occasional missed treatment appointment, with a strong faith that it would be made up with the smallest of nudges, and they reduced or eliminated program requirements given that they trusted that these participants could not or did not need to meet them to the same degree as others (if at all).

This contrasts significantly with participants who fell at the other end of the continuum, those who staff see as deserving of increasing control and punishment *due to* setbacks and obstacles they face. According to staff, these participants are resistant to, disengaged from, and/or, most problematically, manipulative of the goals of the program.[30] Again, most conspiciously, this interpretation is tied to behavior as participants are identified by staff as behaving in ways deemed incongruent with program goals (e.g., using substances, missing appointments, and/or not appearing at court). Participants who exhibit such behaviors frequently or repeatedly across time reveal themselves to staff as not trying and unwilling to engage in the kind of personal tranformation the program aimed to instill through the recovery process.

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[29] Miller (2014) finds that in contexts like these courts that do not resolve broader inequalities and resource deficiencies in communities (specifically, in his case, prisoner reentry organizations), criminal justice subjects are expected to turn inward to correct themselves indefinitely. "Personal transformation is not an achievable status…but an aspirational category. …Successful embodiment of this category is evidence by [a] willingness to submit to being a work in progress" (324).

[30] To some degree, staff understand manipulation as an inevitable byproduct of the court's design. Coerced to engage with program goals across time and heavily (but partially) surveilled, participants look for ways to encourage staff to not punish them when they fail to meet expectations and/or adjust those expectations deemed undesirable. Staff accept this to an extent. They know the participant might claim to be sicker than he or she really was or play up the nature of a transportation obstacle. They sometimes see such claims as part of the participant's mental illness or addiction, as evidenced by Judge Ash, who explained of lying: "Number one, I think that's part of their disease – number one. …The depth and complication of their disease just makes them do things that make no sense. But it does to them somewhere. Oh god, how'd you like to have all that going on in your brain?" However, according to staff, some participants not only engage in specific acts of manipulation vis-à-vis program goals; they are manipulators. They intentionally take advantage of the goodwill being offered.

Yet, in tandem, this interpretation manifests in how this behavior is presented by participants (or inadvertently revealed) to staff. These participants are perceived by staff as failing to confess to noncompliance, appearing to dissemble about their noncompliance, or, after noncompliance is detected, justifying it in ways that deflect personal blame. Further, they can simply present as apathetic and/or unwilling to follow corrective pathways recommended by staff. Moreover, at an extreme, such participants can present as actively manipulating the program by asking for accommodations they do not need or trying to access social services for which they are ineligible. Finally, in their routine interactions with staff, they fail to demonstrate openness to or enthusiasm for program goals, in some cases saying little at all about themselves and their problems or, alternatively, feigning engagement.

In this vein, according to staff, some participants showed themselves to be "just trying to manipulate the program," "abusing the system," "trying to scam," "blatantly dishonest," or simply "closed down." As a staff member concluded of one such participant: "[Until *she* decides this is not working for me and I need to do something different, nothing will improve]." Staff could not trust that participants exhibiting this kind of disposition would engage in and benefit from what was on offer. They advocated for jailing participants rather than simply increasing treatment given a perceived need for punishment. They did not recommend giving participants more chances when program removal was raised and, in some cases, directly advocated for program removal (a practice more common in Kent County where termination decisions were deliberated over much more frequently in routine decision-making). Moreover, the missed appointment or positive drug test became a sign of something much greater – who the participant was and could be – not simply an act to be corrected moving forward.

These kinds of interpretations were incredibly useful to the decision-making process. They provided overarching frameworks to understand (and simplify) the participant and his or her problems to help resolve the ambiguity introduced by having a set of standards that are not, and cannot be, applied in a truly standardized way, providing a basis of certainty and legitimacy to difficult decisions. Participants either were amenable to the program or they were not. Thus, some were deserving of second and third chances and, conversely, others were deserving of sanctions and program removal.

Moreover, these interpretations help shift the weight of decision-making onto participants, who ultimately decide by their conduct, their fates in the program. It is not staff who

control what happens; it is participants who must prove themselves to be ready, willing, and engaged. Thus, in it its most explicit form, staff would flat out ask participants in ambiguous cases if they wanted to continue in the program, as a program coordinator explained doing in an interview. She recounted that a treatment administrator was headed over to the jail to pose this question to a likeable participant after repeated noncompliance related to substance use:

> "'Do you want help or not? If you want help, we are going to put you in inpatient [substance use treatment] somewhere and you're going to do it. And you're going to get out and get the old [you] back. If you do not want to do this, that's fine, but let us know because we are not going to waste our time.' So that's it. I mean, he's been through this. He knows. So don't waste our time. If you don't want to get clean, that's fine, but we gotta let you go."

Not wanting to have to decide to cut off aid to a participant who might somehow do better (and, in this case, had shown progress in the past), staff asked participants to make this decision.

Yet, a subject to which I will turn in the following chapters, not all participants are equally situated to perform these dispositions. Participants without significant problems in the problem-solving court are more likely to be read by staff as amenable to the problem-solving mission – e.g., they secure (or already secured) housing, participate in treatment, obtain (or maintain jobs), and abstain from substances. Conversely, participants with problems – particularly ongoing substance use – are more likely to be read as disengaged from, resistant to, and manipulative of program goals, often caught up in managing impressions around their problems rather than resolving them. Of course, most participants fall somewhere in between, varying both in the kinds of problems they have and their capacities to present these problems to the court. Moreover, the point is that regardless of what participants are actually doing or the kinds of problems they have, to some degree, participants can shape how they are read by staff. Staff see institutional dispositions as an expression of who participants "are," but they are a performance rooted in institutional knowledge, styles, and skills of participants.

Conclusion

In this chapter, I demonstrated that due to inherent tensions in embedded in the mental health court's design, mental health court staff are caught between competing pressures to hold participants to certain standards and apply these standards in non-standardized ways. In the process, they create room for significant agency on the part of participants.

I am not advocating that mental health courts should pursue standardization to the degree that they hold all participants to the same standards regardless of their attributes or circumstances or that they should entirely individualize their interventions. However, this tension creates room for bias. Thus, for example, in both courts during periods of staff turnover, senior staff became frustrated when newer staff presented as more eager to hold participants to standards, readily applying criminal justice sanctions. At such moments, it was clear staff could maintain different ideas about when and how to apply standards – a tension that emerged further in interviews as staff described a degree of unpredictability to the process by which standards were enforced.

Moreover, this kind of discretion allows for courts to vary considerably – even those who might appear on their face to be similar but whose rules are enacted by staff in different ways. Hence, acknowledging these differences will be important for qualifying the experiences of Rapids County participants explored in later chapters.

Chapter 4
Participant Strategies for Engagement

I. Introduction

The prior chapter deals with how staff employ seemingly neutral criteria when evaluating participants like whether participants buy into – or at least acquiesce to – program goals, are open and honest, and accept personal responsibility for their actions. I now shift the focus to how participants are differently situated to meet these criteria. Some participants can work with or around the program's criteria – they can master the rules of the game – while others will struggle more in doing so. My general contention is that these differences are not merely a matter of an individual willingness or unwillingness to engage with the program; rather, they reflect more fundamental differences between participants in terms of the cultural, social, and economic resources they have at their disposal and their orientations towards institutions like the criminal justice system.

Scholars have shown that individuals develop different ways of interacting with public institutions based on their resources and dispositions (Bourdieu and Passerson 1977; Lareau 2003, 2015). Still, the mental health court context demands a reexamination of the processes by which this unfolds for at least two reasons. First, as an institutionally complex site, it requires its participants to navigate different institutions with unique opportunities and constraints. Already research is beginning to show that traditional assumptions about how individuals interact with public institutions might not hold in some institutional settings such as the criminal justice system (Clair 2018). We thus need to examine how individuals might be positioned to take advantage of (or be disadvantaged by) the institutional complexity they encounter here. Second, the mental health court brings together a relatively diverse participant population in terms of age, gender, and race, as well as to a smaller degree, class. This provides an opportunity to examine how heterogeneous individuals are interacting with this institutionally complex setting,

potentially with different effects. How do these diverse individuals differently navigate the opportunities and constraints of this context? What explains variation in this capacity?

In this chapter, I lay the foundation for answering these questions through focusing attention on key ways in which participant engagement is stratified. I show that participants face similar pressures in this context, particularly the pressure to *perform compliance*, or present as acquiescing to program goals. Yet, given the complexity of the setting, they can carry out this performance in very different ways. Specifically, I present a typology of strategies available to participants to carry out this performance. I describe how each strategy works and show how they are each embedded with unique costs and benefits that participants must be equipped to manage as they navigate the program.

However, I am not using “strategy” to frame participants as rational, calculating actors who are consciously weighing all the costs and benefits of any given strategy. Instead, I use this concept to draw attention to different lines of action made available through this setting that participants can draw upon as they proceed through the program. I note that these strategies are part of a “tool kit” (Swidler 1986) or “repertoire” (Tilly 1992) of cultural resources at participants’ disposal here. While some participants tend to present themselves as abiding by a single strategy, most describe mixing strategies to pursue their desired ends and express some form of ambivalence vis-à-vis the strategies they employ. Still, my argument is that while all strategies are possible in this context, they are not equally possible for all participants. Instead, I contend that given how any strategy works, some participants will find themselves more predisposed towards it than others in pursuing a desired goal, albeit often at unconscious levels of awareness as different ways of being materialize as natural and beneficial.

I begin by resituating our understanding of the mental health court through the vantage point of the participant. I describe how participants experience the program, especially in terms of key opportunities and constraints they face. I then turn to describing the typology of strategies, their characteristics, and the role demands they impose on participants through analysis of select participant cases. I conclude by discussing how this more comprehensive understanding of the possibilities for engagement should refocus our attention away from the individual will of participants to the kinds of resources and dispositions that undergird their actions in the program.

II. Participant trajectories through mental health court and the pressure to perform compliance

To understand the possibilities for engagement with the program, it is important to lay out how participants experience the program. This involves understanding three interconnected aspects of participation. First, the mental health court, like other people-processing institutions, provides cues – both implicit and explicit – to participants regarding how they should produce themselves and their problems (Holstein 1992; Gubrium and Holstein 2001). These cues predominantly signal to participants the importance of accommodating, if not conforming to, program goals. Second, participants are not only cued by the program to pursue its goals, they also potentially can make significant gains from doing so, both intended and unintended by the program. Third, despite such incentives to abide by the program, participation is incredibly demanding and can even be experienced as detrimental. I show that these three aspects of participation together push and pull participants to *perform compliance*, or present as accommodating program goals whether or not they conform to them, with the pressure to do so beginning as soon as participants are first vetted for participation.

Mental health court participants learn early on about the key benefits of participation and the importance of performing compliance. All are introduced to the program as a treatment alternative to traditional prosecution while facing at least one criminal charge. They are awaiting sentencing in jail or out on bond in the community. They are most commonly flagged due to a prior relationship with the treatment system or by a criminal justice professional that deems them a good fit for the program, such as a lawyer or judge. The court accepts both misdemeanor and felony charges and offers an opportunity to dismiss or reduce charges in some cases, depending on the constraints imposed by prosecutors. As such, candidates vary considerably in terms of the sanctions they think they potentially face, for example, from 60 days in jail to longer prison sentences and a criminal record, but all face some undesirable sanction that can be avoided through their participation.

Participants are informed of the program by court-designated professionals at several points prior to joining, all of whom explain potential components of the program in varying degrees of specificity and ask the participants if they are willing to follow its terms. This includes both discussion of potentially desirable components, such as increased access to treatment, housing, and other supports, as well as likely less desirable components, such as the

mandatory nature of treatment and a requirement to engage in activity like community service. Participants are also provided written stipulations of the program with an emphasis on treatment stipulations to which they must provide written consent. Further, participants must have a documented mental illness that meets the criteria of the program (bipolar disorder or schizophrenia), which is (re)diagnosed prior to participants being asked to agree to the program if not yet appropriately documented. The program is "voluntary" (for a discussion of what this can mean, see: Redlich 2005; Redlich et. al 2010). It is a part of a plea deal that participants can either accept or reject, but, as this trajectory shows, accepting this deal means stating a commitment to accommodate program goals and already aligning to a degree with program goals via a diagnosis. If participants agree to the terms of the program, they commence a yearlong commitment to participate in and accommodate it.

Upon entry, participants might identify many rewarding aspects of the program beyond just avoiding an undesirable legal sanction. They are connected to a range of staff members who are clear that their primary goal is to help. Participants thus have new sources of emotional support. They are praised when they do well and encouraged as they face obstacles. They even can receive small presents such as gift cards for their progress, as well as to mark the winter holidays. Perhaps most noteworthy, a judge takes their concerns seriously, spending time discussing problems with them and offering support (for a discussion of shifting judicial roles in this context, see: Nolan 2001; Winick and Wexler 2003, and how this can affect participant conceptions of procedural justice, see: Wales et al. 2010; Kopelovich 2013). However, beyond just emotional support, participants have direct access to professionals who can help them navigate daunting bureaucratic problems. Judges and public defenders might offer aid on certain legal issues.[31] Case managers can more quickly provide links to treatment or social services, both due to increased contact, judicial supervision, and a special status afforded to them as program participants. Furthermore, and perhaps most importantly, participants' lives ideally will improve. They will develop needed skills and supports, and their mental health will stabilize. In the

[31] Public defenders, who are always present at court and thus accessible, can advise participants on legal matters (e.g., landlord-tenant issues and old warrants). Judges can write or have their staff write letters acknowledging the participant's progress in the court program that can be used to help judges in other courts determine how to sentence the participant. Judges also can grant authority—when other legal parties agree—to roll other charges into the mental health court plea deal such that participants do not have to serve separate sentences on emerging charges.

process, they will construct a pathway forward that involves no future contact with the criminal justice system.

Additionally, participants might even achieve a set of incidental advantages associated with having an illness known as "secondary gains" (Parsons 1951) that are legitimized not just by a doctor but also by the court system. This can include, for example, an excuse from social obligations like employment as the ill individual is in recovery or, most relevant here, relief from guilt and blame associated with problems like criminal offending that can be attributed to illness rather than a flawed moral self. Also, participants might be able to gain access to resources such as housing and income that are contingent upon a mental health status. Moreover, participants can make sense of undesirable psychological distress (now labeled as mental illness) and experience a sense of optimism that their distress can improve (through their participation in treatment). In sum, participants have much to gain from their participation.

Participation, however, can also be incredibly demanding. Identifying with a mental illness (and for some participants, also a substance use problem) can be stigmatizing, both in terms of the participant's self-conception and the conceptions of others (see: Link et al. 1999; Phelan et al. 2000; Corrigan and Watson 2002; Livingston and Boyd 2010; Clement et al. 2015). This is not a minor concern; stigma is an attribute that is deeply discrediting, which can result in status loss and discrimination (Goffman 1963; Link and Phelan 2001). Moreover, while identifying with a mental illness can generate secondary gains, these secondary gains can be only partial, with participants continuing to struggle with a durable association between undesirable conduct like criminal offending and their self-image (Conrad and Schneider 1980). Furthermore, identifying with a mental illness involves adopting a medical-legal framework in which the causes of and solutions to participant problems become located in the self, pathologized as the product of disorder and a lack of self-control. Participants, then, must defer to this framework and its advocates, closing off alternative possibilities for understanding and responding to their problems such as recognizing them as rooted in a dysfunctional social system rather than a dysfunctional self.[32]

[32] Conrad and Schneider (1980) described how medicalizing social problems leads to isolating causes of and solutions to complex social problems in the individual rather than the social system ("individualizing social problems"). This depoliticizes these problems and, in turn, can disempower individuals as they must accept responsibility for the problems they face. As discussed in the introduction, a host of researchers lay out how this kind of process unfolds empirically in terms of biomedical and therapeutic discourses and, particularly relevant here, in criminal justice and criminal justice adjacent contexts (e.g., see: Fox 1999; Hannah-Moffatt 2001; McCorkel

Moreover, participants must engage in this identity work as they comply with a range of requirements staff impose on a case-by-case basis that can consume considerable time and effort in any given week. Requirements include first and foremost abstaining from non-prescribed substances and abiding by community mental health treatment requirements. These treatment requirements comprise of meeting with a psychiatrist, adhering to psychiatric medication, and meeting regularly with a case manager (from weekly to monthly, depending on the participant's status in the program), who both help with service needs but also report back to court (for a discussion of case managers as "double agents," see: Castellano 2011). Furthermore, depending on issues that emerge in any given case, requirements can extend into the domains of substance use treatment, housing, physical health, and other social and health service needs, as well as legal obligations such as maintaining no contact with specified individuals. Additionally, once participants have adjusted to basic requirements, staff tend to order that they use their time productively through, for example, 20 hours per week of community service or employment.

Participants might find any or all these requirements to be rewarding but complying is not an easy feat. Not only does it involve a considerable investment of time and energy, but participants also consistently confront their loss of autonomy as they follow orders. For some, this loss of autonomy can be temporary. Yet, research indicates that many participants will experience this loss as part of a broader experience of subordination vis-à-vis state agencies – one in which they are continually but subtly trained how to be better subjects of a social system from which they derive minimal benefit, whether through being required to patiently wait without complaint for bureaucrats to process their cases (Auyero 2012) or told that they should accept discipline and discomfort as fundamental organizing principles of their lives (Kaye 2012). From this vantage point, it becomes clear that requirements are not merely an activity that individuals do, but also a way in which power is instantiated that participants can participate in enacting or resisting.

On top of these activities, participants also must regularly appear in front of the judge with their case manager to have their compliance reviewed (again, from weekly to monthly). These appearances provide direct access to the benefits described above as staff, including a judge, work to help participants. However, appearances also serve as the primary site of

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2010; Haney 2010; Gowan and Whetsone 2012; Miller 2012; Stuart 2016). This topic is returned to in the following chapters.

punishment, with the judge serving the role of rule enforcer. Appearances are held in public court with other participants (and their kin) and court staff filling the courtroom, i.e., these appearances are very public (although, in key cases, the judge will make exceptions and discuss sensitive matters privately with a participant and their case manager in another room).[33] The participant can be randomly drug tested, as determined by staff. The judge also has access to other kinds of information about the participant from a private staff meeting that precedes all appearances, although participants cannot be sure exactly what information has been conveyed given that they do not participate in these meetings.[34] Each appearance involves an interaction between the participant, judge, and case manager focused on key requirements and any issues raised by participants. Appearances conclude with the judge ordering some program response, which can range from no new action to adding or adjusting requirements to imposing a jail sanction or even terminating a participant from the program. In this setting, participants are trained that complying might be difficult, but they are generally rewarded for it and punished for noncompliance.

Yet, while participants are learning about the many benefits and costs of participation as they proceed through the program, they are also learning how to navigate them. For example, the savvier the participant, the more they will observe that what counts as noncompliance and how it counts varies. Certain kinds of noncompliance might matter more than others, such as the second positive test for cocaine versus the first positive test for marijuana. Likewise, the positive test for marijuana might matter less if the participant can otherwise demonstrate a history of complying with other requirements, such as attending psychiatric appointments and obtaining employment, or having a serious setback like the loss of a family member. Perhaps most importantly, such

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[33] Appearances are organized to be public so that participants can observe each other. This aspect of problem-solving courts has rightly been conceptualized as a form of theater in which court staff members work together behind closed doors to determine what kind of message to communicate (to all participants) through these public appearances (Nolan 2003), even if their more public messaging is not entirely consistent with court practices (e.g., Judge Ash acknowledges that she sometimes "bluffs" in part about the prison sentences participants face in this context to encourage compliance). Judges interviewed here certainly view court appearances as an important way in which they can teach participants about the rewards and costs of participation, as well as, help mediate stigma by showing participants that they are not alone in their struggle to achieve better treatment outcomes.

[34] Participants know staff members meet to discuss their case, but they do not necessarily know the exact information being discussed unless the judge reports this in court or their case manager tells them. There are likely several key reasons for keeping this information-sharing process partially ambiguous. It obscures the limits of surveillance. It obscures specifically the role of the treatment case manager in surveillance to limit potential damage to the therapeutic relationship. It encourages participants to self-report noncompliance as part of the recovery process. More generally, having a private meeting allows staff to discuss the participant's case without the participant, who might not share their perspective or motivations.

forms of noncompliance can be managed through the act of confession in which the participant demonstrates an active concern about noncompliance and desire to change, whether through confessing to a case manager prior to a court appearance or to the judge directly in court. (The act of confession, or self-disclosure, can play a very important role both in criminal justice interventions like the mental health court and in drug treatment, see: Andersen 2014; Burns and Peyrot 2003; Mackinem and Higgins 2007; Paik 2006a; Skoll 1992; Weinberg 1996, 2000.) Additionally, participants can proactively try to negotiate how the rules of the program apply to them, contesting the need to attend a treatment group or do community service. In short, given that mental health courts are designed to flexibly respond to participants, participants, then, can learn to manipulate this flexibility to their advantage.

Moreover, the savvier participant will also know that performing compliance does not always require *being* compliant. To gauge compliance, staff often must rely on reports of behavior from others that can be contested through alternative explanations. For example, participants might miss appointments due to a miscommunication with staff or problems with transportation rather than a lack of desire to attend them. Even the seemingly objective biomedical drug test is open to contestation (see: Paik 2006b; Mackinem and Higgins 2007). Drug tests are not consistently conducted and participants have multiple strategies for manipulating their results, including for example, navigating the timing of when they test to masking substance use through other licit substances. More noteworthy, mental illness symptoms are detected almost wholly through participant self-reports and behaviors exhibited around court staff, providing room for manipulation. Likewise, consumption of psychiatric medication is difficult to track outside of participant self-reports, with the exception of the minority of participants who take medication by injection or take one of a select number of medications that can be monitored through blood testing.

Furthermore, while the program can animate an extensive web of actors to participate in surveillance—including not only case managers, but service providers that do not appear at court such as substance use counselors, psychiatrists, and employment specialists, criminal justice actors such as police and correctional officers, other participants, and kin—participants can similarly work to manage their performance across contexts. The participant can be equally emphatic with the judge, psychiatrist, and parent that they are missing appointments due to depressive symptoms even if they do not personally believe they are struggling with depression.

Alternatively, the participant can adapt their performance to each context, focusing on depressive symptoms with the psychiatrist versus the hardships of attending appointments with the parent to differently activate sympathy and advocacy.

Participants have many goals but eliminating court infringements into their lives and graduating from the program is something most likely desire, particularly given that a common message projected by the judge is that participants can face undesirable legal outcomes if they are unsuccessful in the program.[35] Participants can successfully complete the program by demonstrating enough compliance to staff as determined on a case-by-case basis across their designated year in the program. Those who fail to demonstrate such compliance can be removed from the program to face re-sentencing on their initial charge. While some participants will abscond from the program prior to entry (i.e., as soon as they are released from jail), those who remain in the program cannot outright resist its rules if they are to persevere. Instead, they must try to find some ways of accommodating the program. This might be accomplished through being compliant. Yet, the dynamics of the court indicate that participants will feel compelled to feign compliance when they find being compliant too challenging or unappealing or otherwise find ways of negotiating what counts as compliance with staff. In short, the program provides multiple possibilities for how participants tackle the role of performing compliance. Hence, it is important to lay out in greater detail what options participants really have at their disposal to engage with the program, which I turn to now.

III. Results

Engagement strategies and their demands

These findings present a typology of the different strategies participants have at their disposal to engage with the court program given the pressure to perform compliance. I approach these forms of engagement as ideal types following the Weberian (1949) model. Ideal types

[35] The legal outcomes of participants terminated from the program were not tracked, but interviews with a sample of nine judges who had sent offenders to the program painted an ambiguous picture, which is in part unsurprising given the varied charges participants faced. In some instances, judges might sentence participants more harshly for being unsuccessful in the program. In other cases, judges might try to identify further alternatives for the offender given that they already deemed him or her worthy of special treatment, such as placing the offender on probation and making treatment engagement a requirement. Regardless, the mental health court judge routinely evoked this idea that participants can face harsher punishments—particularly prison—to encourage compliance.

allow for the comparison of the often messy, complex reality of participation. They serve as paradigmatic cases that do not map perfectly onto this reality but condense essential attributes around which participant cases cluster. These strategies thus do not reflect the full complexity of any one participant's engagement with the program. In fact, a key theme that will emerge across these next three chapters is that participants often are exhibiting elements of different strategies and these modes of engagement can change across time, with participants presenting conflicting and contradictory ideas about their engagement. In other words, participants can draw on a toolkit (Swidler 1986) or repertoire (Tilly 1992) of strategies, adopting different strategies as they pursue diverse ends, their circumstances evolve, and they experience emotional ambivalence around their program engagement.

Still, in whatever unique ways participants are engaging, they ultimately face clear constraints. These strategies emerged as the primary lines of action made available to engage in this setting. Hence, it is important to examine what participants can gain from them and how participants must be equipped if they are to successfully employ them. Mapping out each in turn will provide a better understanding of how participants must be positioned to thrive in this context and thus also what can get in their way.

Below I review each type of strategy and attend to the kinds of demands they place on participants and the benefits they offer, explaining why some participants will be more predisposed towards them than others. I use participant cases that came closest to exemplifying the strategy to help carry out this analytic work, while acknowledging that even these participants did not perfectly match the ideal. Still, to better elucidate how these strategies materialize in a variety of ways in this setting, I also investigate a participant case in which different strategies were prominently employed simultaneously. I reiterate here that participants can outright reject the rules of the program, failing to exhibit any compliance, but these participants do not remain in the program (and are not part of the sample) and thus this strategy – rejection – is not investigated individually here (for a discussion of how resistance must be expressed surreptitiously, see Scott 1985). See Figure 1 for a table summarizing the key characteristics and demands of each strategy.

Table 1 Types and characteristics of engagement strategies

	Accepting goals as applied to case	**Rejecting goals as applied to case**
(Presenting as) conforming with goals "on books"	Buy in	Strategic acquiescence
Non-conforming to goals "on books"	Entitled Acquiescence	Rejection

Buy In

Participants can exhibit *buy in*. Generally, this involves the participant embracing program goals and the modes by which these goals are pursued by the program. Specifically, the participant identifies with her mental illness and/or substance use disorder, using her disorder(s) as a frame for making sense of her life. Furthermore, she expresses support of the causal model that her disorder(s) is a source of problems, particularly her recent criminal offending, and value for the treatment requirements the program imposes, including, for example, adhering to psychiatric medication and drug and alcohol abstinence. She also, then, reports readily complying with treatment requirements and taking an active role in identifying her treatment needs with staff to better target requirements. She would participate in this process with treatment providers whether required or not and she expects actively participating in treatment will lead to a better life. In short, she conforms to program goals.

Complete conformity to an institutional model is difficult in any setting, but particularly challenging here given the demands imposed. First, buy in requires participants to believe they have a disorder, which they might not think they have[36] or otherwise might resist due to concerns

[36] In some cases, participants might only align with a mental illness strategically, not experiencing the kind of psychological distress that is labeled mental illness or otherwise viewing psychological distress differently from a medical model. Still, a concern might be that participants do not have self-awareness about their biopsychosocial condition (what is called anosognosia). This is not a participant-based concern and thus hard to measure through my data. However, most participants described accepting at least one of their mental health diagnoses and those who covertly rejected their diagnoses did not present in any way that contradicted their beliefs. Moreover, it is important to acknowledge that how staff assess mental health conditions can reflect organizational demands and not simply a more objective understanding of the participant's condition (e.g., see: Hannah-Moffatt 2004; Pollack 2005, 2006; Haney 2010; Kilty 2012; McCorkel 2013), making it difficult to measure anosognosia even from a staff perspective.

about stigma. Participants will not equally be able to overcome such concerns given how stigma is mediated by social positioning, dependent on social, economic, and political power (Link and Phelan 2001). The loss of status and discrimination associated with stigma can be amplified or mitigated by social identities such as race, class, and gender or role identities such as employee or student. For example, women might experience less stigma compared to men with disorders like depression that are stereotypically and epidemiologically associated with femaleness, just as men might experience less stigma around disorders associated with maleness like alcohol dependency.[37] Moreover, how participants experience stigma is likely to vary by race and class, both for mental illness (Nadeem 2007; Campbell and Mowbray 2016) and substance use, particularly given that participants of color can experience a compounding stigma from a minority status (Gary 2005; Corrigan et al. 2003) and are disproportionately subject to criminal stigma (Alexander 2010; Van Cleve 2016). This variation in experience is further exacerbated by the social networks and institutional contexts in which participants operate, which can be differently organized around how mental illness and substance use are conceived and addressed.[38]

Second, participants must be able to accept the expertise of the medical and legal systems in defining and responding to their problems. More specifically, they must trust that openly engaging with and following the advice of community mental health treatment and court staff members is a worthwhile venture. Some participants will be more predisposed to do so given that this advice meets their needs. For example, identifying with a disorder can help them construct a positive self-image and experience a sense of greater control over their lives as opposed to masking social problems they face, as will be discussed in greater detail in the sixth chapter.

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[37] Researchers have already shown that gendered expectations, stereotypes, and lived experience map onto how individuals experience illness and are treated (Bendelow 1993; Lorber and Moore 2002; Anspach 2010) including in terms of mental health specifically (Ussher 2010), which could be extended to experience of mental health stigma. However, Wirth and Bodenhausen (2009) show that individuals also might be less likely to experience stigma precisely because they do not fit a stereotypical diagnosis for their gender, signaling they "really are" sick. Further, mental illness stigma varies by disorder (Angermeyer and Matschinger 2003). Alcohol and drug use can be stigmatizing, although this varies, particularly in terms of its legal status and degree of perceived misuse and abuse (Room 2005; Magdalena et al. 2013; Fraser et al. 2017), with stigmatizing effects likely amplified in moments of moral panic around specific substances and social groups (e.g., see Gusfield 1963; Reinarman 2003).

[38] For example, research shows that attitudes towards mental illness vary across social groups, particularly in terms of race, gender, and education (Corrigan and Watson 2001; Rao et al. 2007). Thus, individuals might be embedded in networks in which mental illness is viewed more or less favorably. Throits (2011) also shows that individuals are more likely to resist stigma when they have past familiarity with an ill family member or friend. Furthermore, individuals access treatment in very different contexts, which can further shape the ways in which they experience stigma.

Participants will also be more likely to follow such advice when they are not part of social groups who experienced legal and institutional exclusion that breeds distrust towards these systems, as discussed in the introduction (see: Bell 2017). Such participants, then, enter the program more disposed to view the legal and treatment systems as legitimate, responsive, and equipped to meet key needs. However, it is noteworthy that researchers also find that some individuals are so desperate for aid that their desperation can shape a belief that programs like this can work to their advantage (Leon and Shdaimah 2012; Shdaimah and Weichelt 2012; Kaye 2012) or, given a lack of tenable alternatives, they rely on such systems in key moments to meet specific needs (Bell 2016).

Third, buy in requires being able to envision, and likely experience, the efficacy of meeting program goals. On the one hand, this might seem as simple as psychiatric medication alleviating symptoms, which is far from a guaranteed outcome (Hughes and Peak 2013). However, as the treatment system has increasingly acknowledged, it often involves improvement across many domains from housing and income to physical health (SAMSHA 2002, 2012). Participants are more likely to experience the program as efficacious when they have or can achieve a level of material stability that allows them to pursue the kind of lives they want to lead. What this means in practice varies, but it suggests that participants who do not struggle, for example, to obtain formal employment or access quality housing will be more likely to experience program goals as beneficial. Participants also will be less likely to struggle with intensive requirements, which are time consuming and require getting to and from places, when they have personal transportation and when their primary concern is not, for example, securing housing. In short, some participants will be better equipped to envision and experience the efficacy of program goals.

Despite these demands, buy in can also offer key rewards to participants beyond just access to a treatment alternative to traditional prosecution. It can potentially help participants achieve intended program outcomes like improvement in mental health as they work with the program rather than against it. It can provide access to secondary gains, such as helping participants maintain a positive self-image in the face of a criminal offense, although this too is likely to vary by social identity and prior experience with the criminal justice system.[39] It can

[39] Some participants enter the program with no prior criminal record beyond the charges that led to their participation in the program, which in many cases, can be dismissed, with greater opportunity to move beyond a

generate favorable consideration from staff who want to help those deemed accommodating of and open to program goals. Hence, while many participants might struggle to buy in given the demands embedded in doing so, other participants are likely more predisposed to buy in and can reap significant rewards in the process. They trust that the public institutions with which they interface are designed to and/or can help them, and they have the capacity to use these institutions to achieve desired outcomes.

Strickland provides an example of how these dynamics play out for those who tended to exhibit buy in. She was, by her description, a "Wonder Bread white" woman in her early forties who reported struggling with symptoms of depression and schizoaffective disorder. She also identified as an addict, with a history of drug use including primarily heroin, although she reported that she had abstained from use for well over a decade by the time of starting the program and regularly participated in a 12-step programming voluntarily (something no other participant reported consistently having done prior to entering the court program). Strickland attributed the criminal charge that landed her into the court program directly to her mental illness: voices compelled her to steal a credit card from a purse she found in a public building (an act which was video recorded). Furthermore, Strickland expressed a strong desire for treatment and thus reported eagerly participating in treatment programming. In fact, shortly after completing the program, Strickland's biggest concern was how she would continue to receive the same level of treatment she had received while in the program. She was the only participant to state hesitation about completing it—"I felt like I wasn't ready"—although she maintained very favorable views of the program and its staff.

The degree to which Strickland presented as buying in across these domains was relatively exceptional among participants. Only a handful of participants—all female (6) and predominantly white (5) and middle-aged (4)—came similarly close to exhibiting this kind of strategy. Yet, it made sense for these participants given how suited they were to its demands and

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criminal identity. Yet, setting aside this baseline variation, it has been well documented that criminal stigma is differentially experienced across social groups. Most notably, black men (although also other minority groups including Latino men) are consistently portrayed as criminals (Barlow 1998; Lundman 2003; Rome 2004; Welch 2007) and perceived as criminal (Devine and Elliot 1995; Eberhardt et al. 2004; Graham and Lowery 2004). This has significant impacts, as evidenced in growing attention to the disproportionate killing of black men by police officers. However, it also has been demonstrated by Pager (with colleagues) who repeatedly has shown that black men with criminal records fare worse than their white male counterparts in the employment market due to discriminatory hiring practices (2003, 2017, and 2009 with Western and Bonikowski) and, in some cases, black men *without* criminal records fare worse than white male counterparts *with* criminal records. In short, some participants will more likely have to contend with stigma due to their social positioning regardless of what unfolds in the court.

rewards, as Strickland can demonstrate. Strickland was relatively materially stable in comparison to most participants, as both she and her husband were employed, but going through a bankruptcy and divorce. This relative material stability had the effect of easing the demands of requirements, for example, with personal transportation that made getting to and from appointments less taxing and employment that could substitute for a community service requirement (and Strickland reported no problems with requirements). It also likely had the effect of intensifying the benefits of participation, specifically as a pathway to maintaining a desirable stable material trajectory. Notably, all but one of the women who similarly demonstrated a high degree of buy in had stable housing and income or achieved it while participating, most had personal transportation, and all either had or obtained employment during or after participating in the program. (Thus, another such participant with a job and housing but facing prison time commonly described her program participation as a chance to avoiding "losing everything" and starting all over again – "I don't know if I could have started over, all over again.")

Yet, even beyond material stability, these participants were unanimously characterized by an expressed willingness to surrender to being labeled with a mental health and/or substance use problem. For example, Strickland readily reported that she had struggled with symptoms of schizoaffective disorder for years as well as a history of psychiatrists being reluctant to diagnose her with a stigmatizing mental illness, being told she did not "fit the traditional mold" for the disorder and was not "crazy." Strickland, however, expressed no such reluctance at the time of her interviews. She recounted telling one psychiatrist prior to joining the program, "I'm like, 'Dude, I am crazy.'" In fact, for Strickland, mental health symptoms defined much of her life problems, including her past substance use and most recent criminal offense. While she recognized the potential for stigma, only disclosing her diagnosis to close friends and family, she also described her diagnosis as a reprieve from the guilt associated with her problems: "You know I can't help that my brain has a disease. You know, I didn't ask for it, but it's allowed me to get services and help that I need." Like her peers, treating mental illness gave her a pathway forward beyond past missteps. It is thus noteworthy that all but one of these women had limited prior involvement with the criminal justice system and described significant embarrassment around their criminal offense.

Moreover, these women tended to have faith that the court and/or other public institutions such as community mental health system worked to their benefit, as was clear in Strickland's case. For example, even in discussing the past failure of the mental health system to help her, Strickland focused on how psychiatrists' inaction was a product of their concern for her wellbeing. Moving forward with the mental health court, Strickland routinely emphasized how court and treatment staff worked to support her and how this support directly contributed to improving her life. For instance, she recounted midway through her participation:

> "For the first time I feel good. I feel stable and I feel you know like even going through all this crap, I still got these people [staff] who are holding me up saying, 'You can do it. You can do it. I'll hold your hand while you do it.'"

For Strickland, staff wanted to help her and were helping her. Thus, she recounted that even when court staff recommended reducing supervision, she requested they maintain a higher level of supervision as a form of "support," desiring the contact (and supervision is something almost all participants report eagerly awaiting reducing). Furthermore, and importantly in this context, while Strickland maintained some anxiety about how she would perform vis-à-vis program goals, she generally expressed confidence she would not be jailed (and she had already avoided being jailed at the time of the offense through hiring a private attorney). Like her peers, Strickland could accommodate the program and its goals across time because she could envision that doing so was to her benefit. The court was designed to help people like her.

The vast majority of participants did not exhibit this level of buy in. It was undoubtedly a demanding role in a program with intensive rules and supervision. In fact, even Strickland did not manifest the ideal. For example, she initially wanted to continue to be able to drink the casual glass of wine with dinner every now and then (viewing such substance use as unproblematic), although she ultimately stopped to abide by the program's rules, and sometimes talked about other requirements as something to complete for the sake of the program rather than her own self-improvement. Still, buy in commonly featured in how participants talked about their engagement in a variety of ways. Most participants expressed buying into some aspects of the program, if not others, and at some moments in their participation, but not all times.

The point here is that to the extent these participants exhibited some level of buy in, they also tended to exhibit a capacity to meet the key demands such buy in imposed and/or signaled they were gaining something from their buy in, even if this was often in subtle ways that they

were unlikely to immediately recognize. For example, those who bought into their mental health diagnosis or a substance use problem often presented as comfortable with such labels, not focusing significantly on concerns about how they could be stigmatized by them and instead using them to make sense of troubling experiences such as criminal offenses or guilt around how they coped with past trauma (a theme that will be discussed also in the sixth chapter). Likewise, those who expressed buying into the idea that the program was generally helping them, presented as unconcerned about the possibility for the program to mistreat them. They had faith that it would work for them and not against them, often tied to a lack of negative experiences with such public institutions and ongoing positive interactions with program staff. Of course, this became quickly complicated, as for example, one participant who described buying in had prior negative experiences with the court system and Judge Ash specifically, but, facing a significant and aberrant criminal charge, was incredibly open to the aid on offer and became an enthusiastic supporter of the judge and court staff (as will be discussed in the fifth chapter). Further, another participant who described buying in maintained faith in the general program goals but reported becoming disillusioned with court staff when they jailed her due to a miscommunication and failed to secure her any housing across her participation. Still, even these participants bought into key parts of the program, because, like Strickland, they were situated to experience doing so as beneficial.

Buying into *all* aspects of the program and its goals, however, clearly was not experienced as beneficial in most cases given that only a small minority of women came close to typifying this strategy and even these women had ambivalence towards different aspects of the program. Hence, to better understand participant engagement it is important to examine another strategy possible in this context that also featured in how most participants engaged with the program.

Strategic acquiescence

Participants also can exhibit *strategic acquiescence*.[40] Broadly, this is when the participant covertly rejects key program goals or rules while giving the appearance of

[40] Key elements of the framework for this and the following strategy borrow directly from Lareau (2003, 2015) in terms of her conceptualization of variation between middle- and working-class children, as will be clear, but adapts it to the specific opportunities and constraints generated in the mental health court context. Furthermore, Soss (2002)

accommodating them for the sake of the program. Specifically, this involves the participant rejecting the notion that she has a mental illness and/or substance use issues that require intervention. She thus also rejects the causal model that these are sources of her problems and/or key treatment solutions imposed by the court such as psychiatric medication and drug and alcohol abstinence. Still, this participant views herself as in need of assistance, whether in terms of the legal issues she faces or other needs such as housing and income. She thus works with the program to the extent it helps her achieve her personal ends such as completing it and accessing desired goods, seeing little benefit in its intended purpose. Upon achieving these ends, compliance will cease. She thus is strategic in what she reveals to staff. In short, she works to generate the appearance of conformity to program goals that does not exist.

Strategic acquiescence differs markedly from buy in. Participants who strategically acquiesce, thus, face many opposing pressures in comparison to those who buy in. They are more likely to experience detrimental effects of aligning with the program and its goals, such as mental illness stigma, rather than benefits, such as relief from criminal stigma. They are more likely to experience distrust generally towards public institutions. They are less likely to experience the program as efficacious to meeting their needs, both because the program has misdiagnosed them and is ill-equipped to respond to them. Still, these participants work to present as accommodating the program. In so doing, they operate with "a sense of constraint in their interactions" (Lareau 2003, 2015, p6). They might state frustrations or contest decisions in specific interactions, but they ultimately resign themselves to working within its limitations, often signaling that they are powerless to customize the program to meet their needs.

Regardless, strategic acquiescence also can be a demanding role that not all participants are likely equipped to fulfill. First, it requires participants to have some understanding of how institutional rules work and thus how they can be navigated. For example, the participant opposed to her diagnosis but open to complying with the label to the extent it helps her access housing must have some knowledge around how housing can be secured through the community mental health system. Likewise, the participant opposed to abstinence but eager to complete the program must understand how drug testing works and can be evaded. Second, it requires

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also helps provide some leverage over the distinctions between these next two strategies in drawing attention to external efficacy, or the ability to make systems responsive, and internal efficacy, which is the ability to navigate or work systems to one's benefit.

participants strategically performing compliance to avoid triggering social control or losing desired benefits. They must do so while accommodating rules they likely do not value across both time—a year—and space—from the public court room to waiting rooms and offices at treatment centers, as well as in some cases, at home with family or in public spaces like bus stops. They thus must be savvy in determining when and where they maintain the performance and remain particularly attuned to what they can reveal to staff about beliefs and behaviors that break from this performance, including navigating when and how to "confess" any detected departures from program goals.

Third, participants must be able to envision, and likely experience, the efficacy of abiding by a program to meet their personal goals without experiencing excessive costs. Strategic acquiescence cannot be unduly burdensome. Hence, these participants likely require a level of material stability and wellbeing that makes the benefits of performing compliance outweigh the costs of noncompliance. For example, the participant who is a casual user of substances living with family members that do not use substances might have an easier time navigating their drug use around drug tests than a participant enmeshed in addiction and a network of substance users.[41] Likewise, the participant with personal transportation will have an easier time attending appointments and demonstrating overall compliance than the participant with no transportation who struggles even with such basic requirements, making the performance too taxing to pursue. Furthermore, participants also must be able to manage the costs of aligning with the program's interpretation of their problems. Thus, for example, the participant must be able to cope with potential stigma they experience around a mental health or substance use label, which might be more difficult for the participant dependent on a family member who routinely stigmatizes them with such labels than the participant living independently who does not have to regularly contend with this kind of disregard.

Despite these demands, strategic acquiescence offers many of the same rewards participants can access through buy in. They can avoid traditional prosecution and garner special consideration from staff due to appearing to conform. They can access secondary gains such as

[41] It should be noted that, alternatively, an older drug user with lengthy experience navigating treatment and corrections supervision in some cases might be better equipped to navigate drug tests than a younger user (particularly if the latter is using marijuana, which can be detected after lengthy periods of not using) despite an ongoing addiction. However, the older participant still requires a level of material stability that keeps the court at bay. For example, if the older user is squatting in houses and/or struggling to maintain any finances, he might draw greater attention to his case and thus more frequent drug testing that undermines this strategy.

access to desired goods including as housing and income, that are often desperately needed but otherwise difficult to access. (Although, they personally relinquish the ability to draw on their illness to alleviate feelings of guilt associated with problems they face, which might be difficult for some who face ongoing problems.) Hence, it is likely that participants not predisposed to buy in will engage in strategic acquiescence. Such participants are likely to distrust that the public institutions with which they are interfacing can help them, and instead see these institutions as a set of constraints that must be navigated to meet personal goals. Still, the savviest among them have the capacity to use these institutions to achieve desired outcomes, such as avoiding jail and maintaining stable material trajectories.

Shankland, a black female in her mid-twenties, demonstrates this kind of strategy. Shankland remained very open regarding how she did not buy into her diagnosis of bipolar disorder, referring to it as "just something to label." She also did not view her use of marijuana—her substance of choice—as a problem, saying she would abstain from it for the sake of the program and making statements like "Tylenol is worse than marijuana." She thus did not buy into her need for treatment. Still, Shankland recounted accepting the diagnosis publicly with professionals affiliated with the court and participating in treatment requirements geared at mental health and substance use. She was motivated do so out of fear of undesirable legal consequences that could result due to her charge of attempting to flee from a police officer in her car (when driving without a license and with an open warrant). She in fact maintained that she would have chosen regular probation over mental health court but was uncertain whether she would have to stay in jail if she rejected the mental health court plea. She was particularly unhappy when a judge made her serve jail time *before* starting the program, asserting that she was "double jeopardied." Shankland was explicit that mental health court was a strategic choice to avoid (further) incarceration or, in her words: "It was a requirement and I made the best of it."

Shankland stands out with a small minority of participants in the degree to which she described her engagement as strategic—most identifying as black (3) and all from lower income backgrounds (4) that left them struggling financially although still better off than some of their peers. These participants were explicit in their rejection of key labels employed by the program to make sense of their problems, signaling that such labels generally did more harm than benefit, but had learned how to use these labels to their benefit, as Shankland can demonstrate. Shankland recounted being diagnosed with bipolar disorder and attention deficit disorder early

on when her school recommended a psychiatric evaluation for problems like "insubordination" and "just not paying attention and stuff" (which she attributed to family problems and youthful rebellion). Such problems in school eventually led her to be channeled into the juvenile justice system, but she never maintained a treatment regimen, citing her mother's hesitation to place her on psychiatric medication.[42]

Shankland was clear that she had wrongly been channeled into and labeled by the mental health system. She did not trust that this system was designed to benefit her, bolstered by experiences in which mental health labels had been used to make sense of legitimate problems she had, whether in school or with family members who liked to tell her she was "being bipolar." Rather than taking Shankland's problems seriously, they became translated solely into problems of mood. Shankland thus recounted:

> "I mean, I do have times when I get upset so…where I feel like someone upsets me, but not like it's bipolar. No, I have a reason, like somebody, you know, sometimes I make myself mad."

Shankland also was clear that such labels were wrongly employed to paint her as out of control. For example, she explained of what bipolar disorder meant to her:

> "I just think it just means like your mood swings are unmanageable. That's why I don't think I am because my stress is manageable. 'Cause like you kind of, don't have a control over your moods or you know what I'm saying, I definitely have control over mines."

Through such talk, Shankland signaled she faced significant pressure to counter this image. She was much more in control than how she would be interpreted through the mental health label—"I know how to control myself."

Still, Shankland learned that she could use the mental health system to her advantage. She had worked in the service industry in various positions, but as a relatively new mother, Shankland was in need of support. Prior to joining the program, she had turned to the mental health system after learning from a friend she might find support there:

> "Well, she just said that they [*case managers in the mental health system*] were good about helping with you getting your housing and stuff, but she just don't like how they come to her house and make her take her meds."

[42] All four participants described what sounded like past mistreatment by public institutions including public schools, foster care, and the criminal justice system. In fact, it is noteworthy that the only white participant among them reported significant prior victimization within the criminal justice system.

Shankland was eventually able to access subsidized housing through the mental health system (although she was not successful in pursuing another support—Social Security Income). Thus, when asked if she thought she had needed the case management at the time, she was clear: "I definitely needed it because I got my home." Like all her peers, Shankland purposefully engaged with the mental health system to meet basic needs outside of mental health prior to joining the program and, like most of her peers, she was successful. Moreover, all then gained access to a treatment alternative to traditional prosecution—mental health court—and all planned to continue relying on the resources to which they gained access after participating in the mental health court. Shankland, in fact, planned to reapply for Social Security Income.

In the process, these participants exhibited a sense of constraint in what they could expect from public institutions but also an ability to navigate within these constraints. For example, Shankland was not open with treatment professionals about her treatment behaviors, including a lack of adherence to medication: "Well, unfortunately that will be considered not going with treatment. To them they think that you do, it's like you think that would be your own decision." She reiterated the same logic in explaining why she did not reveal her lack of mental illness to court staff generally and explained her approach to the program: "I'm just trying to get it over with" and "walk it down" "so I can get on with my life." Keeping strong boundaries with the program helped her navigate its rules. Although, notably, some of her peers found being more transparent with key actors about specific departures from program goals (such as discussing with treatment case managers their plans to not adhere to treatment after the program) could be beneficial in developing positive relationships with staff. Regardless, all such participants were clear that they had to be strategic within settings like this, which was made easier both due to their relative material stability—all secured housing and some form of income in most cases partially tied to their mental health status—and social skills as most—with Shankland proving the exception—developing very positive relationships with key staff members. In short, they had the supports and skills necessary to make the program work for them, even if not in the way the program was designed to work.

Shankland and her counterparts stood out in the extent to which they were explicit about the nature of their performance as performance. They obscured the needs they believed they had by linking them to a disorder they believed they did not have or, at least, did not require the psychiatric treatment advocated for by the mental health system. Of course, even participants

like Shankland were not fully strategic in their engagement. Shankland, for example, was focused on the program as a set of requirements she had to "walk down," but she also recounted changing across her participation: "I got a lot more self-worth and values not just being on bull crap." In some ways, she described the program working as intended—as a pathway to self-improvement that would lead her to desist from crime.

Again, how participants talked about employing this strategy could not be boiled down to one universal template. One participant was initially very explicit that mental illness was not her problem and she did not need psychiatric medication, but increasingly identified with her mental illness and became invested in working with key court staff and treatment programming across her participation (albeit while remaining suspect of medication). Another participant described both covertly using substances and only identifying with mental illness initially to collect Social Security Income, but then switched into discussing how he believed he did struggle with symptoms that required psychiatric treatment. Although it is difficult to disentangle such talk from the pressures to perform compliance, participants certainly maintained some emotional ambivalence vis-à-vis the degree to which they strategically acquiesced – or felt they should present themselves as strategically acquiescing. This likely in part can be explained by the positive relationships they developed with key court staff who they might have wanted to please or whose expertise they increasingly trusted (despite remaining wary of their power).

Indeed, most participants exhibited elements of strategic acquiescence, but in other ways, expressed buy in, as will be elaborated on further below. Moreover, as will be the focus of the fifth chapter, some participants changed in how they exhibited these strategies across time. However, to the extent participants exhibited strategic acquiescence, they signaled that the program could not adequately or appropriately diagnose and respond to all their problems. Some also, like Shankland, were clear that aligning with the program's problem definitions could be detrimental. Still, many demonstrated that they knew how to work within program rules. For example, they could use substances around drug tests or otherwise mitigate the negative effects of a positive drug test through proactively confessing drug use to a case manager. They could take the lowest dosage of a medication while they were in the program, with plans to stop immediately after the program, or conceal that they had not taken the medication. Furthermore, they could say a medication was working to appease the court, even if it was clearly not considering ongoing symptoms.

As should be clear, strategic acquiescence in many ways exists opposite to buying in on a continuum that might seem to encompass the range of engagement possibilities in this context. Yet, not all participants are fully confined to this continuum as the next strategy shows.

Entitled acquiescence

Participants also can exhibit *entitled acquiescence*. Generally, this is when the participant secures accommodations from the program that help her meet program goals or rules. Specifically, this involves the participant actively negotiating a more favorable mental health or substance use label or no label at all, commonly in the medical diagnosis process, and/or personally desirable treatment options. She may or may not view mental illness or substance use as a source of her problems, but generally recognizes a problem that generated an institutional response. Regardless, once subject to this institution, she views herself as entitled to specific kinds of consideration. She is relatively comfortable in interactions with institutional actors in identifying her needs and ensuring they are met. Whether or not she views herself as needing assistance beyond reprieve from her criminal offense, she generally abides by the rules of the program *or* openly negotiates them. In short, she generates conformity in part by ensuring the program is adapted to her needs.

Entitled acquiescence is a particularly demanding role for securing accommodations from institutions and is not an easy feat. To do so, participants might have special access to institutional actors such as private attorneys that can help them negotiate the terms of participation or private psychiatrists through whom they negotiate a diagnosis.[43] Alternatively, participants might confidently request greater access to or support from institutional actors such as public defenders, community mental health case managers, psychiatrists, and therapists, and the judge who can advocate for them or otherwise support their claims. Either way, participants

[43] Diagnosis might be assumed to involve an objective process in which standardized categories are uniformly applied to a universal set of experiences of different individuals. Yet, diagnosis is a social process (Brown 1990, 1995; Jutel 2009; McGann and and Hutson 2011). Conditions and complaints must be transformed into disease through considerable interpretive work. Lay individuals are often central to the discovery of conditions. Thus, some participants, such as the case described in this section, actively seek out psychiatric care (of course, others are referred through family members or through lay actors in schools or the criminal justice system). They, then, work with providers to construct their condition, playing an active role in this process (Clark and Mishler 1992). Further, providers' decision-making is shaped by their social identities, experiences, knowledge, and beliefs and the organizational and institutional contexts in which they operate (for psychiatrists, see: Brown 1987; Godderis 2011 and for physicians generally, see: Heritage and Maynard 2006; Conrad and Barker 2010).

must be comfortable navigating such interactions (see: Lareau 2003, 2015). Far from operating with a sense of constraint, these participants maintain expectations about the kind of institutional consideration they deserve. They are adept at advocating for themselves and asserting demands. Importantly, within the program context, this involves knowing when to defer to the expertise and authority of professionals (see: Clair 2018; Van Cleve 2016; Lipsky 1980). In contrast to other settings such as a doctor's office or school, such deferrals play a particularly critical role in the criminal justice system given the sanctified role of authority and dynamics of the courtroom workgroup, supplanted here by the treatment team. Hence, entitled acquiescence requires a level of both self-confidence and skill in navigating institutional interactions.

Entitled acquiescence also requires participants to envision, and likely experience, the efficacy of program goals or abiding by program goals without experiencing costs that significantly outweigh the benefits of doing so. Despite securing accommodations from the program, participants still otherwise must comply with it. For example, the participant might negotiate with a psychiatrist to change her diagnosis from schizophrenia to depression but must regularly meet with a psychiatrist. Likewise, the participant might convince the judge she does not need a certain kind of treatment programming, but still must meet all other requirements imposed by the program. Hence, even these participants must maintain or achieve a level of material stability and wellbeing that makes accommodating the program worthwhile.

Still, overall, entitled acquiescence is likely a particularly rewarding approach to engage with program goals. Not only can it lead the participant to secure similar benefits as those who buy in or strategically acquiesce, but participants can also thwart potentially undesirable effects such as potential stigma from a mental health or substance use label they are able to invalidate or the time commitment to participant in undesired treatment programming. Particularly noteworthy, as the example below should show, in many ways these participants have the skills and supports to still access key secondary gains—such as reprieve from guilt—without identifying as ill. However, this strategy requires very specific resources. Participants must be comfortable and adept in making demands of the institution if they are to be successful in this type of engagement.

Lutz, a younger white male, provides an example of this strategy, with only one other participant—also a young white male—following a similar pattern.[44] Lutz joined the program after engaging in his only property offense, attempting to steal marijuana from a grow house with his cousin. After being released on bond, he went to see a private psychiatrist with the support of his white-collar parents. He explained of this process:

> "I just thought that it would be good for me to do that considering the legal issues I was in, and I also thought, you know, if the court knew that I was trying to better myself, then it would help."

Lutz was diagnosed with bipolar disorder. His private lawyer, then, negotiated a plea deal in which he could participate in mental health court with the stipulation that his felony would be reduced to a misdemeanor upon successful completion. Shortly after joining, however, Lutz was reevaluated by a psychiatrist affiliated with the court program who determined he did not have bipolar disorder and did not need medication—something a second psychiatrist reaffirmed midway through his participation in the program. Instead, Lutz was told he had a "character defect" that required "learning coping skills and being more self-aware of the actions that you make," which Lutz found very agreeable ("I mean, who wants to be told they have this crippling mental disorder?"). Already enrolled in the court program, Lutz was permitted to continue, albeit still periodically checking in with the psychiatrist (as was required of all participants).

Lutz, however, not only gained a significant accommodation from the program, but he also presented as willing to advocate for such accommodations, viewing himself as deserving of special treatment. Lutz, for example, recounted being charged with an offense:

> "I was honestly, I was kind of upset because I was thinking, you know, I don't really feel like, I mean, I'm not just saying that the crime that I committed was okay in any regards, but the type of person I am and the character that I have, I just think this was like a really stupid mistake that I had made. ...I personally do feel like I'm a perfect candidate for something like that [*mental health court*]. So okay, this person, you know, they did commit a semi-serious crime, but they're not necessarily somebody that needs to be thrown in prison, they just need somebody that have some sort of guidance and accountability."

[44] Both sought out a private psychiatrist with the support of white-collar parents upon being charged with an offense but ultimately continued to participate in the program after the mental health diagnosis was then retracted by another psychiatrist while in the program. Lutz's counterpart, however, was only interviewed once, as he never returned a call to participate in interviews after graduating in the program and was enrolled in the study late into his participation. Hence, it is more difficult to gage how he grappled with the program and its requirements, although he was also very clear that he felt he deserved special consideration.

Lutz further identified as “the type of person that should not bear the full consequence of the action that they committed if they could learn their lesson and improve that.” He suffered from a sort of youthful folly that could be corrected: “So it’s really more like learning to be an adult versus making immature decisions that could inevitably, you know, put you in handcuffs or however you wanna, whatever metaphor you wanna use.” He just needed to learn how to be “responsible” and “get on the right path.” As such, he deserved special consideration.

Moreover, Lutz *expected* certain kinds of consideration. In many ways, he was incredibly favorable of the program and its staff, but he was also one of the most vocal participants in describing the ways in which it should work and how it departed from this ideal, both drawing on his observations of other participants and his personal experience. For example, Lutz recounted that when he had a particularly busy week, his case manager encouraged him to cancel a therapy session to ensure he did mandatory corrections-based community service that would otherwise create a time conflict:

> “I’m thinking to myself how backwards is that, this is called mental health court and you want me to not go to therapy so I can go clean up trash? Well, that didn’t, that just didn’t resonate with me.”

Lutz was clear that corrections-based community service (i.e., picking up trash) was not a form of treatment and thus something that should not be a focus of the intervention. This kind of certainty emerged across a range of issues from over-medicating participants to jailing participants for not taking medication to faulty drug testing practices to how case managers should be carrying out their jobs.

Furthermore, Lutz indicated that he was adept at advocating for the kind of consideration he expected. He described actively engaging with psychiatrists, case managers, and his probation officer to discuss critiques he had of the program and developing very amiable relationships with such staff. However, he also recognized that he had to be wary of when and how he was critical. For example, after receiving a jail sanction he perceived as unjust, he ran into the judge at a local park. He weighed the costs and benefits of discussing his concerns, ultimately deciding not to raise them, but maintaining that he might in the future:

> “And then I just thought about okay well if I sound bitter then I'm running the risk of irritating her. She’s obviously happy with me now. So if I ever did bring it up with her it would be like after I'm out of the program and maybe I just happen to see her in the park

> and then at that point she…I'm kind of owned by the legal system right now. So once I'm out of that then I can ask that question [*about why he was jailed*].”

While Lutz was comfortable discussing his concerns with staff, he also recognized when he needed to defer to their authority to ensure the most favorable outcome. Moreover—and importantly—even in such deferrals, he maintained that he could continue to advocate himself, if at a future date.

This level of confidence was likely undergirded by key supports available to Lutz. For example, his father came to court and advocated for Lutz after deeming a program action towards his son “ridiculous” (by Lutz’s recounting). Lutz indicated that staff did not interpret his father’s advocacy favorably; however, it resulted in a favorable action. His case manager was changed. Moreover, Lutz viewed such advocacy favorably, signaling that his father had acted to support him given a shared understanding of his plight as he struggled to meet impossible demands. Perhaps even more significantly in this context, Lutz knew he had support within the legal system. For example, upon graduating from the program, court staff told him “hopefully” his charges would be reviewed and reduced. This upset Lutz.

> “I didn’t say it, I wanted to, like, ‘What? Hopefully?!’ I was like, ‘I signed a plea agreement and this is not a hopefully, this is you will do that, because otherwise I wouldn’t have signed up to do any of this crap in the first place.’”

However, rather than arguing about this with staff, he spoke with his private lawyer, who ensured he would gain the outcome he desired.

In many ways, Lutz—and his male counterpart—typify entitled acquiescence; however, as should be clear through the description above, even they still struggled to ensure that the program worked as they desired. For instance, after being caught drinking on more than one occasion, Lutz could not negotiate himself out of having to do corrections-based community service and other requirements that he found to be sometimes “arbitrary” and “pointless,” alongside being jailed for reasons he viewed as unjust. Similarly, his counterpart was placed in a residential treatment facility he did not value and extended in the program when he was caught on a new offense. Regardless, both young men garnered significant accommodations from the program and conducted themselves in ways that signaled they were deserving of and could achieve such accommodations.

While the vast majority of participants did not similarly come close to exhibiting this strategy, elements of it emerged in many cases when participants, for example, recounted how their interactions with psychiatrists had led to: (a) limiting the scope of their mental illness by eventually labeling less desirable aspects of it as "acute" (i.e., a temporary manifestation versus a chronic problem) or (b) eliminating diagnoses such as schizophrenia in favor of conditions deemed more appropriate by the participant such as depression or anxiety. Furthermore, participants also described actively shaping psychiatric regimens, eliminating or limiting undesirable medications, or gaining support through medical doctors to use controlled substances without the court outright restricting this use (as might be required in other cases). In short, many participants demonstrated some capacity to negotiate certain components of the program, aspiring for the kind of consideration they thought they deserved and actively pursuing this kind of consideration. Some participants were better equipped to customize institutional interactions in their favor. These participants bought into some aspects of the program and strategically acquiesced to others but doing so was made easier when the program in part accommodated their beliefs and needs.

Hence, in key ways entitled acquiescence introduces a second continuum in this context, positioned opposite to strategic acquiescence. Some participants made demands upon the program, others worked within its constraints, and most did some combination of both, with such variation reflecting the varying levels of cultural, social, and economic resources at their disposal (Lareau 2003, 2015).

Dynamic and complex engagement strategies

As should be clear, participants generally were exhibiting elements of different strategies as they engaged in the program across time. Moreover, only a small minority of participants' mode of engagement came even close to typifying singular strategies like the participant cases detailed above. Hence, it is important to attend to how participants drew on strategies partially as they presented as accepting some aspects of the program and not others, found ways of rendering some demands worthy of recognition and not others. Again, even here it becomes complicated as participant cases are complex and dynamic. No two participant's cases are exactly alike, and some are incredibly different. Given this diversity, the goal of this section is not to provide an example of what a "typical" mode of engagement looks like. Instead, it is to further elaborate on

how the strategies already introduced could materialize in this setting in divergent ways given the varied orientations and resources of participants. Most participants were more explicitly employing different strategies simultaneously because they were not situated to benefit from any singular strategy alone.

Best provides an example of this phenomenon. Best was a white male in his fifties who recounted joining the program due to "the stupidest fucking thing in the whole world…trying to sneak pills into the jail." More specifically, he reported that after being told he would be incarcerated for a parole violation, he decided to covertly take his prescribed medication in with him "terrified of…decamping off the meds and fucking being in a totally manic state," but was caught. While he was only jailed temporarily on the violation, he was charged for possessing the medication (a felony), albeit after "waiting all the way till the end of my parole [*more than a year later*] and now they got me on the hook for another two years, you know. It's like fuck you." Along these lines, Best described significant cynicism towards the legal system, angry about what he described as the "sadistic overtones" of how his latest felony case was handled. Best thus agreed to a mental health court plea deal somewhat begrudgingly, mostly interested in avoiding the alternative prison sentence he thought he could have faced.

Still, Best was not entirely at odds with the program's treatment goals. Best had a lengthy background in the mental health system, including prior hospitalizations. He was diagnosed in his teens as "manic depressant," which morphed into bipolar disorder and eventually also Post Traumatic Stress Disorder after the death of a daughter and a subsequent house fire in which he almost died. Best expressed that he bought into having mental health issues, talking extensively about symptoms of depression and mania that had led him to being suicidal at times. For example, he said of such symptoms:

> "I experience really deep, deep depression that goes on forever. And then one day I'll snap out of it and I'll think I can take on the whole world and then I run myself into the ground staying up for two or three days at a time just taking care of everything that I you know…and then things will mellow out for a while and I'll just be like I am today. And then it'll either cycle back to the mania or I'm running around you know or it'll go right back in the depression. And there's no telling how long any of these, you know, state of minds or state of being is gonna last, you know."

Best thus indicated that medication was critical to his wellbeing: "I think that without it, I would probably kill myself. I mean, I really do." Best maintained such viewpoints even after completing the program. "I'm probably gonna have to take some kind of medicine for the rest of

my life, you know." While Best sometimes transitioned into talking about such issues in terms of the trauma he experienced in his life and a hope that symptoms would eventually subside, he was clear that he generally bought into the importance of treating his mental health and would continue to do so independently of the program.

Yet, Best described a much different relationship to the program's push for abstinence from non-prescribed drugs and alcohol. Best had a lengthy history of drinking and driving related offenses (resulting in one of his two prior prison sentences) and expressed that his alcohol use had been out of control at times in the past. However, he often expressed that it was not a problem for him currently and that he intended to continue using it causally along with marijuana. Even when he reported a period when his alcohol use intensified while in the program, he explained: "My issues was not really substance abuse. My issue is…not knowing how to deal with trauma." He explained further: "It just might not be just a substance problem or a behavior problem. It might be something a little deeper." Best thus signaled that the program's intervention focus on substance use missed the roots of the problems he faced. He maintained that any reduction in use while in the program was driven by a concern about strategically complying with the rules and maintaining a positive relationship with court staff. However, Best also was clear that the rules were not appropriate for him. He indicated that he would not report substance use to staff unless *he* deemed it a problem or was concerned he might otherwise be caught. "As long as it doesn't get out of hand, I don't really think it's any of their business." (And he recounted that he was caught and had to engage in such self-reporting.)

Hence, Best employed different strategies as he engaged with different elements of the program. Best bought into some elements. Already invested in understanding psychological distress in terms of mental illness prior to joining the program, Best continued to value this interpretive framework. Some of his emotions, thoughts, and behaviors had felt out of his control at times—even while in the program. He had plans to participate in treatment regardless of what unfolded at court. Moreover, Best thought staff really cared about participants (and found it particularly meaningful when the judge came to visit him in the hospital when he was briefly hospitalized – a moment he attributes to deciding to invest more in meeting the demands of the program). However, Best varied considerably from participants who exhibited a more comprehensive type of buy in like Strickland. He did not have an outright faith that the program would work to his benefit or had accurately identified his needs. In many ways, Best was much

more strategic, particularly around drug and alcohol abstinence. Still, unlike participants like Shankland who more strictly adhered to strategic acquiescence, he wavered in his adherence to this strategy. He exhibited this dual perspective in describing the program as:

> "… a way to stay out of jail. It keeps my head where it's supposed to be. You know because I do have a lot of grief issues, you know…and so you know if I wasn't in this program I would probably be spending a lot more time just sitting on my ass, you know, feeling sorry for myself. And I don't like to do that you know. So it's 50/50, you know, whether or not I think it's a good program; some days and other days I don't."

Best neither bought into or rejected the program's goals as a whole. He could see some aspects of it working to his benefit. Furthermore, like Lutz, Best was very vocal in describing issues he had with the program, maintaining strong beliefs about the kind of consideration he should receive in this context. However, unlike Lutz, Best was more resigned to presenting as following the rules of a legal system that he viewed as already having actively worked against him without providing him with meaningful recourse. He described a desire to have frank conversations with staff but feared the repercussions and instead engaged in performance out of "self-preservation."

Best, thus, helps demonstrate how participants could employ strategies in different ways. While participants varied in how they did so, he followed a relatively common trend in buying into a mental health diagnosis but rejecting the need to abstain from substances, especially marijuana and alcohol. Often enough, participants expressed some benefit in identifying with a mental health diagnosis but described the program's solutions to their mental health—particularly drug and alcohol abstinence but also psychiatric medication and psychosocial interventions—as ineffective or otherwise undesirable (only a handful of participants explicitly rejected their mental health diagnosis in full).

Best also further shows how such engagement maps onto pre-existing orientations and resources that are relatively durable. He thus described of the program's focus on treatment, "I can do that for myself. I don't need somebody to monitor my mental health." Likewise, Best rejected the program's need to cultivate marijuana abstinence, explaining: "I already live a pretty ethical life, you know. My politics might be a little left of other people's, but I don't hurt people. …I try to live the best life that I can." Of course, Best might not have been able to identify the ways in which the program was acting on him and cultivating change. Perhaps it intensified his favorable beliefs about treatment or ultimately contributed to him reducing his substance use overall to his benefit (as he sometimes remarked it could possibly be doing). Such an impact is

beyond the scope of this analysis. What is clear is that whether the program impacted participants like Best, often they revealed themselves already predisposed to buy in or reject some of its goals.

IV. Discussion and conclusion

This chapter has introduced different modes of engagement – or strategies – made available to participants in the mental health court context. As should be clear by now, the program is designed in ideal to push participants towards one of these strategies: buying in. Conversely, in many ways, the program is also designed to sort out those participants who merely strategically acquiesce to it. These participants, after all, do not have or will not work towards resolving treatment needs that once addressed will, ideally, help them desist from crime. Of course, as discussed in the previous chapter, staff recognize that participants are complex beings with diverse problems and motives. They help many participants despite worrying – or knowing – that participants are strategically acquiescing to key elements of the program. Thus, the vast majority of participants interviewed here were likely successful in the program in part because staff members continued to help them regardless of any skepticism they maintained towards participants' motives at times. Still, staff members often are constrained to think about participants as either invested in trying to work with the program (i.e., buying in) or, alternatively, not invested in, and even manipulative towards, the program (i.e., strategically acquiescing). These frameworks, then, can easily be invoked by staff as they face complex decisions with limited time, energy, and resources.

Thus, a primary goal of this chapter is to begin to challenge the utility of these frameworks for evaluating participants. Participants do not enter the program to work with or against it; rather, they enter trying to meet needs through it. Like a fish in water, the kinds of strategies they gravitate towards to do so reflect a deeply ingrained understanding of how the world works and their place in it. From this vantage point, the participant buys in because she benefits from doing so. She finds relief from troubling symptoms and, often enough, relief from guilt and blame associated with problems that can be attributed to such symptoms. Furthermore, she can envision the program as a safety net, recognizing and responding to her humanity, and she thus she can work with it to meet her needs. In a similar vein, another participant turns to

strategic acquiescence. It makes sense for her. She finds some relief from blame and repercussions associated with problems she faces, as well as needed remedies to these problems, such as stable housing. Yet, reluctant to rely on public institutions to recognize and respond to her needs, she must find ways of doing so with some degree of independence. Both participants are equally driven to meet their needs, which they might pursue through a series of calculated decisions. However, fundamentally such decision-making is rooted in different sorts of orientations and resources that render such distinct modes of engagement obvious, natural, and beneficial to each participant.

Another goal of this chapter is to draw attention to a perhaps more invisible mode of engagement: entitled acquiescence. Staff certainly identify some participants as what could be described colloquially as "entitled." By their account, such participants make too many demands. They are coddled by parents. They are unwilling to put in effort. Yet, entitlement here does not simply refer to a demanding or lazy disposition; rather, it encapsulates a set of institutional knowledge, skills, and styles that allows the participant to render some demands as worthy of recognition and response (Lareau 2003). This is an important distinction as researchers already have demonstrated how working class and poor defendants articulate demands in a way that is not congruent with the expectations of the court setting or otherwise rendered problematic due to institutional bias and discrimination (Clair 2018; Van Cleve 2016). Certainly, in a context in which participants frequently must interact with professionals, all are likely to try to make demands. However, as should be clear, participants vary in the degree to which they are equipped to realize those demands. Only some expect accommodations and resourcefully and persistently pursue them.

Hence, while all participants are similarly working the program to meet their needs, it is critical to draw attention to the ways in which strategies are unequal. First, these strategies offer varied rewards and costs specific to the program. For example, the participant who strategically acquiesces must engage in more work to maintain a boundary with the program than the participant who is buying in or engaging in entitled acquiescence given that her performance does not reflect her beliefs, behaviors, and/or circumstances. This participant, then, also maintains greater risk, including the risk of losing program eligibility.

Second, even beyond the program, these strategies generate very different kinds of benefits for participants. To the extent that the participants buys in, for example, she will

continue to reaffirm that public institutions are legitimate, responsive, and equipped to meet her needs. To the extent the participant engages in entitled acquiescence, she reaffirms that public institutions are designed to be responsive to her needs. Furthermore, to the extent the participant strategically acquiesces, she will continue to envision public institutions as unresponsive and ill-equipped to meet her needs, and so requiring manipulation. Of course, program participation might disrupt these orientations, as the participant who initially buys in is unfairly jailed or faces undesirable regulation or the participant who strategically acquiesces receives meaningful assistance through the program. However, more likely such orientations will prove relatively sticky, undergirded by durable and transposable dispositions (Bourdieu and Wacquant 1992) that might evolve by degree given the conditions in which one operates (see: Edgerton and Roberts 2014), but are more easily reinforced in institutional encounters rather than fundamentally changed by them. Moreover, a key problem for increasing buy in, of course, is the reality that significant resource constraints make it difficult for programs to provide meaningful aid like desirable housing or employment to many participants efficiently if at all and the program often turns to control and punishment to motivate participants, which can undermine a sense of the program as helpful even when staff remain so committed to helping participants.

There are several limitations of this analysis. First, I am not examining the proportion of participants who exhibit any one strategy. Instead, the primary empirical contribution was to draw attention to this variation in engagement. Second, I do not systematically investigate variation within and across strategies. Participants who buy into the idea that they misuse or abuse substances might be different, in part, from participants who buy into their mental illness. Similarly, participants who strategically acquiesce to marijuana abstinence might differ in key ways from those who are strategically acquiescing to cocaine abstinence. Third, I do not track how strategies are employed under different conditions and situations that might place contradictory and conflicting demands upon participants (e.g., see: Bell 2016). This analysis tends to overemphasize participants as falling between continuums such as distrust versus trust and stigmatized versus not stigmatized when participant experiences are likely to vary in part across contexts and due to participants inhabiting multiple social categories that differently shape their needs in any given interaction. Future research should more closely attend to this variation.

Still, the variation between strategies tracked here matters. Regardless of when and how participants engage with these strategies, they certainly are constrained by them within the

context of the program and each provides a different set of opportunities and constraints that clearly not all participants are equipped to effectively navigate. In fact, it is important to note that the participants who sustained these strategies across time in many ways maintained a clear advantage in this setting: they could perform compliance, even if through different strategies. This advantage is noteworthy because some participants struggled much more to sustain any given mode of engagement across time, as discussed in my next chapter.

Chapter 5
When Strategies Break Down: Examining Movement in Participant Strategies

I. Introduction

In chapter 4, I described different strategies of engagement available in this context and how participants could be predisposed towards them based on pre-existing orientations and resources. Yet, participants are not only differently predisposed towards various strategies, but also unequally equipped to carry out their strategies across time. For some participants, performing compliance becomes an increasingly difficult and undesirable challenge as they struggle to reconcile their needs with program demands. They face growing contradictions between what they are asked to do and what they have the resources to do in the face of various setbacks and adversities. Thus, rather than persist, they adapt their strategies.

In this chapter, I turn to the processes by which this pattern unfolds, attending to the kinds of impediments and disadvantages that cause strategies to break down. To make this case, I refocus attention on the challenge of performing compliance. While participants are compelled to present as accommodating the program and its goals, they undoubtedly have access to many images, models, and templates for self-production that extend beyond those provided through the institutional framework of the program (Gubrium and Holstein 2001b; Brekhus 2008). For example, a participant can buy into having a mental illness, but also might see themselves as experiencing temporary psychological distress due to housing instability, unemployment, or interpersonal conflict. Furthermore, across time and space, participants face varied situational and structural constraints that shape the utility of different kinds of self-production (Ethier and Deaux 1994; Nippert-Eng 1996; Grazian 2003). Identifying with a mental illness might be beneficial under some conditions, such as when it leads to improved access to services and resources, and not others, such as when doing so is accompanied by greater forms of regulation and stigma. Thus, even though participants face pressure to perform compliance, they also

confront other kinds of pressures that can lead them to break with this performance. When and how do they break form this performance? How do strategies break down?

I focus my analysis on three processes by which participants are pressured to adapt their strategies. First, participants experience *reality creep* in which the participant's life is increasingly experienced as mismatched to and potentially undermined by the institutional framework of the program. Second, participants experience *institutional disappointment* in which the implementation of the institutional framework by program staff goes against the participant's hopes and expectations, increasingly generating frustrations that shape how they relate to the institutional framework. Third, participants experience a struggle to *manage mistrust* in which concerns about punishment, eligibility for resources, and external judgment distorts what the participant shares about their private beliefs, behaviors, and circumstances in ways that generate contradictory relations with the institutional framework. Each process, then, generates a set of pressures that can lead participants to change strategies, with participants increasingly adapting how they perform compliance as pressure builds. Hence, I argue that all participants are susceptible to the pressures of any given process, but only some participants succumb to them, often because they experience multiple processes unfolded simultaneously.

I begin by describing how the breakdown of strategies was conceptualized and identified before turning to my results.

III. Defining and tracking how strategies break down

To understand how strategies can break down, it is important to first rehash the basic elements of performing compliance. Whether participants buy in or find ways of acquiescing to the program and its goals, they ultimately must grapple with the same elements of the program's institutional framework—hereafter called the *court model*. These elements include: (a) a problem definition tied to mental health or substance use issues; (b) a causal model in which these issues cause other problems like criminality; and (c) a set of solutions including primarily psychiatric and psychosocial treatment and drug and alcohol abstinence, but also social service interventions around housing, employment, and income (although, as described in the fourth chapter, the latter can materialize differently for participants based on how they are equipped upon entering the program as some might be housed or have employment and thus not be subject to further

regulation across these domains). Participants certainly might view themselves and their problems in ways that depart from this model, but they generally recognize the importance of producing themselves and their problems through it in this context.

Yet, despite this recognition, it was not uncommon for participants to change how they went about producing themselves and their problems across the course of their interviews and even within an interview. Some participants, in fact, exhibited significant movement in their strategies. For example, they could buy into and then reject the notion that a mental disorder was the cause of their problems or that they had a disorder at all. Alternatively, they could express having no problem with substance use only to later reveal significant issues with substance use or describe being committed to psychiatric medication to later report no longer taking it. Of course, participants might exhibit smaller movement, as well. For example, a participant would report not valuing marijuana abstinence but still describe plans to abstain while in the program to then report having used marijuana detected by the program. Alternatively, a participant might express psychiatric medication as critical to their mental health but then increasingly express ambivalence about its value. In so doing, participants exhibited changes in how they were relating to the court model.

This argument thus is constructed largely around a pattern of movement between buy in and strategic acquiescence, with greatest movement towards strategic acquiescence.[45] This movement emerged most prominently in two key ways. In some cases, participants acknowledged they had been strategically acquiescing to a key tenet of the program retrospectively, such as when they graduated from the program or after a behavior was inadvertently revealed through a surveillance mechanism such as the drug test. In other cases, participants increasingly adopted a stance of strategic acquiescence the more the program seemed mismatched to their desires or needs across time. Yet still, in a minority of cases, participants exhibited a shift towards buying in. They signaled that they were gaining the skills and supports they had not realized initially that they desired or needed. Moreover, multiple participants recounted this shift occurring prior to starting interviews – i.e., they joined the

[45] This pattern in part reflects how few participants were equipped to engage in entitled acquiescence, even temporarily, which would likely be anticipated by the literature (Lareau 2003, 2015) given the resources required. Furthermore, entitled acquiescence often involved gaining accommodations from the program that were relatively durable once achieved, reducing the possibility for participants to fluctuate significantly in the kinds of accommodations they were garnering.

program strategically, but then found some benefit to it early on. Finally, as will become clear, participants also moved back and forth between these two strategies.

Importantly, a goal of this analysis is not to quantify the type of changes observed across cases or the degree to which each participant exhibited change. Data collection methods employed here do not lend themselves to such an analysis. Participants were interviewed at different rates. They also could be interviewed at very different points in their participation. Thus, for example, one participant's interviews might have been conducted in proximity to times when they were jailed, while another participant who also was jailed multiple times was interviewed only prior to such experiences and/or long after. The timing of such interviews certainly could impact how participants talked about their engagement. Hence, this analysis is not organized around explaining differences between all participants, but instead how change in strategies manifests at all. I show that to the extent participants were adapting their strategies, they generally faced growing impediments and disadvantages, including in some cases looming jail sanctions, that positioned them at odds with the court's framework.

Moreover, it is critical to refocus attention on how participants' talk in interview was shaped by context. Participants were subject to a court model to which they might have genuinely (if sometimes temporarily) bought in or strategically acquiesced. However, it is difficult, if not impossible, to disentangle these two through the interview methods employed here given that participants were actively grappling with the pressure to perform compliance with a wide variety of actors, including a quasi-official actor (a researcher). My goal, then, is not to track the underlying motives participants privately maintained or figure out who is and who is not lying. Instead, I am trying to track how participants employ strategies in the program and how these strategies break down at all. Tracking when and how these strategies break down reveals the ways in which participants struggle with the demands of engagement. These struggles emerge around key impediments and disadvantages to conforming to the court model that ultimately lead them to break with it – regardless of whether it is a strategic break or not. Ultimately, some participants present as equipped to manage their performance across time and others signal they are not. I next turn to examining how strategies break down.

IV. Results

Impediments and disadvantages that cause strategies to break down

Below I discuss three processes that result in strategies breaking down. I describe how each process works, with a focus on how the process produces pressures that can lead participants to break with the court model. I note that these processes are generally interconnected, leading some participants to struggle with a compounding set of pressures that make it difficult to present as accommodating the program and its goals. In so doing, I show how some participants are at a disadvantage in this context. They face significant impediments to performing compliance as they experience various setbacks and adversities across time. See Figure 2 for a table summarizing each of the processes and their key characteristics.

Table 2. Types and characteristics of processes by which strategies break down

	Disconnect	Strategy breaks down when….
Reality creep	Court model does not match participant's interpretation of self and problems	Lived experience reveals and/or amplifies shortcomings of court model
Institutional disappointment	Implementation of court model does not match participant's hopes and expectations	Program and its staff inappropriately or inadequately respond desires and/or needs
Managing mistrust	Pressures and pulls to achieve certain kinds of eligibility and avoid regulation and punishment cultivate concealment of mismatches	Disconnect is inadvertently detected *OR* purposefully revealed as relationships change

Reality creep

A fundamental impediment to performing compliance emerges from the disconnect between the participant's understanding of the needs for which she requires assistance and the institutional framework used to define and respond to her needs—i.e., the court model. Accommodating this court model requires a great deal of interpretive activity in which the participant works to identify with the program's problem definitions and solutions. Yet, this model can be experienced as partial and even inappropriate. It can fail to provide remedies to emerging or persisting problems, whether, for example, in the form of psychological distress, interpersonal conflict, or lack of employment opportunities. It also can fail to adequately

recognize the legitimacy of problems, particularly given its focus on changing the individual skills and habits (a theme that will be picked up on in the sixth chapter through an analysis of how participants differently grapple with the program's focus on helping them achieve self-control). Thus, for example, biased or otherwise negative treatment by police officers, landlords, psychiatrists, and so forth can become a subsidiary concern to changing the participant's reactions to these actors. Moreover, the participant might have a very different experience of what counts as a problem, including, for example, prohibited drug use that can be experienced positively or emotionally tumultuous relationships that could be interpreted through the court model (but not by the participant) as ultimately harmful.

To the extent these kinds of disconnects lead participants to change how they relate to the program and its goals, they demonstrate the effects of *reality creep*. Reality creep refers to the process by which contradictions between the participant's lived experience and the court model creates a pressure to break from it. Maintaining a commitment to the court model—even strategically—becomes increasingly untenable. Most fundamentally, doing so will stand in opposition to the participant's experience of reality. Thus, for example, the participant might have difficulty identifying with a mental illness when not experiencing associated symptoms. Similarly, the participant will have trouble viewing psychiatric medication as an appropriate solution when symptoms persist while consistently taking it. However, even more so, maintaining such a commitment can have deleterious effects. It can inhibit the process of identifying an appropriate remedy as the participant opts to accommodate a remedy forwarded by the model that is not beneficial to them. Likewise, it can draw attention away from legitimate problems as the participant accommodates a problem definition forwarded by the model that does adequately reflect their problems. Moreover, it can focus intervention efforts on beliefs, behaviors, and circumstances that are not problematic for the participant. Hence, participants might experience significant pressures to break with the court model.

These kinds of pressures are likely experienced to some degree by most participants given that institutional frameworks like the court model are bound to be partial and imperfectly matched to the diverse and contradictory facts of social life. Yet, they are likely to intensify as the disconnects described above emerge or grow, particularly in the form of new or persisting problems that the court model is ill-equipped to recognize or remedy. Lacy, a black female in her 20s, can provide an example of how this unfolds. Confronting an intensifying problem, she

eventually made a break from one of the court model's tenets. Rather than continuing to describe mental illness as the primary cause of her problems, she began to demand recognition of the ways in which her problems were rooted outside of the self, as will become clear. In so doing, her case demonstrates how participants' efforts to accommodate the court model could face significant hurdles as reality crept in.

Lacy presented as buying into the program and its goals in her first set of interviews months into starting the program. In fact, she outstripped Strickland and her white, middle-aged counterparts in the fervor with which she expressed this buy in. With great enthusiasm, she talked about the program as a "second chance" offered to her "by the grace of God." "He gave me a second chance and I feel like, with mental health court, and God on my side, all things are possible." By her account, the program was offering a desperately needed opportunity to change the trajectory of her life. This orientation clearly stemmed from Lacy's somewhat unique experience. Charged with the most serious offense the program accepted—assault with intent to murder—Lacy was particularly concerned about the alternative she thought she faced: 25 years in prison in which she would be separated from her young son for whom she was the primary caregiver. She also might have been concerned with the stigma associated with such a serious criminal offense, which could be mediated in part through identifying with a mental illness that defined her as "sick" rather than "bad." However, regardless of her motivations, Lacy was crystal clear: she had the sort of problem the program was designed to address, and the program was an appropriate—and even ideal—solution for her.

Lacy identified strongly with her diagnosis of bipolar disorder and depression. She attributed her charge to her mental illness. After significant and ongoing harassment from her son's father's romantic partner that culminated in this woman verbally attacking Lacy at her residence, Lacy went into a "bipolar-anxiety kind of rage." Off her medication, she "blacked out" and let "the devil" take control of her, getting into her car and running the woman over. However, beyond this offense, Lacy reexamined her life with an eye to how her illness had affected her more generally: "Now, when you look back on stuff like that, yeah, you be like, 'Okay, something's wrong with me, I got a problem, and now I can finally admit it.'" While she had been resistant to being diagnosed with mental illness in the past (which started as early as 14 and led her to feel stigmatized as "crazy"), she no longer experienced such resistance:

> "This program makes me be like, you know, 'Hey, this is what I'm diagnosed with, these are the steps that I have to take in order to become a better person. I know that I have to take my medication. I know that I will feel better, and if I don't, I might have one of these episodes.' So, I love the program. It's great."

She reported eagerly engaging in treatment, becoming so invested in it that she turned to raising "awareness on Facebook about mental illness" and becoming a "mentor" for others. Whether strategically or not, Lacy presented as particularly committed to the court model in which attending to her mental health could help her lead the kind of life she wanted.

Yet, five months later, Lacy's life had changed. She reported that she was successfully meeting program goals, but she was struggling outside of the program. By her account, the victim of her crime was suing her and had started harassing her again to the point that Lacy had to quit her job due to safety concerns. Court staff were encouraging her to seek a personal protection order. In the face of these challenges, Lacy began to reinterpret her criminal offense, focusing more on the external problems she had faced as opposed to her mental health: "I have a lot of, you know evidence that I wasn't in the wrong because this particular individual came to my home. They were on my property threatening me, you know." She explained how she had been working with detectives and attorneys, as well as court staff, to deal with this harassment and claimed that these professionals now understood:

> "I'm not the person that's, you know, causing this…well, you guys thought I was crazy for doing what I was doing, but hey you know when you have a person keep threatening you and say they're gonna come kill you and your kid you know you take that very seriously. You know that's something you don't play with."

Lacy maintained that she went "mentally insane," but her emphasis changed: "I had enough to the point where I wasn't thinking like a normal individual. I was thinking like I have to do whatever it takes to protect myself." Lacy's initial commitment to the program's definition of her problems—i.e., rooted in mental illness—began to shift.

Lacy generally expressed investment in the treatment goals of the program and completed the program successfully. Still, her case demonstrates how reality creep can operate. Taking a pill or checking in with a case manager did not resolve a primary problem she had faced that had led to her program involvement—ongoing harassment from someone embedded in her immediate social network. Ideally from the perspective of the program, she had developed the skills and supports to react differently to such harassment. Rather than lashing out in fear or

anger, she would instead reach out to support such as a case manager or not react at all. Her life would be different because *she* was different. Yet, regardless of changes she personally experienced, the key problem had not changed, forcing her to amend how she applied the court model to her life. She could not simply turn to mental health as a lens to make sense of her problems. Instead, she latched onto a new interpretive lens, one that drew attention to problems outside of her control—an individual threatening her safety. In short, Lacy began to demand a different kind of recognition.[46]

Lacy's experience demonstrates a fundamental impediment to meeting the demands engagement imposed: reality could creep in, forcing participants to react to the shortcomings of the court model. This could be true whether they had bought into it or merely feigned such buy in. Their lived experience generated pressure to provide greater room for possibilities closed off by committing to a model that wrongly pinpointed or remedied their problems. This pressure could be amplified by a need for institutional support, such as a response to ongoing harassment from the criminal justice system, or a need for recognition of a legitimate problem like harassment, which might otherwise be minimized by a focus on a flawed self who poorly responded to such harassment. Moreover, pressure could simply build because a problem like harassment emerged at all, creating a disjuncture with a prior belief or hope that treatment could fundamentally change how such problems manifested (a pressure that likely impacted multiple participants who were most optimistic about the court model early on as they latched onto it as a pathway forward in the face of recent criminal justice involvement). In sum, reality creep could materialize in the form of different kinds of pressures. As they built, it became increasingly difficult for participants like Lacy to brush off or otherwise ignore disconnects they experienced with the court model. They were compelled to adopt a new stance.

In some ways, Lacy's case is ideal to examine how this works. She was clear about a key problem she faced and explicit in her changing views, shifting her perspective as her problem intensified. Furthermore, relatively materially stable (she had independent housing and, after receiving a small inheritance, a car) and highly motivated to complete the program, she

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[46] Furthermore, due to an unplanned pregnancy, she stopped taking medication long before her third follow up interview, which likely emboldened this shifting perspective, especially since she expressed no problems with her mental health despite facing ongoing harassment. She could handle it this time. Yet, it is noteworthy that Lacy was operating under very different circumstances. Her harasser had not again gained access to her home address, seeking Lacy out, and Lacy had a group of professionals eager to support her, offering ongoing encouragement and praise and even helping her cover the costs of delivering the personal protection order to her harasser.

otherwise remained consistent in how she exhibited buy-in, providing an isolated shift to investigate. Multiple participants presented as facing multiple, shifting problems and shifts in their modes of engagement, making it more difficult to isolate such effects. Still, the cases described below will help further demonstrate varied ways in which reality creep operates. While the focus of analysis shifts to other processes, it will be clear that these participants were also struggling with the pressures reality creep generated in the form of an array of persisting and intensifying issues they experienced across time.

Institutional disappointment

Another impediment to performing compliance stems from the disconnect between what participants aspire to gain through their interactions with the program and its staff and how these interactions unfold in practice. Participants, after all, are not just engaging in the interpretive work of aligning with a static court model that exists "out there," but doing so in interaction with program staff members who instantiate this model on the ground. These interactions can create an affinity with this model, as staff members encourage participants to view it as helpful and enact it in ways that are experienced as efficacious. Yet, these interactions can have the opposite effect, generating significant frustration with the court model. For example, staff members might not provide the kinds of supports the participant needs and/or desires. Staff also might foist undesirable regulation and punishment onto the participant. Furthermore, the participant might even feel disregarded or discredited in interactions with staff members.

To the extent these kinds of negative interactions lead participants to change how they relate to the court model, they demonstrate the effects of *institutional disappointment.* Institutional disappointment refers to the process by which contradictions emerge between what the participant hopes and expects to gain through their institutional interactions and what unfolds in practice, reducing the pull to accommodate the program and its model.[47] Maintaining a commitment becomes increasingly frustrating. It appears to fail at producing desired results, whether in terms of specific kinds of supports or reducing undesirable forms of regulation. However, it also can produce other kinds of undesirable effects, particularly given that most

[47] Research already shows that relationships with staff members influences treatment outcomes (e.g., see: Canada and Epperson 2014; Solomon et al. 2010) and court outcomes, particularly in terms of how participants perceive procedural justice in these contexts (Canada and Hiday 2014; Canada and Watson 2013).

participants are likely to experience acutely any sort of injustice in this setting due to both the intimate nature of interactions with staff (participants must disclose very personal information) and the considerable control staff maintain over their lives (as gatekeepers to resources and agents of social control) (see: Lipsky 1980; Hasenfeld 2010). Specifically, then, participants might view accommodating the court model negatively, as a way of symbolically supporting an institution that has neglected them. Similarly, they might construe accommodating the model as giving control (to define and respond to their problems) to an institution not invested in respecting their personal autonomy.[48] Resistance to the court model, then, might become increasingly appealing.

These kinds of pressures were likely a common element of participation since participants were subject to intensive regulation and/or punishment. However, they could build in some cases as participants increasingly perceived the program as failing to meet their needs and imposing unnecessary regulatory burden and punishment on them. As these pressures intensified, participants were compelled to break from the court model. This was exemplified most conspicuously in the case of a mixed-race female participant in her 20s, Glick. Across the course of six interviews, Glick's relationship with the program and its staff changed significantly. As she experienced these changes, she shifted in how she related to the court model, particularly in the form of how she talked about accepting a diagnosis of bipolar disorder. Specifically, when she experienced minimal institutional disappointment, she was most accepting of this diagnosis and viewing it as connected to her troubles, but as her institutional disappointment grew, her acceptance of the diagnosis wavered and eventually broke, revealing the way in which institutional disappointment can function as impediment to performing compliance.

Glick entered the program already having a background in both the juvenile justice and mental health systems, which was initiated by domestic disputes with her mother and problems in school in her youth. She was diagnosed with bipolar disorder and participated in treatment for

[48] Lipsky (1980, p58) explains how the client-worker relationship involves a careful balance of control given that both parties maintain some power over each other. Clients clearly remain at a disadvantage but can try to control professionals through using the resources they have (e.g., time and the capacity to not comply) to shape how professionals work with them. In a similar vein, Stuart (2016, p21-22) builds on the work of James Scott to describe how individuals subject to state surveillance and regulation "find creative ways of exploiting the blind spots of surveillance and regulation to satisfy daily needs and secure a modicum of autonomous personal dignity." Resistance serves as the tool of the powerless to establish a degree of control—a tool that participants are arguably less likely to give up when they feel mistreated by the program and its staff.

some time, but she recounted that she had not bought into the diagnosis and found treatment ultimately ineffective. However, after being caught firing a gun with a friend in his backyard (for fun), she was charged with a felony and her two young children were removed from her care (both present on the property when she engaged in the offending behavior). She independently returned to the treatment system "'cause I was depressed" and to help in court: "to show them that I'm getting help, but at the same time I'm not doing it for them, I'm doing it also for myself 'cause I know I need the help." Glick was eventually referred to the mental health court.

Glick entered the program optimistic that the program would work to her benefit. Less than a month after starting, she described it as offered to her by a judge as a chance:

> "…To get everything in my life back situated. And I'm glad that they kind of do help me with stuff like that as far as getting my kids back…but I still got to get stability and employment, so, until I can get them back."

Glick foregrounded the opportunity to regain custody of her children (temporarily under the care of her mother) as a primary benefit of participation, but she was also relieved to avoid a potential two-year prison sentence and have a felony charge dismissed that would otherwise interfere with employment. Moreover, Glick expressed that she generally shared the goals advocated for by the program. Requirements were "commonsense" and often things she would have done independently—such as securing employment and independent housing. Furthermore, she expected staff would "help me in a lot of stuff that I need to get done to get myself together" and often noted how they "actually [do] care." Exuding such optimism about the program, Glick presented as amenable to accommodating it. Most notably, in a break from the past, she expressed buying into her diagnosis of bipolar disorder, as well as diagnoses of depression and anxiety. She now saw "I do have a problem" made clear through "all the episodes I had." She used this mental health lens to make sense of key problems, including the recent loss of her children, explaining of how she now planned to stay on psychiatric medication: "I don't want it to get to…I don't ever wanna lose my kids again. And that was kind of another thing too, is just how I react and the way I handle myself." As Glick experienced the program as working for her benefit, she presented as buying into its model.

Yet, across her first five months in the program, Glick faced many challenges to getting her "life back situated" from being de facto homeless to significant conflict with her romantic partner (resulting in a court-imposed and undesired No Contact Order) to being twice jailed in

the program, to name just a few. Her legal fight to regain custody of her children proceeded, but remained far from over, particularly without housing secured. During two follow-up interviews conducted over this period, her faith in staff shifted. She still spoke favorably of them, but she felt like she had been treated unfairly and her concerns disregarded at times. For example, she recounted of her experience of being jailed:

> "I feel like when I talk to Judge Ash now she doesn't let me talk, she doesn't reason with me at all. And like I said, I told her I can't help, I can't help not compare myself to other people, but she treats people that have way more issues than I do and she gives them chances. Like some people come in here like I said drunk or stuff like that or, and stuff like that and she just like lets them go like, like that's normal. But when I'm, this time missed an appointment and because I have to work because I missed that appointment, like I get penalized for that and I don't find it fair."

Moreover, she also complained of her case manager at the time, "I don't feel like she stands up for me like in court." She further said of staff, "I just wish they would have more sympathy for me instead of always trying to, like jail is not going to do nothing for me."

As Glick failed to realize some of the positive effects she had thought the program would generate, such as a pathway to housing, and became increasingly burdened by negative effects, such as being jailed, she expressed disappointment in the program. For example, she said of what she was gaining from the program: "I don't think I'm gaining anything right now. Like, but I want to because I like, I don't know really what to gain from it right now." As this disappointment manifested, Glick presented as less eager to acquiesce to the court model's definition of her problems, expressing ambivalence when explaining whether she agreed with her diagnosis of bipolar disorder:

> "Sometimes. I could possibly have, I don't, I guess I don't, to me I feel normal, but around someone else I'm probably crazy, but I don't see that. I don't feel… The only thing I really feel is my anxiety and when my anxiety kicks in I know that, like something is wrong. So that's probably yeah, I kind of do believe in bipolar just because like, if someone else is around me, especially someone close to me knowing that saying that I changed, obviously I changed. I got worse."

Glick did not outright reject her diagnosis, but she displayed a buy-in that was weakening, presented as dependent on the interpretations of others as opposed to her subjective experience.

After spending almost 13 months in the program, Glick's relationship to it had shifted dramatically. She had been extended in the program, which she explained positively as a way for

staff to help her regain custody of her children. She was now incredibly enthusiastic about staff and clear that they were working hard to help her, saying of them:

> “I really feel like…they’re really not there to hurt you at all. …It may seem like that because …what they tell you sometimes you don’t want to hear, but at the same time, …they really helping you, like they really support you. …If you give them what the heck they want, they’re gonna have your back 100 percent, and that’s exactly what they’re doing for me.”

This optimism was bolstered by her experiences outside of the program. She had started a new romantic relationship that she described as both positive and stable, unlike her last. Furthermore, living with this partner, she had access to much needed housing to regain custody of her children, which she now envisioned doing within a matter of months. Experiencing a renewed faith that participating in the program was working to her benefit, Glick exhibited some realignment with its model, again identifying with her diagnosis of bipolar disorder. For example, after rehashing how she was experiencing an increase in anxiety, she confirmed anxiety was her biggest problem, but added: “Yeah, and my prime one, I'm bipolar.” She then went on to explain of how she identified with her diagnosis of bipolar:

> “Like generally when I be mad I just want to be loved. Like I can be so mad at him [*romantic partner*] or so mad at someone like my grandma or someone like that and all I want them to do is talk to me; and I’m mad at you but you’re not gonna leave me, like you’re not gonna, like you're not gonna…talk to me. Talk to me. …It’s weird like, but that’s just how my bipolar is; like I’m mad as hell but why would you like, (short laugh) why would you leave?”

Glick’s problems had not fundamentally changed. She was still experiencing ongoing interpersonal conflict, even with her new romantic partner. However, in a moment of renewed excitement about what she could achieve inside and outside of the court, she comfortably returned to interpreting these problems through the lens of her mental health.

Yet, four months later, Glick’s relationship to the program had again shifted dramatically. She recounted how she had been unceremoniously discharged from it after testing positive for marijuana. Glick found the whole experience humiliating and unfair, expressing that the court had essentially communicated to her: “I just failed. I look at it like you guys just think I just failed and I don’t feel like I did.” (By her account, she had been successful in terms of remaining employed, staying focused on her kids, and attending appointments, as well as generally not using any substances, unlike some of her peers who she observed did graduate.) Moreover, her

discharge meant that she lost staff support on her children's case, including the support of her case manager, who had unexpectedly transferred Glick off her caseload, leaving her feeling "ditched." This shift was particularly troublesome given that her boyfriend had fallen behind in rent and was informally evicted, leaving her again de facto homeless and custody of her children out of reach. In the face of these experiences, she expressed significant institutional disappointment, saying of the program:

> "I really feel like they weren't doing nothing for me for the simple fact that every time I went in there [*to the court hearing*] it was more like 'How you been, I see you been doing good,' and then it was like a hi and bye thing. Like she [*the judge*] didn't take the time out to actually talk to me and like really like, I don't feel like she actually really got to listen to me because it was a lot more that I wanted to say."

As she experienced this disappointment, Glick made a clear break from the court model. Currently off medication due to a pregnancy, she explained of how she was doing:

> "Everyone thought that I need medication, but I don't really feel like I need to. I really feel like…I acted that way because I wanted to. It's not because I needed medication. Let me put it like this. I really feel like…when someone says stuff to you to make you mad, of course you're gonna retaliate and you're gonna feel some type of way and you're going to be mad. That's an emotion. That's something that, I mean, you can't control really. …So it's kinda like everyone wants to blame it on being bipolar. It's not being bipolar. That just means that I was just happy for a minute and then something just pissed me off."

Glick reevaluated her problems, dropping the lens of mental health to explain them. She was especially clear that she did not identify with bipolar disorder:

> "I really don't understand where they get that from to be honest. Now the anxiety and depression, okay, yeah, I'm really for that because I'll literally just cry out the blue or I'll feel down sometimes when like I don't have no reason to feel down for. I can understand that part, but the diagnosis that they gave me for bipolar, I don't see it."

While Glick remained in treatment services both out of hope that she might be able to access housing and with intentions to return to medication for her depression and anxiety, she no longer felt compelled to fully accept the court model. The primary problems she faced could not be explained away by bipolar disorder. (Although, Glick's views softened again in her final interview several months out from completing the program, at which point she secured independent housing. She again started to speak favorably of the program and its staff. In fact, still employed, she was eager to return to the program to show them how well she was doing to counter the bad self-image she felt had been generated when she was discharged.)

During and after participating in the program, Glick wrestled with what she could hope and expect from the program. At key moments, she was enthusiastic about how the program could work to her benefit, particularly in providing a pathway to secure housing and thus regain custody of her children, but also helping her better regulate troubling emotions that contributed to problems such as the loss of her children and interpersonal conflict. However, Glick also experienced intense moments of institutional disappointment. The program did not always deliver in the ways she had hoped. She struggled to secure housing. She did not regain custody of her children. She experienced ongoing interpersonal problems with romantic partners and family members despite treatment, some of which even led to legal problems. Furthermore, the program itself could be a source of problems, whether in terms of jail sanctions or undesirable treatment requirements or even leaving her feeling humiliated, such as when she was discharged from the program. As Glick experienced institutional disappointment, she presented as less enthusiastic about the program's way of defining and responding to her problems, ultimately rejecting a key aspect of the court model—her bipolar disorder diagnosis—outright.

Glick stands out in the degree to which she exhibited this pattern. No other participant matched Glick in the degree of back-and-forth movement she displayed in her beliefs. This likely reflects her participation in multiple interviews in which such shifts could be documented as Glick experienced fluctuations in a range of experiences and reactions to them across both good and bad days. It also reflects a relatively durable willingness to try to acquiesce to the program (as some of her peers who were interviewed multiple times were not so accommodating). Glick indicated that she was very pliable across time. This level of pliability might reflect any number of factors, including gender, youth, or influence of social support (e.g., both of her parents had prior involvement with the mental health system and she recounted that her grandma – who she loved – often described her problems in terms of mental health), and perhaps also the level of psychological distress she was prone to experiencing (although this was not measured comparatively here). However, as should be clear, this pliability directly correlated with significant shifts in the kinds of institutional interactions Glick was experiencing. Glick more readily acquiesced to the program when she felt like it was supporting her, particularly as a young mother eager to meet criteria such as having housing that would allow her to regain custody of her children.

Glick's experience thus demonstrates how institutional disappointment functions as an impediment to performing compliance. The ebb and flow of institutional disappointment in the form of jail sanctions, undesirable requirements, negative interactions with staff, and a lack of desired support could make it difficult for participants to experience accommodating the program as beneficial. This pressure tended to be undergirded by reality creep, which both could lead to greater regulation as participants failed to meet program goals disconnected from their lives and failed to realize solutions to their problems, such as lack of stable housing and custody of children. Of course, as labeling theorists have long pointed out, individuals do not have to have problems to receive undesirable attention and intervention (Becker 1963, 1973), which can produce institutional disappointment. Participants might experience it if they are wrongly accused of failing to comply, for example due to an error with a drug test or faulty record keeping, or otherwise treated unfairly due to bias.

This pressure was also amplified by institutional dependency. Participants who relied on the program and affiliated organizations like the community mental health center to meet needs like housing or regaining custody of children could experience disconnects with the program and its staff acutely as any perceived program missteps had considerable impact. Yet still, pressure to break from the court model could build simply because participants like Glick felt disregarded or discredited in this context. Such participants might feel a pull to accept to the court model to symbolically support case managers, judges, and treatment administrators they experienced as supporting them, such as when Glick entered the program and was later extended in it. However, participants also might want to retract such symbolic support in moments when they view staff as working against them, such as when Glick was jailed and later discharged.

Finally, following from my argument in the introduction of this dissertation and fourth chapter, participants were likely more susceptible to institutional disappointment to the extent they had experienced a pattern of being disappointed by institutions across time. Thus, for example, participants like Glick who were first diagnosed due to juvenile and criminal justice involvement and experienced this diagnosis as the result of being misinterpreted and discredited were more likely to have a difficult time consistently feeling supported and correctly diagnosed by institutions like the mental health court. Such experiences can be compared to participants such as Strickland, described in the fourth chapter, who had a history of psychiatrists being unwilling to diagnose her with schizoaffective disorder out of a concern for her wellbeing. In

short, a foundation of mistrust could increase the likelihood of experiencing institutional disappointment here. Moreover, while this analysis relies on the perspective of participants and not providers, institutional disappointment is also likely to be shaped by the kinds of implicit biases providers have. These biases impact how providers interact with participants, which research suggests will disadvantage the poor and people of color (Staats et al. 2015; see also: Van Cleve 2016; Van Cleve 2016 and Lara-Millan and Gonzalez 2017). For example, Glick recounted how her psychiatrist told her that her pregnancy was a result of "poor judgment" and "a poor decision, you know, you should never had got pregnant knowing that what you're going through now, you don't even have your two kids," likely drawing on classed and raced cultural tropes. While Glick did not have similar experiences with court staff, such negative consideration could have contributed to her ambivalence towards and eventual break from accepting a bipolar diagnosis.

In sum, institutional disappointment both generated and was the product of multiple kinds of pressures that led participants to break with the court model. As should be clear, reality creep and institutional disappointment played important roles in strategies breaking down, pressuring participants to adapt as the institution acted upon them. Yet, to fully understand how strategies break down, it is critical to examine how participants proactively tried to manage these actions, as I turn to now.

Managing Mistrust

Another impediment to performing compliance emerges out of the pressure to perform compliance itself. Incentivizing and rewarding this performance leads participants to see it as a goal important to the program in and of itself, as well as a pathway to various resources such as housing subsidies and income supplements. Any disconnects participants experience with the court model or its implementers, then, can be perceived as putting them in jeopardy. They could face greater regulation and punishment. They could lose eligibility for resources, including the program itself. Furthermore, they might experience disconnects such as prohibited substance use and a lack of desire to pursue education as stigmatizing – or at least the focus of undesirable judgment – particularly given the orientation of the program and its staff. In short, the program is

structured to breed mistrust. Participants cannot fully trust that revealing disconnects with the program will result in favorable outcomes.

To the extent participants experience disconnects with the program, they must struggle with *managing mistrust*. Managing mistrust refers to the process by which participants actively try to control how they present themselves and their problems as they work to make sense of an – often evolving and ambiguous – set of costs and benefits. Sometimes participants knowingly lie because there can be value in doing so.[49] It helps them achieved desired effects, as described above. However, participants also experience pressure to reveal what they know to be true about disconnects with the program. They are explicitly told by judges and staff members that they are rewarded for telling the truth and punished for lying, with confession serving a possible pathway to avert undesirable punishments. Furthermore, participants will be able to recognize that rewards and sanctions doled out by the court are not determined by a rigid set of rules, providing some space to reveal disconnects from the program – such as drug use – without major impact – e.g., simply being reprimanded rather than jailed. Moreover, participants interact with staff members such as case managers or therapists who might help them mitigate the consequences of revealing any disconnects, for example, by not reporting them to the court or qualifying how they are reported.[50] These staff members also, then, might help them garner favorable outcomes such as eliminating an unnecessary treatment programming requirement. Participants must assess when and how revealing certain kinds of information can work in their favor. Moreover, this goes beyond simply strategic calculation. Participants might let something slip unintentionally, for example, revealing a disconnect in a moment of frustration. Such frustration might build across time or emerge acutely as participants experience both good and bad days.

[49] This a space where lying matters greatly and yet most participants are probably lying in big or small ways at some point across their participation to appease staff. This is because lying provides a certain kind of agency, creating protection against court control. Thus, even when lying is detected in an interview, the research question becomes centered on what kind of effects lying helps the participant achieve and why some participants end up caught up in lies more than others.

[50] Watkins-Hayes (2008) aptly documented how street-level bureaucrats like staff affiliated with the court approach their work with their own social identities, experiences, knowledge, and beliefs that shape how they carry out this work. Thus, even staff members in the same position might have very different approaches to how they work with their clients. In this context, for example, a case manager might perceive it important to report any noncompliance directly to the judge and advocate for sanctions, whereas another might be predisposed to personally handling some forms of noncompliance at the community mental health center. Participants, then, must assess how staff members enact their roles. This kind of assessment process certainly emerged as important to participants, particularly for those who were transferred to new case managers and could discuss the differences in case management styles.

Managing mistrust, then, manifests in the form of multiple—often contradictory—pressures that can lead strategies to break down. Participants experience pressure to conceal disconnects to support their performance, which can be difficult to carry out. For example, participants might struggle to consistently present a set of beliefs they do not privately maintain. They also cannot always conceal behaviors or circumstances from the court's web of surveillance. Furthermore, they might struggle to integrate new revelations about their behaviors or circumstances into an existing account, presenting contradictions or gaps that invite greater scrutiny of their private perspective and experiences. Yet, participants also experience pressures to reveal disconnects. Doing so can help build trust with staff and potentially mitigate harsh punishments. Moreover, as discussed above, participants experience the program and its model as inadequate and even inappropriate and might deem these shortcomings as worthy of recognition. Participants, then, might experience pressure to demand such recognition as they perceive the costs and benefits of doing so changing, for instance, due to completing the program or developing a relationship of trust with a staff member. As participants face a set of evolving constraints, they experience pressure to adapt their self-presentations and, thus also, their stance vis-à-vis the court model.

Such contradictory pressures reveal that participants confront different pathways to managing mistrust. They can do so defensively, working to conceal key disconnects. They can also, however, proactively reveal key disconnects to the extent doing so is deemed beneficial. Each reflects distinct ways in which managing mistrust can lead to strategies breaking down and thus I discuss each in turn below.

Defensive management

Some participants worked predominantly to *defensively manage* their mistrust, persistently trying to conceal key disconnects they experienced with the court model. In so doing, these participants signaled that they experienced considerable pressure not to break with it. Graves, a black male in his 40s, demonstrated across four interviews how such pressure could operate. At key moments, he was exposed as invested in concealing key disconnects with the court model. Moreover, even when proactively revealing some disconnects, he often presented as

reticent to explicitly acknowledge how he was (re)describing himself and his problems as disconnected from the court model.

Graves initially introduced himself as someone who bought into the court model, even if he was distrustful of how the program would work. In his first interview, he explained about the options he faced at the time of joining the program:

> "Well, I think my option was did I really need the help and I call it a blessing…because I could be going any kinda way, you know, and she [*the head treatment administrator*] really helping me."

He foregrounded medication in explaining what he wanted out of the program and directly attributed his offense—felony retail fraud—to mental illness. He described how he went into a store and would take merchandise such as baby formula "throw it up in the air" and state "it was snowing." He explained: "The voices in my head telling me to do it." Already diagnosed with schizophrenia and bipolar disorder and participating in treatment at the time of the offense (with the details of the depth of this participation often conflicting), he expressed that he was eager to continue treatment, buying into his diagnoses. Furthermore, reporting not having engaged in drug use characterized as "marijuana and stuff" in decades, he reported plans to continue abstaining.

By Graves' account, the program had an appropriate model for his problems. Still, Graves also was clear that he maintained significant mistrust towards the program, particularly having already experienced some institutional disappointment in the form of a despised community service requirement.[51] He would do what he had to do—"I do everything I'm

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[51] Embedded in Graves' initial narrative that he bought into the court model was another kind of claim that he did not think the program would work to his benefit. This might reflect any number of factors. He was particularly upset about being required to do community service. He was concerned about being jailed for missing an appointment with his case manager, which did in fact happen and led him to express further institutional disappointment later. He also recounted that he was wrongfully incarcerated for 15 years and thus had little faith in agents of the criminal justice system, including more recently, many of the staff with whom he interfaced as a part of the program and who could exert control over his life. For example, he reported that he did not trust the judge and explained: "The reason why I say that is because after doing 15 years, you learn not to trust…I mean I just can't trust someone that got my life in their hands. I mean, what if she come there with a bad day? And say, 'Go to jail.' She still get to walk home…No, I don't trust people." However, regardless of the exact cause, what is relevant here is that Graves was engaged in a dual set of potentially contradictory claims from the outset: (a) the court model was appropriate and (b) the program would not benefit him. However, he did not, then, go onto a more fundamental claim that the court model itself could not benefit him, which very well could be tied to a concern that such claims might signal that he was inappropriate for and should be removed from the program, possibly facing imprisonment (Graves reported with concern that he was uncertain about the kind of incarceration outcome he faced if he did not complete the program).

required to do even when I don't want to do it"—but otherwise hoped to be "left alone" and "move on with my life."

Yet, despite his initial orientation, Graves failed to do everything that was required. He missed appointments with his case manager. He failed to complete community service hours. He began testing positive for cocaine on multiple occasions. Through such behaviors (which generally became salient at court before being discussed in interviews), Graves signaled that accommodating the court model was difficult and more disconnected from his life than he initially suggested. Most notably, he began reworking how he talked about his relationship to substance use. He revisited past use of "marijuana and stuff" with new details, describing how he had a history of doing cocaine "all the time" in his 20s (although this was a time period he previously described in terms of being imprisoned for 15 years). He also started talking about his more current use, albeit only that detected by the program. For example, he maintained that he had abstained for well over a decade until he "slipped up" and "relapsed" while in the program. He also maintained that he had no plans to continue using after and in between several relapses detected while in the program.[52] In sum, Graves' buy-in to the court model became more complicated as such behaviors were exposed.

Moreover, this buy-in also became more complicated as Graves began to tentatively signal key ways in which his fit with the court model was not quite as he initially presented. This emerged most clearly in how Graves talked about his past criminal behavior. In his final two interviews, he increasingly moved towards a new way of interpreting this behavior. For example, when asked to revisit the reasoning behind his criminal offending in his third interview, he introduced a new interpretation, albeit without directly applying it to his case:

> "People can break the law by doing, in this depression anything. You know, you cannot have a job; doing it for trying to support your family; whatever. It can be many reasons why you break the law, the main thing is don't get caught. (short laugh) But nah, one thing that it taught me is don't break the law. …Being caught up, it ain't worth it."

When probed for more information, Graves went on to describe his law-breaking again as related to throwing baby formula in the air due to being off medication and symptomatic. However,

[52] It would be surprising—although certainly not impossible—if this was his only use given that to be caught using in the program he would have had to limit use to periods immediately prior to attending court which happens on the same day every week (i.e., he would have had to use within days of attending court given how drug tests work) and he would have had to hold off on relapsing until he was in a program for which he could be punished for such relapses.

Graves more directly reinterpreted his criminal behavior in his final interview after completing the program when asked if his substance use was linked to his criminal offending:

> "Well, I was doing the retail fraud at first, but to get some extra money to help my son. …I don't have no family here…Not a cousin or friend, no nothing. And whether you tell your son you running out of Pull-Ups or when somebody hungry that you can't provide, they just look at you and say you hungry. That's what I did. So I took matters in my own hands and it wasn't a good choice, I know that, but I did what I had to do."

By Graves' shifting account, his criminal behavior was not just a result of symptoms; he had been going to stores seeking material relief. Graves did not ultimately retract his prior accounting, but he now presented an account posing contradictions with it.

One interpretation of this shift could be that Graves came to a new understanding across time. He no longer believed that his actions were compelled primarily by the voices he previously had thought he heard. Graves was not directly questioned about his reasoning for this shift. However, this would be a very drastic change in understanding. More likely, Graves struggled with mistrust. As he adjusted to the interview process and felt less of a need to prove his deservingness of the program (i.e., of a treatment alternative requiring a mental illness diagnosis) the longer he remained in it and after he completed it, he could try out alternative interpretations, tentatively introducing one across the course of a couple of interviews. Moreover, it is noteworthy that this shift unfolded alongside the increasing visibility of his substance use, with Graves not fully adopting a stance that his criminal behavior was driven by material need until he was asked specifically about the potential role of substance use in this behavior. It is thus possible that Graves also experienced pressure to counter potential judgments associated with an assumption that this behavior was driven to support a drug habit.

Regardless, this was not an isolated pattern. Graves often employed different sorts of narratives—sometimes contradictory—for making sense of himself and his problems.[53] Rather

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[53] For example, Graves provided conflicting details about his past, such as whether he had been taking medication around the time of his offense. He initially attributed his symptoms to the psychiatrist unable to: "…Stabilize my dose. They was like, they kept upping my dose because I guess they start low and continue to go up till they can find the right one. And before they did I used to go in the store and open up cans of merchandise and throw it in the air and walk out the door with it, without paying for it and it was the voices in my head telling me to do it." However, he also later reported that he "had stopped taking my medication for a little bit" because he could not afford it. He then also reported he had stopped taking it "because it wasn't feeling like it was helping me," explaining how a psychiatrist had stopped prescribing a medication "because a lot of people was getting addicted to it, but I wasn't and it was helping me, so they took me off of it and put me on something else that was garbage." All explanations might have played a role in his behavior, but Graves did not present them as a comprehensive accounting of his behavior. Instead, he employed them at different times in response to different questions,

than signaling cognitive difficulties like confusion or delusion that might be associated with mental illness, such shifts often materialized as tied to the struggle to perform compliance. Graves, in fact, was relatively exceptional in the degree to which he exhibited such conflicting viewpoints without clearly establishing a break from the court model.[54] For example, while he sometimes spoke about his mental health symptoms in terms of depression associated with unemployment and signaled his criminal offense was related to a lack of income, he did not then go on to clearly outline that the court model had inappropriately or inadequately diagnosed his problems. Such critiques, instead, were embedded in a set of contradictory claims that remained fundamentally rooted in establishing himself as mentally ill. Likewise, despite signaling an ongoing relationship with cocaine use, he often tried to draw attention away from this use, for example, commenting on positive drug tests but then redirecting the interview towards the ways in which he had been unjustly jailed for reasons unrelated to his drug use. In such moments, Graves presented as extremely hesitant to reveal the ways in which his life was disconnected from the program and its model, likely undergirded by a concern about how these disconnects

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generating inconsistencies as he seemed to be navigating a different set of stakes and struggling to maintain a coherent account. Similarly, he could be hazy and contradictory about current experiences. For instance, he sometimes vividly described how his mental illness manifested in the form of voices that directly impacted his ability to function, such as when discussing his past criminal offense. In other moments, he was vaguer about his mental illness, for instance, explaining of what it was when directly questioned about it: "[*schizophrenia and bipolar disorder*] means that I sometimes, like I forget things and stuff like that" or describing the emergence of his symptoms in terms of depression associated with unemployment. For example, Graves explained of why he reconnected with the treatment system prior to joining the court: "Because I felt that I needed the help." He elaborated: "It was peer pressure. Not having no job and seeing your fiancée struggle to pay all the bills and you can't do anything." He started seeing the psychiatrist with symptoms he describes as depression ("I was depressed"), but then added: "depressed that I didn't find work." He also referred to this time as "rock bottom"—"Rock bottom is when I couldn't find work." Likewise, Graves was adamant that he had physical disabilities that made it impossible for him to do community service at a local food bank despite describing at length his struggle to procure work and later describing seeking out employment at fast food restaurants. Rather than indicating some shifting understanding of reality, such moments often revealed Graves as trying out different narratives, unable to trust that he could safely meet his needs in the interview context without carefully attending to how they were presented.

[54] It is important to note interview effects here. The interviewer contributed to how inconsistencies emerged and were smoothed over in Graves' case, which is unsurprising given what we know about face work and the ways in which people interact together (in this case, the interviewer and participant) to save face (Goffman 1967). While the interviewer probed some inconsistencies as they emerged, others were only realized after the interview, and thus not probed, or they were not probed out of the interviewer's discomfort, such as the shift in talk around substance use when the interviewer's attempts to solicit greater detail about the specific use were met with minimal elaboration or deflection to other topics. This is a shortcoming of this study. A better trained interviewer would have been more transparent with Graves about the information she wanted to solicit and been more attuned to how interview questions could contribute to a stigmatizing process (Cook 2012). Still, this does not undermine an argument that mistrust shaped how Graves was presenting himself here. Instead, as discussed in the methods chapter, it suggests that external factors—in this case the identity of the interviewer and her orientation towards Graves' problems—shape how that mistrust manifests, which requires greater attention in future studies.

could put his eligibility for mental health-based resources like the program in jeopardy or be used to discredit him by court staff or, in this case, an interviewer.

Graves thus exemplifies how some participants felt compelled—but struggled—to defensively manage mistrust. These participants faced pressures to reveal themselves and their problems. They remained under the intensive surveillance that exposed them.[55] They also had reason to proactively expose aspects of their lives in a demand for certain kinds of recognition—such as the way in which Graves had turned to describing his criminal behavior as driven by his efforts to be a good father by making ends meet. Still, these participants overwhelmingly presented as pressured to engage in concealment. This pressure was likely exacerbated by the greater degree to which their beliefs, behaviors, and circumstances were perceived as stigmatizing and/or sanctionable[56] and linked to retaining eligibility to services and resources.[57] It also was likely exacerbated by a lack of rapport with professionals such as, in this case, the interviewer. Rapport could be built across time in many cases, but it could be undermined when participants maintained greater mistrust towards the institutional context or expected the issues they faced to be misinterpreted or discredited in specific interactions with actors such as the

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[55] Participants are bound to experience "differential visibility" (Chambliss 1973), i.e., the issues they face are not equally detectable by the program and thus some participants can conceal issues from the program better than others. For example, Lacy's conflict with her harasser likely was more visible given that it was unfolding in the legal system in the form of a lawsuit and Glick was explicit (and unhappy) that the court turned to regulating problems she experienced with her romantic partner after these problems became more visible when she sought out inpatient treatment due to them. Other participants might not experience such exposure. For example, their problems occur in the privacy of their homes and do not generate any institutional contact. Alternatively, their problems do not affect their program engagement, such as when conflict at home contributes to a participant failing to attend an appointment and thus having to account for this failure at court. Furthermore, their problems are not physically visible, such as in the form of weight loss or shifts in demeanor that accompany substance abuse.

[56] For example, only three participants discussed past cocaine use positively and these participants maintained that they would not use it moving forward (although fifteen participants in total described at least a past relationship to it). This contrasts significantly with how participants commonly talked about marijuana, alcohol, and/or, to a lesser extent, prescription pain killers as acceptable and desirable substances that would be used again. Similarly, participants seemed hesitant to reject a mental health diagnosis despite some signaling reservations about the way it was applied to their experiences or, in a couple of cases, rejecting a diagnosis after completing the program, as Glick's case demonstrated. This is unsurprising given the importance of this diagnosis for ongoing participation and as a gateway to resources. Furthermore, participants were more likely to discuss past disconnects with the court model, given that current disconnects—such as ongoing substance use—could still trigger social control. Moreover, the degree to which participants perceived beliefs, behaviors, and circumstances to be stigmatizing was likely mediated by their social identity, as described in the last chapter.

[57] For example, Graves continued to access Social Security Income, tied to his mental health status, and remained on probation throughout and after participating in the court program. Whether or not such institutional pressures shaped Graves, they certainly can function as added pressure to perform compliance for the many participants who had or worked to gain access to such resources or faced greater legal sanctions for departures from program goals.

interviewer.[58] In the face of such pressures, these participants adopted strategies as they struggled to defensively manage mistrust. Yet, this was not the only way mistrust could trigger such shifts.

Proactive management

Participants also could manage mistrust through purposefully breaking from their performance under certain conditions. They *proactively managed* their mistrust, revealing key beliefs, behaviors, and circumstances that departed from the court model as deemed beneficial. Some participants did so consistently, such as those described in the prior chapter as exhibiting strategic acquiescence. However, proactive management function as another way in which strategies broke down because many participants switched from defensively managing their mistrust to revealing key disconnects as the stakes of doing so changed, particularly as they completed the program or appeared more trusting of the confidentiality of the interview process. This was exemplified in the case of Vaughn, a white woman in her 40s who presented a very different accounting of herself and her problems across time, particularly as she was completing the program.

Unlike Graves, Vaughn presented in many ways as unreserved about the many problems she faced.[59] She had a story to tell and she was eager to tell it. For example, prior to being asked

[58] See the methods chapter, but it is important to refocus attention on how the interviewer's social identity and disposition towards participants and their problems shaped how participants engaged in interviews. This emerged as particularly relevant here given that participants who seemed most reticent to share disconnects with the program that emerged inadvertently tended to hold identities different from the interviewer in terms of gender, race, and class, which contrasted in some cases with more middle-class male participants or white female participants who provided greater detail about departures from program goals, although it is difficult to separate the effects of social identity out from the varied nature of their problems (e.g., marijuana versus cocaine use), the degree to which these problems were detected by the program, and length of participation in the interview process.

[59] Vaughn stands out in the degree to which she answered questions at length and often provided unsolicited—and sometimes very sensitive—information. She also explicitly talked about herself as someone who was unreserved. For example, she recounted how the prosecutors were changed on her case after she revealed too much information informally: "I had to have two different prosecutors because I'm so friendly I'll walk up to somebody in the hallway and tell them, 'Hey, how you doing?' and start talking to them and I'll tell them my life story without even knowing who the heck they are. I had two different prosecuting attorneys have to drop out of the case because I wound up telling them the entire case before we went into the court and they realized, 'Oh wait a minute I can't, you know, do this because she already informed me of everything.'" Vaughn similarly described how affable and intimate her relationships could be with a host of characters who floated in and out of her life from the judges she interacted with on her case who were more like friends and family members to a treatment provider who offered her personal phone number rather than the typical work number to an employer-best friend of four years who she met by happenstance when walking down the street and saw the woman "picketing outside of an abortion clinic…and we got into talking

directly about her criminal background, she was one of the few participants to launch into a detailed explanation of it at the start of her first interview. Vaughn recounted that she had become involved in a check fraud scheme in which she unwittingly and repeatedly cashed bad checks with a group of individuals as they drove across the state. Charged with a felony offense—Uttering and Publishing—she was eager to do something about the matter—"I actually wanted to get these people [*the ringleaders of the group*]. I told him [*a police officer*] I said…'I don't want them doing this to anybody else.'" Vaughn elaborated on this narrative when asked about her criminal offense throughout most of her interviews. She thought she had been doing a legal job that she desperately needed as a former panhandler. She did not know what was happening—"I wish I was that bright but sometimes I don't catch on right away." Her crime was "accidental." It also was uncharacteristic of her. "I've never been in trouble with the law. I've been prominently a good kid all my life, a good adult, I'm an honest citizen, I don't steal." Vaughn was thus particularly thankful when a judge could see she had been "majorly taken advantage of" and referred her to mental health court, having previously thought she might be going to prison for 15 to 25 years. Vaughn was equally descriptive about her mental illness[60] and history of substance use including alcoholism,[61] describing each in vivid—and often provocative—terms.

Yet, despite presenting as unreserved in key ways, Vaughn, like Graves, revealed herself to be invested in defensive management. For example, despite talking at length about substance use and noting major reservations about marijuana abstinence, it was not until interviews conducted around her graduation from the program that Vaughn noted she was a recovering

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and I told her that I was looking for a job." In terms of how Vaughn presented herself, she seemed like an open book, ready to sit down and share her story with anyone who was ready to listen.

[60] Vaughn also stands out in the degree to which she readily identified with having mental health and intellect problems that she very descriptively recounted as developing in her youth. By her account, she was very ill, not very bright, and easily led. More specifically, she was "handicapped," a "frickin' wacko," "fried," and "completely and utterly mad. I think the mad hatter has got more sense than I do sometimes." She generally expressed agreeing with her diagnoses, including "multiple personalities, schizophrenia, bipolar manic depressive all that other happy mumbo jumbo blah blah blah, you know, stuff." She also, then, tended to express that mental health treatment—something new to her—could provide her "a little bit more control up here [*in her head*]," helping with sleep problems, racing thoughts, and fluctuations in her mood, as well as gaining better control over her personalities. (Although, she also often expressed reservations about whether such treatment helped her symptoms while maintaining that it might with the right regimen.)

[61] Vaughn further stands out in the degree to which she rehashed a lengthy history of substance use starting when she was given whiskey as a baby and independently drinking at six and tied to problematic family dynamics that led her to be a "hardcore alcoholic." She was particularly descriptive in discussing the way in which her alcohol use led her to be abusive towards men (which she seemed to view as both concerning and comical)—or, in her words, "the two 'fs"—fight or fuck." She, as will be addressed, maintained generally a favorable orientation towards marijuana.

heroin addict and that her criminal involvement could be attributed to heroin use.[62] Such an omission is not surprising. Drawing greater attention to this use could make her role in her criminal offense less sympathetic while she was still being processed for it. It also could lead staff to intensify treatment requirements or reinterpret her use of other drugs while in the program—prescription pain killers and anti-anxiety medications she reported that she had received from the hospital on at least a few occasions—as products of this addiction and thus requiring greater regulation. Moreover, Vaughn never reported using (or being caught using) heroin while in the program. Hence, in some ways, it might be surprising that she decided to report such use at all, even when graduating.

However, unlike Graves, Vaughn showed herself to be very comfortable proactively asserting key ways in which the court model was disconnected from her life, particularly upon graduating. She recounted that once "free and clear off of paper," she "partied like a rock star." She went to a strip club with friends, drank White Russians, and smoked "like a pound of weed," which she had been using since with plans to continue. She explained:

> "Now I can go back to my medication [*marijuana*] that actually works. And I'm sitting there going man, you know I feel mellow, I feel calm. This year that's went by, I've been anxious and the medication that he's giving me doesn't cope with anything. It's just... I still get anxious and irritable and all that and I'm like forget this medication crap. I hate taking pills anyway. Finally, when I got to smoke again, I was like oh God, I feel so relaxed. My brain is like hey and then I started writing again. I haven't wrote anything down in over a year. And I actually started writing again because my brain can focus now."

While Vaughn had expressed some ambivalence towards psychiatric medication and marijuana abstinence all along, her resistance to it now solidified. She no longer was taking medication and instead planned to rely solely on marijuana to help with any issues she experienced. Vaughn also had a different perspective of her alcohol use. She still was clear that she had a problem with

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[62] In her fourth interview conducted a day before she was graduating from the program, Vaughn newly presented herself as a heroin addict. She explained how she—for bureaucratic reasons—could no longer attend the same outpatient treatment group, which she mentioned was for methadone (an opioid used to treat heroin) patients. When asked why she would attend such a group at all, she explained: "Because I'm a recovered heroin addict and even though I'm not on methadone, they still understand what I'm going through because most of them are recovered addicts." In an interview not long after graduating, she further elaborated that she had also been addicted to methamphetamines, acid, and MDMA, and had it not been for the court program, she would "probably still be hooked up with the fucking heroin and shit, yeah." When then asked if her heroin use factored into her criminal offense, she confirmed: "Probably because I was using heroin when those people found me on the street holding a sign and asked me if I wanted a job. And I probably would've caught on to what was going on a lot faster if I wasn't doing that stuff."

alcohol but was equally clear that she would continue to drink and manage it her own way: "I tell myself don't let the bitch [*alcohol*] control you; you control the bitch." She similarly explained that while she would not return to heroin specifically, she could use prescription drugs if she wanted:

> "Because if I want that effect I'll just take a freaking Norco [*painkiller*] and it does the same thing. I mean it didn't really do much other than kill the pain in my back and my legs and stuff, which is nonstop; I'm in constant pain every day, but I don't show it."

Vaughn even—for the first time—began critiquing her mental health diagnoses (although she maintained she was mentally ill), recounting how she had told a treatment provider, "I'm not schizophrenic but I do have multiple personalities." In the process, Vaughn proactively asserted multiple ways in which the court model had ultimately proved to be disconnected from her life.

Vaughn thus exemplifies how some participants experienced the pressures to manage mistrust very differently from those who maintained a defensive approach. These participants, too, faced pressures to engage in concealment. However, these pressures lessened as rapport was developed and the stakes of revealing such disconnects changed.[63] Vaughn, then, could reveal her prior heroin use as it became less likely that she would face negative repercussions for it. Moreover, these participants experienced a pressure to demand recognition for key ways in which the court model was disconnected from their lives. They thus engaged in a kind of self-exposure, such as Vaughn revealing substance use beliefs and behaviors that signaled she was better in control of and knowledgeable about issues the program tended to label as problems.

In some ways, then, these participants were at an advantage. They eventually felt secure enough to describe how the program had failed to adequately or appropriately craft an intervention for their lives. They discussed how they had covertly manipulated drug tests, stopped taking their medication, struggled with persistent symptoms, had significant interpersonal conflict with romantic partners or housing problems, and otherwise maintained beliefs at odds with program goals. Some of these participants signaled that they had been able to accommodate the program—performing compliance—on their own terms. Yet still, even here, often these participants showed themselves to be struggling to reconcile their needs with the

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[63] It is noteworthy that unlike Graves, when Vaughn completed the program, her criminal justice involvement was resolved. She no longer was on probation. Furthermore, unlike Graves, Vaughn did not have Social Security Income. (She had plans to reapply for it but had not yet done so after being denied in the past.). Moreover, Vaughn had a different relationship with key staff. For example, she perceived that she could have a very open and honest relationship with her case manager, who she would continue to see, about her beliefs about marijuana.

demands of participation. The demand for recognition arose because the program had failed to see them for who they were and let them determine what they needed. Strategies broke down ultimately because they were not working to their benefit.

IV. Discussion and Conclusion

In this chapter, I build on the last by showing that not only are participants differently predisposed towards strategies of engagement, but they are also differently equipped to carry out the strategies they adopt across time. Specifically, some participants are particularly likely to struggle in this context because the demands of participation are not easily reconcilable with their needs, desires, and aspirations. Hence, I introduce another dimension by which participants are disadvantaged here. The last chapter indicated that participants who strategically acquiesce were least likely to make the institutional setting work in their favor, acquiescing to the requirements of a program that was ultimately unresponsive and ill-equipped to meet their needs. However, I have now shown that it is actually participants who inconsistently exhibit strategic acquiescence who are often show themselves to be struggling to make the institutional setting work in their favor. They, too, face the shortcomings of a program ill-matched to their needs. However, rather than independently meeting these needs as they covertly "walk down" the program or "fly under the radar" like Shankland and her peers, these participants often are caught up in issues detected and deemed problematic by the program and/or disappointed in an ongoing failure of institutions to resolve their problems. Participating in the program, then, becomes a source of problems in and of itself.

Additionally, I focus on how strategies break down across time to examine how the mental health court functions as a "people-changing" institution (Hasenfeld 1972, 2010). In some sense, movement in strategies is ideal from the perspective of a program. It might reflect how some participants are grappling with new beliefs, behaviors, and circumstances that lead them to buy in. Some participants certainly match this ideal in some ways. However, I show that movement in strategies predominantly is the product of a set of situational and structural constraints that make it difficult for participants to consistently adhere to the program's goals. Thus, for example, participants like Lacy might increasingly buy into a mental illness when they routinely interact with a supportive staff who encourage them to do so as their life increasingly

feels on track, but such an interpretive framework might be less useful when they continue to experience psychological distress as problems like ongoing harassment persist. Continuing to take psychiatric medication, then, might feel futile. Alternatively, a participant might buy into a need to treat an addiction after an undesired relapse but see less value in treatment and become more concerned with the stigma or other shortcomings of identifying with addiction as they experience greater stability in their life. Moreover, the challenge for the program is that a significant proportion of its participant base will remain embedded in a set of conditions that produce the very psychological stress and behaviors like substance use or interpersonal conflict it aims to change (Fisher et al. 2006; Skeem et al. 2011; Epperson et al. 2014).

Furthermore, the program itself creates a set of conditions that makes the objective of people-changing difficult. Participants cannot simply test out new self-understandings and various interventions that could help them. They are compelled to perform compliance. This pressure is generated by the program in the hopes that it will force participants to experience the benefits of this performance, eventually seeing its value and thus choosing to *be* compliant independent of social control. However, by its very nature, it undermines the possibilities for open, honest engagement around what participants need and how institutions like the mental health court can best help them. This becomes particularly burdensome for some participants, like Graves, who exhibit significant mistrust and/or have issues that might be helped through treatment but become subject to punishment within the criminal justice system. Importantly, mistrust can manifest idiosyncratically in interactions with specific staff members, but it likely emerges most commonly as part of a more fundamental mistrust of public institutions (differentially experienced across social groups (Bell 2017)) and due to social distance with staff members generated by their social identities, dispositions, and experiences.

Finally, while not the analytic focus of this chapter, it is important to note how movement between strategies can breed mistrust if read by the outsider, notably here staff members, as a reflection of the "moral self" of the participant. As the participant changes stances, she shows herself to not be truly dedicated to performing compliance. Even more alarming, she might have never been dedicated to the performance despite saying otherwise. Her performance was contrived. How can such a participant be trusted? Who really is she? What does she really want? I have argued that such shifts say less about the participant's moral self than an evolving set of conditions in which the participant is embedded. In fact, due to the pressure to perform

compliance, it should be clear that participants often exhibit significant commitment to this performance even when faced with breaks from it, such as in the case of Graves. However, often it is difficult to first and foremost see the conditions that generate this movement and not feel "duped" or "had." Hence, while such shifts might be the result of impediments and disadvantages some participants experience more than others, they in fact might generate further disadvantage as staff become more skeptical of participants' commitment to the program and its goals.

I conclude by discussing several key limitations of this chapter. First, my analysis has tracked how participants perform compliance. I cannot systematically speak to the "backstage" (Goffman 1956) beliefs, behaviors, and circumstances of participants, although some participants signaled at times that they provided some backstage information in my presence. Still, examining this frontstage work reveals how participants are differently equipped to meet the demands of program participation as they engage with professionals like the interviewer who they can (wrongly) perceive as likely to report back to court staff on them as they progress through the program—an important dynamic to explore given the range of individuals with whom participants must interact from the judge to case managers and therapists to peer supports like self-help recovery group sponsors.

Second, this analysis is exploratory. It is not intended to quantify when strategies will break down; instead, I identify some processes by which strategies do break down. I argue that to the extent participants are subject to them, they are more likely to adapt their strategies. However, it is important to note that not all the movement in strategies were the same in degree and they certainly did not reflect an equal struggle on the part of participants to reconcile their needs with program participation. In some cases, participants had been relatively successful in presenting as accommodating the program to later reveal that, like Vaughn, they had been engaged in defensive management of mistrust. Third, this analysis does not account for the ways in which these processes might be influenced by variation in how staff differently intervene upon participants. For example, one participant might be caught using prohibited substances more than another despite both engaging in similar kinds of use or might be caught on days when the judge responds particularly strictly to use largely due to bad luck. Of course, my aim has been to show that participants struggle with more than just luck, but such differences in staff behavior can

certainly play a role in how participants relate to the court model in ways that were not measured here.

Still, this movement in strategies reflects the struggle on the part of participants to accommodate the program across time while meeting their needs. The more the participant's strategies broke down, the more they tended to reveal themselves to be struggling. Yet, to better understand this struggle, it is important to better attend to what participants were differently gaining out of participation, as I turn to next.

Chapter 6
The Payoff of Engagement: Pursuing Self-Control

I. Introduction

The preceding chapters examined participants as participants – i.e., individuals working to fulfill the roles and obligations established by the court program. This chapter shifts the focus to examining participants as individuals – i.e., people striving to make sense of themselves, albeit within the context of a court program that calls upon them to reimagine themselves. An undergirding theme of my analysis has been that participants differently benefit from how they are being asked to reimagine themselves. For example, some are positioned to experience relief from criminal stigma, while others are positioned to experience stigma amplification associated with mental illness (see: chapter 4). Moreover, some are particularly likely to find the court model as partial or inadequate for making sense of themselves and their problems, minimizing the nature of the struggles they face (see: chapter 5). These kinds of findings are important, and, in this chapter, I bring them to the foreground. I turn to more directly examining how participants talk about reimagining themselves in this context to more critically examine what the program is promising and how participants are differently equipped to capitalize on this promise.

To pursue this line of inquiry, I refocus attention on the program as a "people-changing" organization in which participants are the "raw material" that must be reworked and reshaped (Hasenfeld 1972, 2010; Colyer 2007). In select cases, the program connects participants to new resources like subsidized housing, employment, and income, but it is fundamentally oriented around changing the participant. A series of psychiatric and psychosocial interventions are used to help participants better develop their capacity to control emotions, thoughts, and behaviors and make better decisions in their lives – including decisions that lead them to desist from crime. In short, the program primarily operates to help participants gain – what will be called here – "self-control" (see also: Rose 1996; Fox 1999; Fairbanks 2009; Haney 2010). This kind of approach to changing participants (and their problems) can be useful for some participants. They

describe the program's focus on self-control as providing them with a renewed sense of agency over their lives as they move beyond past troubles. For other participants, however, the benefits of self-control prove elusive or undesirable. They do not describe self-control as offering them greater power and control over their lives like their peers. In fact, often enough, they signal that self-control can function to deny them the very sense of power and control that it promises.

To understand these divergent perspectives, I investigate how self-control functions as a social construct (Berger and Luckmann 1966). Social construction refers to the process by which people assign meaning to the world, drawing attention to how this process varies considerably across time and space. In this context, self-control becomes one of many ways of interpreting participants and their problems but one that is readily available and legitimized by the program. Of course, this is not to deny the existence of an underlying phenomenon of, for example, a capacity to regulate emotions. Instead, I draw attention to how self-control becomes a way of constructing such a capacity as visible and intelligible under certain conditions and how doing so enables some possibilities for human imagination and action while constraining others (see also: Rose 1989, 1998). From this perspective, some participants experience a renewed sense of agency because self-control helps them render the positive outcomes in their lives as a product of individual choice, made by a more disciplined self. However, for other participants, the same framework misattributes negative outcomes – shaped by factors like social marginalization and ineffective and unjust institutions – to a self that was out of control.

This chapter, then, continues to build on literature that examines how participants construct themselves and their problems in contexts like the program (Holstein 1992; Spencer 1994, 2001; Gubrium and Holstein 2001), with a focus on how this is embedded in increasingly ubiquitous and often quasi-medicalized discourses on self-control, self-management, and self-regulation (Haney 2004). In so doing, I join those beginning to question how medicalizing an individual's problems plays out differently depending on one's social standing (Anspach 2012; Bosk 2013; Ramey 2015), including whether privileged individuals are better equipped to benefit from the positive qualities attributed to medicalization, such as relief from social obligations (see: Conrad and Schneider 1980). In particular, I build upon the work of Whetstone and Gowan (2017) in demonstrating how self-control results in very different modes of control for those of different social standing. Whereas more privileged participants only require "fine-tuning" self-control (as Whetstone and Gowan argue) and thus ultimately retain significant autonomy, less

privileged participants often remain subject to considerable control inside and outside the court context, particularly as the problems they face trigger regulation.

I begin by conceptualizing how self-control operates in the court context, both from the vantage point of the program and participants. In so doing, I show how discourse around self-control conceals complex social dynamics that undergird it. With a more comprehensive understanding of self-control, I turn to my analysis, examining how participants differently talk about pursuing it. In so doing, I argue that participants are differently positioned to capitalize on the program's focus on self-control. I conclude by discussing how this analysis provides greater purchase for understanding both what program goals are helping participants achieve generally and how their benefits are differentially distributed among the participant base.

II. Locating the pursuit of self-control in context

Self-control encapsulates a set of ideas about willpower, self-discipline, and restraint that hold significant resonance in U.S. culture.[64] While the locus of self-control can be differently located in moral character, biological pathology, or cultural disposition, it generally refers to an individual's internal capacity to forgo immediate benefits for a longer-term goal. Under its lens, individuals are portrayed as rational, calculating actors who can weigh the benefits and costs of their actions. When they lack self-control, they lack the capacity to think through the consequences of their actions and restrain their impulses. They pursue instant gratification. For example, they rashly buy things they cannot ultimately afford rather than appropriately saving money. They impulsively engage in substance use despite how this will interfere with familial or work obligations. They lash out at others as they experience anger or sadness instead of calmly managing their emotions. For such individuals, their emotions, thoughts, and behaviors are out of control. They cannot regulate them and thus think, speak, and act in ways that lead to trouble. Undergirding this set of ideas, then, is an assurance. If one works to achieve self-control, one can gain control over his or her troubles. Self-control, in this way, promises a better life.

[64] It also holds sway in some strands of social and behavioral research, from explaining criminal and deviant behavior (Gottfredson and Hirschi 1990; Pratt and Cullen 2000) to health and academic outcomes (Duckworth et al. 2005; Gagne 20017; Miller 2005; Tangney et al. 2004) to even poverty itself (Bernheim et al. 2015). Its resonance can be explained in part in terms of what Garland (2001, p.198) refers to as "the dialectic of freedom and control" (see also: Reinarman 2003). That is, as certain freedoms, openness, and tolerance have been cultivated, control becomes re-emphasized to impose order, albeit in specified ways that align with the ascendant social order.

In the program, self-control features prominently as a promise for what the intervention – and participants specifically – can accomplish. The program, after all, is geared at changing the internal controls of the participant so that they no longer engage in criminal offending. From the program's vantage point, self-control is an outcome.[65] It is an ideal state to be achieved – a self-regulated way of thinking, talking, and being – that is instilled in participants. But it is an outcome tied to – and producing – ancillary outcomes. Once self-controlled, the participant can better secure and engage in meaningful activity such as employment, education, and family life. She can maintain stable living arrangements and supportive relationships and tend to her health. Most importantly, she will reduce her likelihood of further criminal justice involvement. Of course, supports such as meaningful activity and stable living arrangements, in turn, help enhance self-control. Moreover, in practice, staff recognize that some participants will achieve less than others, remaining dependent on family members or supervised housing units due to cognitive impairments or weighed down by negative social dynamics and a lack of viable employment opportunities. However, in its most ideal form, instilling self-control becomes a way to help participants help themselves lead better lives that will keep them out of the criminal justice system.

Moreover, this is not just an abstract goal for the program; it is intricately embedded in its design. It emerges prominently in the program's focus on psychiatric treatment and drug and alcohol abstinence, in which the internal regulatory process of the participant becomes the primary problem to be addressed. (As discussed in chapter 4, participants first and foremost are ushered towards psychiatric care and told to abstain from non-prescribed substances often prior to adding additional requirements.) Alongside this focus, participants are encouraged (and mandated, depending on the case) to engage in psychosocial interventions such as self-help groups and individual therapy to develop habits and skillsets to regulate and rework problematic feelings, thoughts, and behaviors, further correcting any internal dysfunction. Court sanctions and rewards, then, are used to modify the internal calculation processes that drive problematic behavior patterns, including failure to comply with treatment regimens. Interactions with court

[65] Arguably, the program is focused on a process as opposed to an outcome: recovery, i.e., the process by which individuals gain the skills and supports to manage their disorders across time. Yet, as critics have pointed out, even while recovery retains the language of an open-ended process, in practice it can function more as an obligation. That is, individuals are obliged to recover, living a relatively normal life to the best of their ability. Following a Foucauldian logic, the program becomes a normalizing intervention focused on instilling self-control in its participants, rather than cultivating an open-ended process that will be largely participant-driven.

staff fuse elements of both psychosocial treatment and behavior modification as they both empathize with and chastise participants, depending on the circumstances. In short, the program employs many different approaches to intervene upon the internal controls of the participant.

Given its prominence and legitimacy in the program (and, also, more broadly in U.S. culture), participants face significant pressures and pulls to contend with self-control. Yet, participants are not merely contending with self-control in the abstract; they must do the heavy lifting of "being" self-controlled. As such, they must grapple with what this state of being means in practice and how best to achieve it. At first glance, this appears to involve primarily an assessment of how to fine tune the internal – the functioning of their feelings, thoughts, and associated (impulsive, not fully conscious) actions. How can psychiatric medications be better adjusted? How can the potential for relapse be reduced? How can the participant best develop the coping skills to act differently? For some, even here, achieving this ideal state will prove out of their grasp as, for example, psychiatric medication and abstinence will fail to have the intended effect (see: Hughes and Peak 2012). However, for all, contending with self-control inevitably involves confronting the broader set of assumptions associated with it. Are these internal controls the source of the participant's problems? Will gaining greater internal controls work to her benefit, providing her with a pathway to a better life and the ancillary outcomes it promises? Moreover, is self-control the best way to make sense of her life and the possibilities before her? Whether or not participants tackle such questions consciously, they become central features of making sense of the pursuit of self-control in practice.

Of course, some participants simply might not experience the kind of distress that becomes labeled as a lack of self-control (participating in the program strategically) and thus reject these assumptions outright. However, even participants who experience distress could find these assumptions wanting. After all, in a context in which most individuals are socially and economically disadvantaged, desired outcomes might remain out of reach, whether, for example, in terms of more ideal housing arrangements or simply avoiding criminal justice encounters. Furthermore, even when some outcomes are achieved, they might be far from ideal. For example, select participants might return to trajectories in which they are headed for or already engaged in desirable careers, but most will remain relegated to the lower tiers of the labor market. As Kaye (2012) indicates, some of these individuals will be eager to develop the kinds skillsets that reflect self-control and that are associated with this kind of work such as "accepting

boredom, following rules, and responding calmly to being yelled at by supervisors," but others will reject the inherent value of this pursuit. Moreover, as other scholars have indicated, not only might individuals be relegated to the lower tiers of the labor market, but also simply to employment training – or even therapy – as opposed to gaining employment at all (Haney 2010; Miller 2012; Stuart 2016).

Additionally, and relatedly, participants will confront whether interpreting themselves and their problems in terms of self-control works to their benefit. As sociologists have long pointed out (Parsons 1951; Conrad 1979, 1992; Conrad and Schneider 1980) interpretive frameworks like that of self-control can accomplish important symbolic and material work. This includes providing reprieve from guilt and blame as troubles are linked to sickness rather than moral flaw, as well as relief from social obligations one is or was deemed unequipped to meet, in this case, as a self out of control. It also can help individuals envision the future more favorably, with new tools – such as psychiatric medication and coping skills – to overcome past troubles. These interpretive goods can help participants engage in identity repair, overcoming stigma associated with their troubles (Goffman 1963), and reconstruct a life they want to lead. Yet, alternatively, such frameworks might serve to delegitimize and marginalize the larger social problems participants face, translated into individual problems and thus amplifying personal blame. Furthermore, whether they are used to mitigate conceptions of moral flaw will depend largely on the conditions in which they emerge, with some participants likely to struggle in shaking a view of themselves as "bad" versus "sick" (see: Anspach 2012; Bosk 2013), which is likely to unfold differently depending on race, class, gender, and other kinds of existing inequalities. In short, not all participants will be able to achieve the same kind of interpretive gains through self-control.

Furthermore, participants will also be confronting what self-control does for them specifically in the program context. This involves the reality that performing self-control across time can help ensure their completion of the program to reap the rewards of avoiding criminal sanction and, in some cases, dismissing criminal charges. Yet, also employing discourse around self-control in specific moments can help participants justify noncompliance (tied to a self out of control) and provide a rationale for why certain requirements should not be imposed (as they are too overwhelming and difficult to meet when lacking internal controls).

Hence, while the program is focused on self-control as a relatively uniform objective that is possible and beneficial for its participants, self-control in practice can unfold in a range of ways – many of which extend beyond just a state of being. This indicates the need for a more nuanced accounting of how participants are positioned to capitalize on and achieve self-control. Under what conditions do participants view themselves as experiencing self-control and benefitting from the goods associated with it? Conversely, under what conditions do participants describe themselves as not experiencing self-control or benefitting from it? Moreover, how does program participation complicate how participants relate to self-control? I turn to this line of inquiry next.

III. Results

Deconstructing the pursuit of self-control

In the following sections, I examine how participants of different social positioning talk about pursuing self-control. I aim to show that this pursuit becomes rendered visible, legitimate, and actionable for some participants more than others due to the pre-existing orientations and resources they have upon entering the court. Only some participants are situated to act in ways that allow them to fully leverage the pursuit to their advantage. In fact, for some participants, this pursuit can work to their disadvantage in key ways. I thus present a continuum in which on one end, participants describe benefitting from the program's focus on self-control and on the other, participants describe struggling to do so. I, then, discuss how participants often fall between these two poles, and note that a few participants who ultimately came closest to typifying strategic acquiescence fall outside of this continuum, rejecting this pursuit alongside other program goals (see chapter 4). To provide greater understanding of the complexity of factors driving these differences, I continue to rely on in-depth case studies, drawing attention to broader patterns in the data after discussing each case. Still, given the diversity and complexity of participant cases, I do not maintain that these cases are representative of all participants' experiences. Instead, I use them to identify some salient patterns in participants' relationships to self-control.

When participants describe benefitting from self-control

Self-control as beneficial state

Some participants described experiencing program participation as a beneficial pathway to greater self-control. That is, as intended by the program, their lives were different because something about them internally was different. They developed new skillsets and habits, including often taking psychiatric medication and participating in psychosocial treatment and, in some cases, abstaining from or reducing substance use. They, then, could better regulate emotions, thoughts, and behaviors previously experienced as out of their control and often leading to trouble such as criminal justice involvement. They no longer would have to worry as much about impulsively engaging in substance use, thoughtlessly quitting a job, recklessly lashing out at a family member, or irrationally stealing something. Their lives felt more manageable and predictable.

Jenson, a white male in his thirties, provides an example of this phenomenon. By his description, he joined the program after several years of substance-induced mania led to major disruptions in his social relationships and a career in oil and gas, as well as a series of low-level offenses. Immediately prior to joining the court, he picked up two misdemeanor assault charges, including one against his parents. For Jenson, his life had gone off the rails. A former college athlete who had experienced early success in his career, Jenson recounted a major shift in his behavior that coincided with temporarily moving back home, two deaths in his family, and a turn to non-prescribed Adderall to cope with depression. He increased his alcohol and marijuana use, went through large sums of money, engaged in multiple romantic relationships simultaneously, lost his job, moved around the country, and became entangled with the law (always while under the influence of alcohol). He was linked to several mental health interventions, sometimes in lieu of traditional criminal processing, as in the case of mental health court, and diagnosed with bipolar disorder, but it took him “about two years” to buy into this diagnosis—“after my third or fourth arrest and after pissing off everybody, family and friends, and having everybody angry with me and disappointed.”

Initially somewhat resistant to the program, he quickly found it to be a pathway to self-control. It provided him with a structure of accountability to ensure he took his medication (something he had not done as consistently in the past) and altered his substance use—“I mean, if it wasn’t for this program, I wouldn’t have quit drinking.” Finally taking such goals “seriously,” he could now feel an internal shift. “I’m thinking clear headed,” “on an even keel,”

and “my chemistry is all good.” After four years of tumult, his life began to feel more predictable again:

> “I can see now that there’s hope and I mean, I just, it was a cycle for me, so I can see this breaking my cycle of doing good and then having something dramatic happen, you know, because of my mental illness. So, I can see this starting consistency in my life.”

For Jenson, his untreated mental illness had led him to engage in a series of actions that he described as “rash” and “drastic” such as being: “…aggressive, not sleeping, spending money wildly, just living a wild lifestyle that when you know things are wrong, but nobody can tell you anything.” He described further:

> “I went from down here [*he brings his hand down*] to way up too fast. So. It was obvious. I mean, it was obvious financially. It was obvious by my behavior. It was obvious by me getting in trouble.”

Program participation offered him a way to change this pattern, bringing his behavior under his control. He was no longer caught up in the whims of symptoms. He had new tools to manage himself. As he explained in his second follow-up interview after completing the program, with “a year of good habits” under his belt, he realized “that if you can do it for a whole year, you can do it the rest of your life.”

By his account, like some of his peers, Jenson was achieving the ideal program outcome of becoming more self-controlled – and much to his benefit.

Self-control as identity repair

Yet, when participants like Jenson talk about achieving self-control, they often also were talking about a project of identity repair. For such participants, talk around self-control functioned to help them overcome their troubles in key ways: providing reprieve from guilt and blame, locating agency to overcome them, and reconstructing an identity severed from them. Furthermore, often enough inhabiting more privileged statuses, they were better equipped to reassemble an identity that was not defined by their troubles and instead characterized by other roles, such as employee and family member.

Jenson certainly worked to accomplish significant interpretive work around his past troubles. Jenson, after all, was very focused on breaking with his past. He commonly commented on how past behavior was “not my character” or “wasn’t like me.” “It’s embarrassing what I

went through, what I did to myself." Jenson was particularly concerned with distancing himself from criminality. For example, in describing how he might have ended up in jail had he not done the program, he stated: "And I don't look like a criminal." He then turned more directly to the microphone and reiterated: "I don't look like a criminal." He repeated this kind of concern in explaining how awful it was when he received a jail sanction from the program: "You're in there with all these criminals and you're not…you don't feel like a criminal, so you don't feel like you're in the right place. So, then you definitely don't want to go back." Further, Jenson was clear that his criminal behavior – often described as "terrible" – was not as bad as it might seem. For example, he described of his most recent charges, which included wrestling with his father and an altercation with a neighbor in a nearby store: "They were simple, it was a simple assault, like I threw a guy down like we were playing football. I didn't even hurt him."

While Jenson described his mental illness as embarrassing, it helped him make sense of and disassociate from his past conduct. Thus, he stated: "I can tell you every time that I was arrested, I was drunk or high and off of my medication." He said further: "I don't think I would have committed any crimes if I was – before I was in the program – if I was sober and using my medication either" as "[I'm] a totally different person when I'm taking my medication." His past conduct revealed little about who Jenson fundamentally was; instead, it reflected a past self both symptomatic and under the influence. Now (back) in control, he was his authentic self. This was important for his self-understanding ("it made me understand it"), but it also could help him recraft the self-image he projected to others. He described how his friends and family had educated themselves on mental illness: "So they knew it was temporary and it wasn't like me." Moreover, after describing the challenge of dating given the stigma of mental illness, he moved into discussing how he would overcome the negative judgement he experienced around the conduct he had associated with it:

> "So, I need to, the judge says good history; like I need a full year of not getting in trouble and *showing* [emphasis added] the real person of who I am and that's what the medication does, it keeps me on an even keel and non-aggressive and non-threatening behavior. So, because that was never my personality for 30 years, so."

Self-control became a useful way for Jenson to interpret past conduct and, critically, it gave him a pathway forward. Once a (demonstrated) self in control, he could work to move beyond it.

And, by his account, he did move beyond it. While his (former) lack of self-control was often described in terms of substance use, Jenson increasingly reasoned that now a self in control

he could engage in substance use casually without issue. His idea of being more self-controlled was not ultimately tied to abstaining from substances even though Jenson often described alcohol as playing a pivotal role in prior conduct and valuing an initial bout of abstinence while in the program. Jenson believed he could engage in substance use "socially." Hence, when asked what would lead him to engage in drinking he deemed problematic, he reinforced the idea that such behavior might exist outside of his control: "Just a dramatic incident in your life. Maybe a death or a loss or anything that would push a person to depression, I could see that, you know, altering your focus on your goals."

Still, reconstructing his self-image did not occur in a vacuum; this process was rooted in his material circumstances that allowed him to rebuild his self as he rebuilt his life, as will become clear.

Self-control as desirable ancillary outcomes

Participants who talked about achieving self-control also tended to be those who were more likely to realize the ancillary outcomes intended as a natural outgrowth of self-control, such as improvement in their social relationships and employment and educational opportunities. They tended to return to stable or, in very select cases, upwardly mobile trajectories. They also, then, could more easily disassociate with their troubles, which emerged as an aberrant contingency of the past. They thus were not routinely confronting adversity that caused the kind of psychological distress that made their lives and themselves feel (or look) out of control. For them, self-control could be experienced as a beneficial pathway to a better life.

This was very clear in Jenson's case. After several years of fallout in most of his social relationships, he experienced growing support from friends and family, reestablishing "a safety net" that he viewed as critical to his wellbeing. He also started and maintained a much-desired romantic relationship with hopes that it might eventually result in marriage. He regained employment, working in construction (which he quit because the scheduling did not work for him), part-time retail work (for his girlfriend's parents who ultimately fired him upon learning of some of his problems), and then gaining a position as a fulltime car salesman. He also was on the path to regaining independent housing, living with his mother in a local suburb (although often staying with his girlfriend) with the plan to move into a house with his girlfriend that he and his

father had already purchased for Jenson to fix up and profit from the resale value. By all accounts, as Jenson became more self-controlled, his life was improving, and he envisioned it only continuing to improve, as was clear when he explained where he would be in five years:

> "I anticipate being with her [his girlfriend]. I anticipate having two little ones.…I anticipate possibly being at the position I'm at [as a car salesman] or a greater position. I did it for a year. I'm hoping I can do it for five years and keep going up the ladder, you know, with all aspects of life. So, five years, I mean really just…I'd like to be, really, I'd like to be making about $120,000 a year, have a couple of kids and a wife."

For Jenson, as he progressed through the program and pursued key treatment goals, the life he wanted to lead was increasingly (back) in reach.

Yet, whether this shift can be explained by changes in his mental health, he was also positioned in a way that made these ancillary outcomes possible. He could turn to his social network, predominantly if not entirely middle class (and upper middle class), for different kinds of support. Most notably, his father, who also worked in the oil and gas, provided him with material support in terms of not only housing, but also transportation (regaining his license and a truck[66]) and legal matters (some ongoing). Moreover, in contrast to almost all his peers who remained unemployed or relegated to the lower tiers of the job market, Jenson did not struggle comparatively with gaining employment. As reported, he managed to secure three separate jobs across his participation, viewing his final position working in car sales to be a promising career path. He attributed landing this position in part to his renewed self-control: "If I wasn't taking my medication, I wouldn't have had a good interview." However, by his description, more was at work than just his mental health. Unposted, he learned of the position from an employment specialist telling him:

> "'I got this guy over here and he's looking for maybe someone that was an athlete, you know in college. Somebody that was a go getter, that's not afraid,' you know, and I'm a people person. So, it worked out good."

(Jenson did not reveal his mental health status or participation in the mental health court to the car salesman and his criminal record was not held against him (although for a discussion of how race favorably shapes hiring decisions for white men, see: Pager 2003, 2017, and 2009 with Western and Bonikowski).) No other participant recounted being referred to a similar position

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[66] Jenson reported that he had given his father the truck in the past, but still his father was able to hold onto it and keep it in good repair and drive it up to him from another state, providing Jenson with transportation.

despite, in principle, having access to the same set of employment services and most describing desiring more favorable employment opportunities.

Moreover, such a trajectory must be viewed in terms of Jenson's relatively unique criminal justice history. He already had experienced unusually high level of supports due to his social standing, with his father intervening and supporting him at key moments when he was arrested on other misdemeanor charges. He was linked to private psychiatrists and treatment rather than simply being punished in some cases, and he already had two charges dismissed. He thus entered the court program expecting a degree of leniency, describing of mental illness:

> "You're able to use it in court, you know not mental health court, but just any court that I've been in. I think I've had five or six arrests in four years. So obviously there was a reason for that."

Jenson's experiences in the criminal justice system and in the court specifically thus further shaped his ideas about self-control, as discussed in more detail next.

Self-control as legitimate and/or manageable institutional goal

Finally, it is important to also recognize that participants who described achieving self-control were those who tended to have better experiences in the program and thus could see the program and its goals as relatively legitimate or, at least, manageable (see also: chapter 4). Often enough, their positive outcomes outside of the program translated into positive outcomes inside of the program, where they could more easily meet program requirements (such as obtaining and maintaining employment) and thus reap program rewards without triggering undesirable court regulation. At a minimum, these participants could perform self-control to reap the rewards program completion promised, such as avoiding incarceration and, in some cases, dismissal of criminal charges.

Jenson fits this mold. For him, the program worked. "I think without it [the program], I wouldn't have gotten on the right track. I think I would have stayed with the ups and downs into trouble – in trouble, out of trouble type of thing." It was "strict," but also "definitely helped." However, this was not merely because of his willingness to take medication; Jenson had the resources to make the program work to his benefit. This was particularly clear around his experience with community service. While many participants described significant concerns about this requirement as a form of undesirable court control, Jenson had a much more positive

outlook. Community service had its intended effect. He was one of only a few participants who secured an agreeable placement through a relative (as opposed to being assigned a placement by the court) and then substituted employment for the requirement altogether.[67] He thus concluded of community service: “It gave me something to wake up for, you know, instead of just going to the gym for a couple hours every day, I had a couple hours of that to do. And then I got a job.” His participant tended to enhance his understanding that program goals worked as intended.

Moreover, even when Jenson viewed program requirements as a form of undesirable control, he still found a way to manage them. He maintained a sense of entitlement (as described in chapter 4) around what he could expect. For example, after being court ordered to stay at a substance use treatment facility, he was kicked out, describing issues both sleeping there and dealing with how the rules were enforced by “ex-heroin addicts…I didn’t think that those people had the right to tell me what I could do.” Jenson further likened the facility to jail: “There’s 60 guys in there and you sleep in a room with 8 guys and you’re at a different level. And you’re not allowing any communications outside. Well sorry, I’m out of jail. I did my time.” Jenson was jailed temporarily for being kicked out but ultimately allowed to do what he had wanted—move home with his mother. Hence, while Jenson initially had problems with his placement in the residential facility and also was caught using alcohol (self-reported to a psychiatrist which—to his surprise—was reported back to the judge by his case manager) and marijuana, he generally did not describe himself as struggling to meet his needs through the program. He could accommodate the program, and it could accommodate him. Further, his desire to accommodate it was bolstered by his desire to have his charges dismissed, which he thought could have

[67] According to participant reports: Four participants were employed and remained employed throughout their participation or otherwise were not required to engage in community service (and, in fact, it is noteworthy that Jenson was employed prior to entering the mental health court, which he could not restart, compelling him to identify new work alternatives). Another five participants followed Jenson’s trajectory, gaining new fulltime or part-time employment after entering the program for relatively lengthy durations (albeit comparatively in lower tiers of the service industry). Six more participants gained employment right at the end of their participation (in lower tiers of service industry) or during their participation that was only temporary (in, two cases, only for the holidays). Five more participants reported maintaining contract work with individuals, which helped them avoid community service, but did not seem entirely stable (if existed at all). Three more participants participated in high school or high school equivalent programming. One participant was in college (but had to drop out temporarily) and one participant started technical college courses. The majority of participants, including most of those listed above who were not employed throughout their participation, engaged in community service at some point and fourteen were engaged in community service without ever gaining employment while in the program. Two participants were engaged in more intensive treatment programming and nothing else. One participant was terminated prior to any work-requirement being put in place and one never had a work-requirement enforced (likely because he had a more severe disability).

negatively impacted his otherwise promising employment prospects (although, in fact, given his privileged status he was able to obtain employment despite this criminal record).[68]

Self-control as package deal

Many participants described benefitting from self-control at various points during their participation, if not increasingly across time. Yet, understanding such talk requires excavating what it helps individuals accomplish as a package of goods, which Jenson's case demonstrates. Jenson certainly might have been achieving a greater state of self-control as intended by the program. That is, reducing his substance use and taking psychiatric medication positively altered the biochemical processes driving depression and mania, and psychosocial interventions helped him develop the habits and skillsets to make better decisions. Still, this achieved state cannot be viewed in isolation if we are to investigate why it becomes more possible for some participants and not others. For Jenson, self-control was not just a state of being, it was also an interpretive framework that he could accommodate and from which he could derive benefit. It was a way to jettison the stigma of undesirable conduct, associated with a past self out of control, and render the positive outcomes he was now experiencing in his life as an outcome of his (self-controlled) efforts. Moreover, Jenson could engage in this interpretive work while maintaining that he ultimately maintained a capacity to be self-controlled. Medication assisted him, but only to the extent it helped him realize his authentic self. This is an important point of distinction, as will become increasingly clear below, given that it establishes that Jenson ultimately could be trusted to take control of his life.

Importantly, Jenson represents an extreme case as almost all his peers were less privileged than he. He thus likely both experienced heightened concern around stigma associated with his troubles (relatively aberrant within his social group and which could otherwise degrade his relatively high status) and had the greatest resources to rebuild a life in which he could move

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[68] He also avoided an alternative sentence, but Jenson seemed most concerned about the dismissal of the charges. He stated that he would just have "got time served" if he did not do the program, but he was concerned about having the criminal record—"just for jobs, I mean it would have hurt my record, you know, having that stuff on there, so it's a good thing getting it taken off." However, given multiple charges even beyond those that led to his program participation, Jenson still struggled with having a criminal record. For example, despite only needing a few credits to graduate from college he was cynical that doing so would work to his benefit given that he could not work with kids as intended due to his criminal record. Moreover, he wanted to coach basketball at a local church, but was informed he could not do so due to his record.

beyond them. In other words, he was particularly well-situated to draw upon and benefit from the interpretive goods self-control had on offer.

However, other participants turned to self-control to accomplish similar kinds of interpretive work, such as securing reprieve from guilt and blame. For example, about half of participants focused on how symptomatic or under the influence they had been at the time of their offense, with some especially clear that they were not themselves at the time of the offense, e.g.: “I was really high the last time. I don’t remember really nothing.” “I wasn’t all there upstairs.” “I completely lost my mind.” “I wasn’t really a willing participant in what I did.” These participants might have been speaking to a mental state, but, like Jenson, they were also staking claims about personal responsibility, as the last quote most directly shows. From this standpoint, even a participant like Lutz (described in chapter 4) who was ultimately only diagnosed with “a character defect” and thus arguably never symptomatic, still could carry out similar kind of work. He, like a couple of other participants, reasoned that he did not deserve to be incarcerated given that his criminal offense had been “a stupid mistake” resulting from a “bad decision” and problems with “impulsivity.”[69] Mirroring Jenson’s case, these participants worked to disassociate from past conduct, signaling that it was connected to a lack of self-control that did not reflect their true self (now again in control). Many, then, could use their program participation to reaffirm this sense of self and, often enough, provide a material basis for it through the dismissal of criminal charges and/or avoiding incarceration.[70]

Moreover, while these participants were comparatively less privileged than Jenson, they still tended to maintain the cultural, social, and economic resources that allowed them to both accommodate and benefit from this kind of interpretation of themselves and their problems. These participants commonly envisioned identity repair as possible given that their social

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[69] Recall that Lutz was also eager to distinguish himself from his criminality: “I’m not just saying that the crime that I committed was okay in any regards, but the type of person I am and the character that I have, I just think this was like a really stupid mistake that I had made.” He explained further: “I’m not a bad individual; I made a bad decision I made a bad decision, I know that, [...but] I’m not necessarily the type of person that should bear the full consequence [of] the action that they committed if they could learn their lesson and improve that.” Notably, a couple of other more privileged participants similarly attributed their offense to impulsivity and poor decision-making.

[70] Thus, a female participant who saw her offense as a product of symptoms described how the program helped her learn “forgiveness of self. It showed me that it’s okay…not to be perfect.” She further described of what she gained from the program: “The opportunity to get this off my record and have a clean record again is just, to me, something this remarkable, you know. A misdemeanor to me is just something that was, you know, just horrifying, you know, I've always took pride in having a clean record and being a good citizen, but it [the offense] wasn't done at a malicious means.”

identities and prior (limited) criminal records (or lack thereof) were not otherwise likely to lead to status loss and discrimination. Additionally, they were more likely to achieve the kinds of positive ancillary outcomes like gaining employment or social support that could be attributed to self-control and not routinely confronting adversity that could be attributed to a lack of self-control. This translated across their experience in the program, where such positive outcomes meant they faced less regulation and could envision the program's focus on self-control as working to their benefit. In such cases, participants were positioned to ensure a state of self-control was possible, necessary, and beneficial.

Yet, to better understand this position in which participants were capitalizing on the program's focus on self-control, it is important to examine comparatively those that struggled to do so, as I turn to next.

When participants describe struggling to benefit from self-control

Self-control as elusive state

On the other end of the continuum, participants described a significant struggle to benefit from the program's focus on self-control across their participation. Like Jenson, they recounted experiencing emotions, thoughts, and behaviors that had felt out of their control and caused them problems. However, achieving a state of self-control was described as at best temporary or otherwise out-of-reach. The skillsets and habits that participants were being taught were not changing them or their lives. They were continuing to confront the same set of issues the program intended to regulate and improve upon such as substance misuse and abuse, education and employment setbacks, interpersonal conflict, and, in some cases, ongoing arrests. Their lives were not becoming more manageable.

This was exemplified in the case of Stevenson, a black female in her late teens. Stevenson reported that she joined the program after being charged with her first criminal offense—misdemeanor retail fraud. She did not view this offense as linked to her mental health. In fact, she attributed it to wrongly being assumed an "accessory to a crime" when shopping with her aunties and their friend who had engaged in retail theft unbeknownst to Stevenson. She decided not to fight the charge because "people be racist and plus they can do anything to that camera [in the store recording the incident]." Already participating in the mental health treatment

system, she was referred to the program by a judge who she thought told her it was a six-month program, although it turned out to be yearlong. She said suspiciously of the conflicting information: “So who is lying?” Still, she maintained that she chose to do the program over spending a day in jail “because I think it would have helped me better and stuff like that.”

Stevenson thus presented as much more cynical about how she had entered the legal system when compared to Jenson, but she still described being very open to the pursuit of self-control. She expressed that she bought into having a mental illness that required treatment. By her account, she had been diagnosed with bipolar disorder, anxiety, and attention deficit hyperactivity disorder “when I was real little,” possibly five or six years old.[71] She had difficulty remembering the specifics of how it happened but linked it in part to “throwing temper tantrums, anger problems and stuff like that” and reported remaining in mental health treatment ever since.[72] She described her mental health condition as “one minute I’m happy, one minute I’m mad.” Thus, also like Jenson, she reported wanting treatment to help regulate her emotions, particularly her anger, and the problems they caused with her behavior. For example, when asked how treatment could have been better tailored to her in the past, she suggested: “To help me more probably put me on some stronger meds so I won’t, um, fight or nothing or get in trouble or be disrespectful and stuff like that.” Furthermore, she explained of how she would know when she could discontinue medication: “If I’m mature enough and act civilized, stuff like that.” Along these lines, Stevenson consistently expressed that she remained in pursuit of self-control.

However, unlike Jenson, Stevenson signaled that self-control was elusive. Already actively participating in treatment at the time of joining the program, she was clear that treatment had not provided her with the “stronger meds” she had needed in the past. In fact, this became a reoccurring theme across six interviews. Stevenson repeatedly was caught up in interpersonal

[71] Stevenson also suggested in her third interview that she had been diagnosed with “schizophrenic” through one treatment provider, but when asked whether she viewed herself as having schizophrenia, she said, “I don’t know. I don’t even know what that is. They say I was diagnosed with it.” She did not bring it up in any other interviews and never discussed or presented symptoms specific to schizophrenia.

[72] Stevenson appears to fall under a larger a trend in which children’s problems, particularly at school, have increasingly become medicalized (Conrad 2017, with Potter 2000; Ravalovich 2001, 2005; Malacrida 2004). That is, disruptive behavior becomes labeled as the product of a disorder such as Attention Deficit Disorder or Oppositional Defiance Disorder and treated through psychiatric care as opposed to, for example, discipline by the principal or parents. While some behaviors so labeled have been found to have a genetic basis, it is also clear that diagnosis is shaped by many social factors including changing expectations for children in schools (Hinshaw and Scheffler 2014) and the increasing medicalization of social problems (Conrad 1992), as well as the racialization of these problems (Gold and Richard 2012).

conflict with family members, classmates, and teachers that could lead to trouble like when she "busted out" her grandma's window or was kicked out of class by her teachers. She also sometimes was accused of being disrespectful with court staff, along with more typical forms of noncompliance such as missing appointments and using marijuana. As such problems emerged and reemerged, she doubled down on her pursuit for (medication-generated) self-control. She just needed "some stronger medication" and "the right medication": "My medication can help, but then they not prescribing the right medication. My momma also said that too." Stevenson maintained such a perspective even when her medications were adjusted. Hence, upon completing the program and while still connected to and participating in treatment, she reiterated this theme: "My anger and anxiety is still acting up. But I'ma find me a new counselor or med doctor and prescribe me my medicine."

Self-control as identity trap

Importantly, similar to their peers who described achieving self-control, participants like Stevenson were very concerned about identify repair. However, in contrast to their peers, they did not signal that talking about self-control could help them engage in such repair, or at least to the same degree. In fact, as will become clear, such talk could function to minimize their problems and tarnish their identities. Still, adopting it could also function as a protective buffer from court regulation (and school teachers and family members), signifying participants were trying to achieve an institutionally-legitimated goal (i.e., becoming more self-controlled). Many participants thus often were caught up in trying to determine when and how to employ a discourse of self-control without being misread or discredited.

Stevenson elucidates how this could happen. The more Stevenson repeatedly returned to a need to adjust her medication to better achieve self-control, the more Stevenson also signaled that she found such a solution inadequate given the kinds of problems she was persistently confronting. Stevenson certainly struggled with managing how she reacted to others in ways that appeared as though her emotions, thoughts, and behaviors were out of her control. However, often enough, Stevenson described such reactions as rational responses given how she interpreted the social world around her—a world in which she struggled to feel understood and respected. Outside of relationships with her mother and grandmother, Stevenson tended to

describe herself as otherwise isolated from meaningful relationships with others. By her account, she was routinely disrespected, whether by extended family members who were "fake" and exploited her, classmates who called her "retarded," educational staff who misunderstood her or just did not care about her—"they don't care, nope"—or social workers who sometimes "be coming to get an attitude too."

With this kind of orientation, ordinary interactions could give Stevenson reason to shut down or lash out, as she signaled in recounting her frustrations with a psychiatrist who asked her seemingly routine questions:

> "He just asking me stupid stuff, like he gonna say something, 'Um why are you here?' You know why I'm here 'cause you got the paperwork. Somebody already informed, so why is you asking me why is I'm here? You know why I'm here, that's what irritate me."

Similarly, Stevenson recounted how she got in trouble with an assistant principal at school:

> "Because the principal said I could sit up there at the front [of the school] and wait on somebody and then the assistant principal come up and hand me out a one-day referral. I said, 'Why do I get a one-day referral if the principal say I could sit up here?' So, I told him just to give me the referral and get out my face and he wouldn't do that so. I was pushing him. We got…I got all rowdy because *he know what he was doing to piss me off* [emphasis added], so he gave me five days instead of one day. I'm like why did I get one day anyway if the principal said I could sit up here. I don't know."

In such moments, Stevenson did not seem to view herself simply as out of control. Instead, she described herself as responding to a lack of appropriate consideration—or as she said in one such instance of perceived mistreatment: "I treat her right back." Hence, a focus on self-control alone missed a more fundamental problem Stevenson repeatedly faced.

Moreover, it missed the ways in which Stevenson was positioned to gain very different things from self-control than someone like Jenson. For Jenson, self-control was a means to overcoming a set of bounded troubles located in the past while achieving positive outcomes. For Stevenson, self-control became a way of talking about problems that extended into the present and for which she was being held to account publicly in court (as well as at home and school)—most of which she did not view herself as personally to blame. Self-control did not help her make sense of a crime she did not believe (or did not want to claim) she committed or the routine types of interpersonal conflict she experienced with peers, family members, educators, and social workers. In fact, it could be used to minimize legitimate grievances she had with others or lead her to being punished given a focus on her problematic (and irrational) reactions. Moreover, with

a self-image she perceived as constantly under siege, Stevenson was hard-pressed to consistently envision that aligning with such a pursuit would lead to desirable outcomes such as the ever-elusive respect she wanted. In other words, self-control did little to help Stevenson secure lasting reprieve from undesirable blame, locate the kind of agency that made her feel in control of her life, and reconstruct an identity disassociated from the kinds of problems she faced.

Still, Stevenson commonly returned to describing herself and her problems in terms of a lack of self-control, despite the fact that when probed for information it was clear that she had more complex views.[73] After all, she recognized this framework to be the dominant way of making sense of herself and her problems. Even beyond the program context, it was made readily available to her by those around her including her mother, who she described as her closest ally, and educational and treatment staff. Thus, for example, when she argued with the assistant principal she explained that she was placed on a higher dose of psychiatric medication at the recommendation of her school social worker in consult with her treatment providers, with Stevenson's support. Subject to such overlapping forms of control where her choices were heavily scrutinized, she was quick to confirm: yes, she needed more (medication-generated) self-control.

Moreover, Stevenson signaled that self-control offered some benefit as temporary reprieve from blame (as problems could be attributed to the inadequacy of medication rather than a character flaw). Thus, even though Stevenson generally expressed being a devout supporter of medication, she also indicated at times that this devotion was undergirded by strategic motives. For example, as she was asked about her failure to fully comply with several court-imposed requirements, she talked about how she was having a difficult time:

> "I'm still angry. And I told [my case manager] that. …And then I'm telling the judge the medicine not working, I'm telling the judge and they'll probably, in the courtroom it's recorded. Then if something pop off or happen, she can't put me in jail 'cause I been told her that the medicine is not working. I told [my case manager] too, so."

[73] For example, when asked what Stevenson had to do in the program, she explained: "I got to be on my ps and qs and not get in trouble and stuff like that." When asked what led her to trouble, she described: "when I don't either, like, listen to the worker [her treatment case manager]…like when I don't take my medicine or be bad or be disrespectful in school or get kicked out of school, yeah." Stevenson first and foremost framed trouble in terms of managing her "bad" behavior despite also maintaining an alternative interpretation of this behavior, as she explained what led her to be disrespectful when further probed: "When they be disrespectful to me. You can't do that. You gotta respect somebody if you want respect back!"

In such instances, Stevenson indicated that expressing the failures of her medication was not just a statement about her needs, but also an assertion about the kind of consideration she (formally) deserved. (And by that point, Stevenson had already been jailed twice for noncompliant behaviors, recounting how she had been unable to convey to the judge how she "was stressed out, having a hard time" when jailed. Hence, she seemed to think she needed to proactively assert this claim moving forward.) Stevenson thus often wavered between two poles: she could attain self-control if only her medications were adjusted and it was not about her problem with self-control—nobody was listening to the ways in which her perspectives and experiences were being disregarded.

Self-control as circumscribed

Finally, it is important to return to what the pursuit of self-control was delivering for these participants outside and inside of the program. Participants who described self-control as elusive were also describing the ways in which they were facing repeated obstacles and setbacks that revealed the deficiencies of self-control as a pathway to achieving the kinds of ancillary outcomes realized by their peers. While self-control offered the promise of new possibilities for the kind of life they could lead as self-regulated beings, they confronted how these possibilities were circumscribed to and disrupted by the circumstances in which they were embedded. This, then, often translated into the program, where they became subject to amplifying forms of regulation as their problems emerged and reemerged.

From this vantage point, Stevenson's talk around self-control must be understood as part of a relatively durable way of acting, feeling, thinking, and being rooted in Stevenson's past and present circumstances. In stark contrast to Jenson, Stevenson was embedded in a set of conditions in which she was likely to be treated as childlike and in need of control rather than the kind of respect she aspired to receive. By her account, her behavior and attitude appeared to be a constant focus at school, where she was in special education and extended in the 11th grade, and at home, where she remained dependent on her mother and Social Security Income (until the court ordered a state service to manage it close to when she graduated, which Stevenson planned to revoke). She intended to depend on both indefinitely. While Stevenson often talked about pursuing employment, her job opportunities were significantly constrained given her lack of a high school diploma and, likely also, the issues that led her to be placed in special education.

Unemployed, she was often left fighting with her mother for her income or transportation or asking others like myself, her case manager, or her family members for such support and becoming frustrated when her demands were not met (notably, this was a behavior that seemed to contribute to her sense of being exploited by others).[74] Furthermore, whether as a result of cognitive difficulties or coping strategies, Stevenson often exhibited behaviors such as shutting down or lashing out that could garner the very kind of consideration she despised.[75] Hence, while Stevenson was often ready to see mistreatment before it emerged, it is reasonable to assume that these perceptions were rooted in (as well as shaping) her experience.

In some ways, the program seemed to disrupt this dynamic as Stevenson described valuing specific staff members in contrast to her common description of others and feeling very supported in key moments. However, in other ways, the program became another space in which Stevenson replicated her struggle for ever-elusive respect and became subject to undesirable control. For example, when not in school, Stevenson would miss or only partially attend mandated community service or outpatient treatment groups, describing staff associated with them as racist, stupid, and irritating. In fact, in stark contrast to Jenson, she recounted how she decided to stop doing community service (at a food bank to which she had been assigned by the court) not because she had obtained employment but rather administrators were "trying to work me to death" and unfairly enforced rules: "I see stuff and I know stuff. Just like they was stealing, eating candy, stealing eating food, but they expect us not to eat no food." In a similar vein, she described of whether two jail sanctions she had received in the program (one tied to angrily breaking her grandmother's window) were motivating:

> "Something like that. I told you I was still angry. You didn't hear me before? I told you, I was still angry. They not doing nothing about it, so what else can I do? I told her—the judge—already so I don't know."

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[74] Stevenson was unemployed for most of the interview period. After graduating from the program, in her final interview she reported that her mom helped her gain part time employment in the fast food chain she managed. It was too early to say what kind of effect this would have on Stevenson, but she viewed her employment as supplemental to her ongoing dependency on her mother and Social Security Income.

[75] After spending lots of time talking with Stevenson, it was clear how interactions with others could break down. Stevenson was easily distractible and often focused on what she could get out of the interaction, whether in terms of a ride, Hot Cheetos, or just some entertainment (which might become more problematic at school or community service versus a voluntary interview). She generally stayed focused for the first twenty minutes of interviews and then her attention started to wander significantly. Furthermore, concerned about how others interpreted her, she could easily become frustrated, shut down, or be purposefully obtuse in responding to questions. It thus took significant effort to figure out how best to engage her. Still, she was generally high spirited when treated respectfully and often described valuing those who she perceived as treating her with respect. Her good regard was just very hard won and had to keep being fought for, along with her attention.

By Stevenson's account, court regulation often proved unfair and ineffective, with her failing to pinpoint an underlying legitimate logic to it. (Although, such accounting served a dual purpose in the interview context. Stevenson was not only describing the shortcomings of court regulation; she was also demanding attention be paid to the kind of consideration she deserved but was not gaining from court staff.)

Self-control as broken promise

Stevenson was an exceptional case in many ways, most notably as the youngest participant interviewed (and one of the younger participants in the court). In fact, one concern might be that Stevenson is not a comparable case to Jenson precisely because she is so different, including in terms of her more extensive mental health history that could be indicative of greater mental health issues. Yet, the goal of this analysis is to move beyond an assumption that participants' differential experiences can be explained away by variation in their symptoms and cognitive functioning. Instead, it is critical to unearth the ways in which such experiences are tied to a broader set of social conditions in which participants operate. It should be clear that Stevenson and Jenson inhabited a very different set of conditions that positioned them unequally to capitalize on the benefits of self-control regardless of their varied mental health experiences. After all, like Jenson, Stevenson was subject to both psychiatric and psychosocial interventions (with the benefits of therapy also proving elusive as her relationship with a therapist quickly devolved when she was accused of stealing a pen and playing with her phone too much – a behavior pattern Stevenson also exhibited in interviews that the therapist did not seem able to overcome).

For participants similarly positioned to Stevenson, capitalizing on self-control became a struggle. The interpretive goods it offered were often not easily accessible or beneficial. Some did not find self-control useful for understanding an offense viewed as the product of unfair and unjust actions carried out by agents of the criminal justice system or difficult moral choices they had to make that had resulted in their criminal justice involvement. Many were not positioned to engage in the kind of identity repair exemplified by Jenson, signaling that the stigma associated with criminality or mental illness proved too sticky or otherwise unresponsive to the kind of

repair the court was offering (and its important to recognize that individuals develop other ways of carving out identities in criminal justice contexts where they are subject to stigmatizing processes, see: Rios 2009; Trimbur 2009; Shdaimah and Leon 2014; Rajan et al. 2014).[76] Moreover, all faced persisting and reemerging troubles that they both did not want to attribute to themselves, but also hoped not to be punished for within the program. Facing dual pressures, they turned to self-control under some conditions, particularly when it indicated they were not to blame for the latest problem that emerged (as a self out of control), and not others, such as when it minimized the legitimacy of their perspectives and experiences. For these participants, then, self-control served a set of more temporary benefits. Often at odds with their lived experience, they could not consistently reap the same goods that their peers were gaining across time.

Furthermore, pursuing self-control could work to their disadvantage, serving to marginalize the real problems they faced. For example, Stevenson often recounted her reactions to the social world as shaped by a fear of disrespect. Whether this perceived lack of respect was the result of her lashing out and shutting down, it certainly did not appear as merely a delusion. Rather, Stevenson signaled such an orientation was the product of cumulative exposure to conditions in which she was subject to disrespect. In other words, she had "internalize(d) the necessities of the extant social environment" (Bourdieu and Wacquant 1992, p.13), even if she entered spaces like case management or psychiatric offices where individuals were not

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[76] Some participants were clear that they would experience stigma no matter what happened to them. For example, at one extreme, a male participant described of how he was routinely judged given an extensive criminal justice background and thus in some ways found prison a reprieve from such judgment: "I didn't miss all the drama. I didn't miss the stares [in the community], the 'oh shit, that guy's been to prison', those kinda things, you know. I didn't miss those little snide comments like 'oh, you know you've been to prison. You ain't going to do nothing. You going to prison again.'" Moreover, many participants signaled that criminal stigma was no longer at the forefront of their mind; it had just become a part of their experience. This emerged most notably in talk around jail sanctions. While Jenson articulated concerns about being around and feeling like a criminal when jailed, for other participants such concerns were absent. For, example, when asked if jail sanctions were helpful, one replied: "Well, it's how people think. Don't nobody want to go to jail. But for a guy like me whose been in jail multiple times—I did [time] in jail, [time] in prison…and she giving me a week in jail, it's nothing to me. Now I ain't saying that it…you know I'm getting it, but I'm just saying I'll do that on my head. I'm in here for a week. I go to jail, in the dayroom, all these guys is going to prison and I'm thinking in my head, I'll be out in six, five days. That's *nothing*." Similarly, another described of how jail sanctions would work for him: "Me personally, I've been locked up since, my first time getting locked up was in [a specified year] and I hated it. But when I caught this charge I sat so long I kind of got comfortable, it's like when I go to jail, I know how to rewire my mind to adapt to jail. ….I just think about, I just visualize, all right look I'm in jail, I'm in the bullpen. It's like once I go into booking and they throw me in and they take my shirt and my clothes off and they put me in oranges and they throw me in the bullpen, that's when the rewiring happens. That's when I'm not Gilbert in the free world, I'm Gilbert that's in the system now that's in the cage like an animal. So therefore I become Gilbert that's in jail."

automatically approaching her with disrespect.[77] Focusing on her "bad" behavior under the guise of self-control would gloss over these conditions. It would neglect the ways in which this behavior could serve a useful function in some contexts where she would continue to contend with the social dynamics that produced it. Moreover, by default, it would compel her to accept those dynamics as natural and inevitable. It was her internal dysfunction that was to be changed, not that of her social environment. While some of the particulars of this dynamic were unique to Stevenson, many participants confronted it as they struggled with the demand to conform to the social arrangements in which they were embedded.

Of course, the vast majority of participants were often describing ways in which the program's focus on self-control both did and did not serve them. Therefore, to better understand the ways in which participants did or did not capitalize on this focus, I turn next to examining the case of a participant who presented a more varied relationship to self-control.

When participants describe losing out and gaining from self-control

Self-control as multi-faceted experience

In many ways, the cases described above represent extremes as two ends on a continuum. After all, the vast majority of participants were more socially disadvantaged than Jenson, but few remained in a set of conditions in which their behavior was continually subject to control mechanisms even outside of the court context like Stevenson. Hence, more commonly, participants were identifying ways in which the program's focus on self-control worked to their benefit just as it also could marginalize some of their problems. I thus now turn to the case of Newman[78], a white middle-aged woman who fell more in between the poles established above to

[77] Furthermore, a more basic challenge to helping Stevenson is that her orientation is embedded with distrust. She certainly identified select staff members who she valued and trusted (although this could be undermined at times by court control and her negative reactions), but Stevenson did not automatically assume professionals would treat her with care or respect. Hence, professionals had to overcome this distrust and, as her experience with the therapist indicates, many could not do so easily. Moreover, doing so could be undermined by the temporariness of provider-client relationships as case managers, therapists, and other treatment providers rotated through the treatment system and/or became increasingly frustrated with her behavior (thus reinforcing the idea that Stevenson could not reliably trust anyone to care about her beyond her mother).

[78] Newman is the only participant who requested having her interviews not recorded (with the exception of the final interview, which was recorded). Hence, quotes are used from the transcribed interview or when I could transcribe phrases she said verbatim and brackets are used to delineate notes typed as she spoke and reviewed by me immediately after the interview.

further demonstrate how the pursuit of self-control could function in a variety of ways (even across the same case) in the court context.

Newman certainly fell somewhere between Stevenson and Jenson. By her account, she had earned an associate degree and had a prior history of employment in retail establishments but had been left dependent on her mother after years of heavy drinking, increasing physical (but mostly non-visible) impairments, and educational setbacks that resulted in the loss of student loans she had been using to get by. Her mother was not financially well off, but she owned a small home where the two had lived together for several years, albeit often in discord. A couple of years prior to joining the program, her mother had called the police on Newman during a fight. Police took Newman to a local hospital rather than arrest her and she was diagnosed with bipolar disorder. She soon applied for Social Security Income, which she was granted. Despite this new source of income, Newman continued to live in discord with her mother, resulting in another fight and intervention by the police. This time, Newman was arrested and charged with misdemeanor assault and battery, but she was given the opportunity to dismiss the charge through participating in the program, which she was eager to do. (A No Contact Order was placed between her and her mother and she was placed in a residential substance use treatment facility.)

Newman had different – and sometimes conflicting – things to say about her pursuit of self-control, particularly across time. Like Stevenson, in some ways she was caught up in a frustrating control dynamic that appeared to contribute to her desire to reject the notion that she struggled with a problem of self-control. However, like Jenson, she was invested in the court's project of identity repair and open to rebuilding her life in part through the pathway the court provided to her.

Self-control as identity trap and identity repair

Newman entered the court program relatively angry – anger that was still very visible less than one month after her entry in her first interview. Most notably, Newman was angry about the ways in which her more recent criminal justice involvement, which she viewed as instigated by her mother, were attributed to Newman's lack of self-control. She recounted with great frustration how her mother had called the police when Newman purposefully knocked over her

own Christmas tree (and, she added in a later interview, accidentally broke her mother's laptop). Newman viewed the charge as illegitimate in part because she did not physically assault her mother – "I did not assault anybody" – but predominantly because she was not personally to blame for it. Her behavior did not reflect a self out of control, but a rational response to her mother who always "does stuff to push buttons" and "likes playing mind games" including moving the Christmas tree after Newman had explicitly asked her to not do so. For Newman, this altercation and resulting arrest exemplified a persistent and dysfunctional dynamic tied to *her mother's* undiagnosed mental illness.

Newman reiterated this kind of logic when recounting how her first arrest was triggered by her mother: [She acts like it's all me. When I get mad, she is calling the police.][79] She explained further: [I'm not saying I didn't do anything wrong. Yeah, I did. I allowed myself to be in that situation. Full well knowing she is like that and I am like this, thinking it could work.] By Newman's account, living with her mother had been the bad choice she had made – "maybe I thought I was Wonder Woman"; not knocking over her Christmas tree.

Newman thus explained in recounting of a therapist asking her if she felt like she needed anger management programming:

> [I think I need somebody who has the problems my mother has to not be in my life. It took three years of living with her for it to get like this. I have patience. I finally snapped on my own tree. I didn't threaten anybody else. This whole thing is blown out of proportion and no I wasn't on any medication. If she were to do that to me right now even though I'm on medication, I might do the same thing. If someone does that to me, I still will react that way.]

Newman further elaborated on this kind of orientation when asked about the disadvantages of having a mental illness:

> [It gives my mother leverage to say I've got problems, but then she acts like she doesn't have problems, but that I do because I've been diagnosed. She has problems too, which aren't taken into account just because she hasn't been diagnosed.] [80]

In this vein, self-control had been used against Newman to attribute interpersonal problems driven by her mother to Newman.

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[79] For an explanation of brackets, see footnote X.

[80] By Newman's own account, her mother had such power prior to Newman having the label (as Newman recounted that she was first diagnosed when her mother called the police on her and she was taken to the hospital by the police). However, this does not ultimately change the fact that Newman described her mother using this label to exert control over her.

Still, Newman also entered the program with a belief that her life had gone off the rails. Once relatively sociable and independent, she had become socially isolated, dependent, and developed physical health and dental problems – all of which caused her serious aggravation and led her to tear up as she talked about it. Thus, like Jenson, Newman turned to self-control to the extent it could help her make sense of this derailment. In particular, Newman focused on the detrimental impact of a drinking habit over which she had lost control. By her account she had been "sick, so to speak," with her life revolving around "medicating" with drinking. "I couldn't control it." She would close bars and sometimes drink all day. This was a problem in and of itself, but it took her time and multiple drunk driving charges to realize it. She started "dabbling" in therapy (after years of probation in which she was mandated to participate in Alcoholics Anonymous) and began to address the "core" issues associated with her drinking. Therapy helped her gain some self-control over her drinking – she learned how to reduce both her consumption and problems like the driving associated with it. Hence, at the time of her first interview, Newman was clear that she did not currently have a drinking problem. However, still caught up in the aggravation of isolation and dependency, she did not view herself as having achieved the right balance of internal controls to lead a better life by the time of her first interview. She recounted that she was still "emotionally and physically a mess." She had "reprogrammed" her brain and needed to "un-program" it. She explained: [I operate in the same sick way even though I don't use substances. It is not the substance I'm trying to beat right now; it's the old behavior.] (Although, Newman had stopped attending therapy before joining the program despite adopting a therapeutic logic to her problems.)

Newman thus rejected key elements of a self-control framework. It wrongfully assigned blame to her for key problems and legitimated court regulation, including being court-mandated to stay in a substance use treatment residential facility, have her treatment monitored, and do community service (Newman was very worried about the latter and had mixed things to say about the rest). However, the framework also helped her make sense of how her life had gone off the rails, providing her a sense of optimism that she could return to a better life like the one she had once led as she continued to address her "core" issues.

Self-control as increasingly viable – if adjusted – goal

Newman might have started the program with a mixed orientation towards self-control, but she increasingly adopted the framework in key ways across time, identifying as someone who struggled with regulating her emotions, thoughts, and behaviors. This was particularly the case in her final interview after graduating as she discussed participating in programming designed specifically for individuals with mental illness and disability that she had come to view as beneficial, including in terms of concrete services such as computer training (which she thought would result in receipt of a free computer), subsidized groceries, and case management (which she was planning on relying on to help her regain her license). Breaking from a viewpoint she had adopted on a prior probation stint in which she saw the same programming (to which probation had referred her) as designed for "idiots," she could now see that that she belonged there – "Who am I to sit there and judge them when I got all this too?" She elaborated:

> "Because a lot of times when people like us, when we get in trouble, you might say, it's not that we didn't know what we were doing was wrong. It's not that at all. You know, we're not like totally stupid and didn't know that it was wrong, but…the control and the brakes of stopping yourself when you know something is wrong and then not doing it, there's a weakness there."

She continued to apply a similar kind of logic in discussing how the programming really helped her:

> "Whenever anything else comes up. If it's something that's too… Sometimes I get frustrated, I'm very intelligent, but when I'm emotionally upset, or stuff is going on, my intelligence goes out the window. I'm like a babbling idiot. It's stupid, can't even figure out the simplest, stupid thing and then go 'Duh!' After you go, 'Why didn't I think of that in the first place?' It screws up all my thinking. And sometimes I just need somewhere to go to have somebody to help me do something. It's crazy because it's as simple as, you know, trying to get some checks ordered for my checkbook or whatever. They were screwing me around and I couldn't get that…and I just get frustrated and I can't do it. And if it's something that has to be done by a deadline, I can bring it here and my caseworker will help me with it. So, I have a permanent caseworker that's just kind of like on call. You know, I don't have to make any appointments to see her on a routine or anything, but whenever anything happens I can bring it in and she will help me work through it or find the right person and send me to where I need to go to work through it and so that's helpful."

Through such talk, Newman conceded that she could struggle with self-control in ways she deemed problematic. Sometimes her thoughts and emotions were out of her control and she thus needed help.

Furthermore, Newman made concessions around her drinking in particular. Rather than describing it as mostly resolved through therapy as she had done in her first two interviews, she started talking about it as a problem given that she newly revealed that she had been drinking regularly enough (a couple times a week) such that she was never fully "cleaned out" prior to program participation. She further signaled that this drinking pattern played a role in her fight with her mother, changing the way she expressed her anger. While she reported that she was not drinking immediately prior to the incident, she suggested that the pattern of drinking still affected her. "The drinking has a lot to do with it. Drinking changes you." She thus described how she came to embrace sobriety cultivated through the program (and initially her stay in the substance use treatment facility specifically):

> "I felt better. It affects you. It changes you. You'd have to be a regular drinker and then stay that way for long enough to like almost forget what it feels like to not be. And then stop. And then notice the difference."

In this way, Newman started to provide greater space for the possibility that she had control problems and that those problems could have contributed to her criminal justice involvement.

Yet, understanding this perspective requires attending to the circumstances in which it emerged. Certainly, Newman increasingly could identify in part as lacking self-control the greater the temporal distance she gained from her charge (to be dismissed once she had graduated), her past drinking, and the personal blame associated with it (and resulting court regulation) that she initially was hyper-focused on deflecting. Moreover, while Newman maintained significant cynicism towards the legal system, she always presented as somewhat open to the court program specifically.[81] This favorable orientation was strengthened as Newman experienced several positive changes in her program participation across time, including being transferred to a new case manager, reconnected to therapy, and allowed to attend the programming referenced above rather than do much loathed community service.[82] Due to these

[81] She could tell there was something different about the program from her past experiences on probation, which she had viewed as ineffective and focused on paper-pushing. For example, she talked about the program as designed to target "the core" of problems, aiming to "heal the person from all of the pain scars substance use causes."

[82] Newman, again, was incredibly favorable towards therapy, viewing it as the one real intervention that helped her. Newman also was very favorable of this switch to the center (psychosocial rehabilitation or PSR) as she loathed community service given several reported physical ailments. Moreover, she received groceries through the center, she was expecting to receive a free computer from it once she completed a computer class that they offered, and she talked about the positive social dynamic of doing activities with other members. She also thought her attendance there would help her as she applied to regain her license. She thus maintained in her final interview after graduating that she would continue to attend PSR but would taper off her attendance. Newman also was very favorable of her

changes, like Jenson, Newman was well-situated to experience the program as a source of aid rather than control and blame. This was true even when she reported to staff using marijuana on more than occasion, leaving her "amazed" that she was never jailed. She thus likely grew comfortable aligning with the program and its goals from which she felt like she was benefitting (see also the discussion of institutional disappointment in chapter 5).

Perhaps more noteworthy, despite initially maintaining she could never live with her mother again, she had moved back in with her after leaving the substance use treatment facility where she was initially mandated to stay by the court. This move back was not probed in depth, but she attributed it to a need to save money (she contributed to rent, but it was reduced in comparison to independent housing) and a lack of meaningful support beyond her mother – "I don't really have nobody else." (Although it is not entirely clear why Newman would choose to live with her mother given an initial zeal around claiming she could never live with her mother again and having some opportunity to gain independent housing through her Social Security Income, albeit likely worse housing.) Newman, thus, no longer was solely focused on being angry with her mother; instead, she began to think about how she could continue to make their interdependency work.

Yet, most critically, such talk must be viewed in terms of the way in which it did not reflect a fundamental change in Newman's narrative about herself. She maintained that she was both ultimately not to blame for and remained in control of her actions. Her talk about a lack of self-control tended to be circumscribed in key ways. It was either discussed in terms of the past (she now had control) or her current environment (she would have control if not for key external constraints), as well as in terms of a justification for receiving support for services (she sometimes got frustrated with bureaucracies and needed help navigating them). Thus, despite increasingly describing her offense in terms of her anger and substance use, when pressed to clarify what caused the offense, she reiterated a common theme:

> "My mother. And then, why is it different now? Because I'm different. She is not different. She still does that. She will until the day she dies. She's never going to be any different and that's where I had to get straight in my mind. Stop getting upset that she's like that and expecting her to stop. She's not going to! And therapy is what really helped me. No AA meeting, or going to these support groups, or all of this other stuff that was

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new case manager and far from alone in describing this switch positively, which occurred when a case manager working with the program took a new supervisory role and thus a new case manager took over his caseload. Participants likely both viewed the new case manager as better and also, often, were then able to associate this new case manager with reductions in court control that typically proceed around midway through their participation.

> about me and focusing on what's wrong with me actually helped me in my frustration with why that happened to me because it wasn't only me. You can't just look at me as to why it happened because that's not the only reason. It was partly her. So, going to therapy and learning what she's about and what makes her click and how her mind works and that you just have to look at it for what it is: she's sick right then."

Newman, in fact, expected to eventually move out of her mother's house and indicated that until she did:

> "I will not be totally well, right. And that's what the therapist has pointed out, 'You're fighting a losing battle because you're thinking you're going to do all this stuff to make yourself well and she's going to turn right back around and make you sick again.'"

Hence, while Newman favorably talked about the program's goal of working on self-control, she ultimately maintained that she was not an individual in need of control. Rather, she had been an individual who had struggled with some controls that she was able to manage *herself* through therapy or other supports like case management. Perhaps she needed more than just "fine-tuning" given her circumstances, but to the extent she needed help, by her account, it often remained in a supportive role that she should have the autonomy to manage.

Self-control as a mixed bag

Newman signaled that aligning with the program's focus on self-control had both costs and benefits. In some ways, it could amplify personal blame, while concealing the social conditions in which actions emerged. Newman often rejected this interpretive baggage. Her actions with her mother were rational or, at least, a normal response to the dysfunction she was experiencing and for which she was not personally to blame. However, self-control also could help her secure agency over some of her troubles, such as social isolation and dependency, providing her with a sense of optimism that she could overcome them. She agreed she did have a (past) drinking problem that could be managed to create a better life. Still, Newman engaged in such identity repair on her own terms. That is, rather than interpreting her problems in terms of a (stigmatizing) mental disorder, she often turned to describing them as the product of psychodynamics that could be overcome through therapy and better housing alternatives (for a discussion of how this reflects a middleclass – higher status – orientation towards treatment, see: Kaye 2012; Whetstone and Gowan 2017).

Newman thus demonstrates more clearly how self-control was associated with a range of goods that participants differently capitalized on in the program. Moreover, in contrast to the participants described in chapter 5, she is one of a few cases in which participants signaled that they increasingly bought into some aspects of the program's interpretation of their problems. They expressed greater commitment to moderating their substance use and tending to their mental health across time. However, as should be clear, this was possible in part given how they were benefitting from doing so. For these participants, evolving circumstances made it more possible to envision the pursuit of self-control as a worthy goal.

Still, most participants were like Newman in that they described striving for some aspects of self-control and not others. For example, some participants described a desire to reduce substance use, linking it to a similar set of values as those promoted by the program in terms of cultivating more motivation to pursue personal goals such as education or employment or simply better physical health. Yet, these participants frequently were not invested in eliminating substance use, which they viewed as beneficial in the right dose (to moderate stress or pain, or simply as a form of fun). In this vein, self-control was not about abstinence, but about an ability to not misuse and abuse substances. Similarly, participants could talk about a desire to reduce distress they were experiencing through medication and/or therapy, but also view their problems as extending beyond biological and psychological states and thus requiring more than merely adjusting their internal controls. Further, some could see consistently adhering to psychiatric medication regimens as reflecting (and producing) self-control, but others were concerned about how such consistency reflected a lack of self-control given a dependency on medication (see also: Conrad 1987). In short, participants had varied relationships to the program's goal.

Importantly, this is not to suggest that participants have some neutral, objective view about their lives and needs impervious to external correction. In fact, it was difficult to know the degree to which participants like Newman exhibited emotions, thoughts, and behaviors that triggered undesirable reactions – and how mental health and substance use played a role in these processes. Newman did not talk about breaking her mother's laptop until a later interview. She also increasingly talked about how *she* had been very angry during the altercation. Moreover, when hanging around with a peer participant (a mutual acquaintance as another interview subject), the peer recounted to both of us how Newman had been talking to herself and walking around in circles around the jail (i.e., acting "crazy") when they were incarcerated together prior

to commencing participation. When the peer recounted this, Newman reenacted this scene in good humor (walking quickly in circles, talking to herself), although she never talked about such behavior in interviews. Hence, Newman might have been struggling with symptoms or substance misuse that contributed to this altercation in ways that she did not recognize or want to discuss. In this vein, the mental health court might have been a very suitable place for her.

Yet, whether or not some normative consensus could be generated around the degree to which greater internal control is both possible and beneficial in any given case, participants had to do the heavy-lifting of being self-controlled – and this process was not a uniform, universal state that all participants experienced in the same way. Some participants were positioned to struggle mightily with achieving it and seeing its value. It could be the least of their problems. Moreover, as Newman's and Stevenson's cases suggest, the imposition of external control often put participants on the defensive. They could not pursue and envision this goal without having to worry about how they were being interpreted and would be regulated. Hence, even if such participants might agree at some points that they needed greater internal controls, for many participants pursuing self-control in the program had clear disadvantages.

IV. Discussion and conclusion

In this chapter, I built on the themes presented in the preceding chapters. I continue to show how the social positioning of participants shape their experiences in this context, with a focus on their experience of the program's goal of instilling self-control. This is important because from the vantage point of the program, participants' experiences of self-control are bound to vary, but all can strive for greater self-control to their benefit. Thus, even the participant who will remain in supervised housing due to cognitive impairments is encouraged to work on better self-managing his behavior to reduce interpersonal conflict with his housemates and housing staff (which led to his initial criminal justice involvement), just as someone like Jenson is encouraged to work on his self-management to improve his relationships with his family and employment prospects.

Of course, as described in chapter 3, staff have complex views of participants. They recognize that participants face many impediments and adversities to achieving an ideal state of self-control. They adapt their expectations accordingly, threatening – but not jailing – the

participant in supervised housing despite his repeated engagement in interpersonal conflict, but jailing participants like Jenson more readily when repeating behaviors deemed problematic. Moreover, staff also recognize that participants' problematic behaviors do not merely reflect selves out of control. Thus, as just one of many examples, the judge drew upon the same analytic lens applied here in talking about how to handle participant cases with other staff, recounting in one instance how a participant's negative attitude reflected her social environment: [The way she treats everybody is the way she has been treated her whole life. She has no self-esteem at all.][83] Staff routinely work to see participants as they exist in larger social contexts and provide tailored interventions given their unique sets of needs. Moreover, when they view participants as having a particularly hard lot in life, they tend to extend themselves in a myriad of ways, whether providing more contact with participants, advocating for them in other contexts, or giving them chance upon chance to meet court standards.

Despite their best efforts to understand and help participants, however, staff ultimately are pressured by the program mandate to change participants' behavior. And they must do so without fundamentally changing much of the circumstances that produce it (see: Fisher et al. 2006; Epperson et al. 2014). In select cases, they can link participants to subsidized housing, employment, and income, as well as dismissing criminal charges and even averting prison sentences, but participants generally will remain in the same relative social position in which they found themselves prior to the program. In the face of this organizational tension, staff inevitably must turn to participants to carry out the work of change.

Self-control, then, takes center stage. It becomes a way of talking to participants to motivate them to cultivate this change even when behind closed doors staff recognize participants face an uphill battle. It also becomes a way to resolve complex cases when participants face significant problems, especially across time. While staff adjust their expectations on a case-by-case basis, by and large they expect participants to find ways to tackle some of their problems. At some point, even the participant whose attitude reflects her social environment must find a way to change this attitude and pursue some of the goals they have set out for her. As such, self-control has a relatively narrow definition within the organizational environment: a form of conduct modification all participants can achieve in varying degree. This

[83] Brackets are used here to signal that this quote was from typed notes taken during staff meetings as opposed to a transcription of a voice recording.

chapter, then, has advanced a more nuanced understanding of self-control. Self-control involves multiple moving parts: not only one's conduct, but also identity and a set of ancillary outcomes that are tied to the idea of self-control. Moreover, how it materializes in any given case is intricately linked to the legitimacy it maintains in the court. In the court context, the performance of self-control is rewarded just as a perceived lack of self-control can be admonished and even punished. However – critically – a lack of self-control also, in some cases, can serve to relieve blame, for example, as the participant's symptoms (not the participant's moral self) interfered with completing a program requirement. As such, self-control can work differently at different times and for different participants. For those already benefitting from existing social arrangements like Jenson, a focus on self-control emerges as a saving grace (albeit, one to which participants of Jenson's social standing tend to feel entitled). Facing setbacks in the form of (a) criminal offense(s), they can turn to self-control to understand their troubles and move beyond them through "fine-tuning" their internal controls (Whetsone and Gowan 2017). They, then, can re-secure existing benefits they were already well-positioned to access in the social system. While they enter the program labeled as criminal offenders caught up in various troubles, they exit the program (back) on a better path, jettisoning the weight of their troubles both symbolically and, often, materially in the form of dismissal of charges and avoiding any significant bout of incarceration. In so doing, they reaffirm the program mandate – self-control appears to have worked. Yet, whether or not they have gained greater internal control, moving beyond their troubles is far from an individual accomplishment. It exists in family resources and connections, educational and employment histories, cultural know-how, social identities, and so forth, all of which are tied to the participant's positioning outside of the program.

At the other extreme, self-control functions more as a broken promise. It tells participants currently disadvantaged by existing social arrangements that they, too, can secure greater benefit from these arrangements. However, without fundamentally changing their positioning vis-à-vis these arrangements, it places the responsibility for doing so squarely on them (see also, for example: Haney 2010; Kaye 2012; Miller 2012; McCorkel 2013). Of course, these participants do not blindly buy into the promise of self-control. They often recognize that it is replete with deficiencies, particularly as they face ongoing adversity across time. However, due to its legitimacy and availability in this context, they must contend with it both in terms of how it fits their life and what they can accomplish through performing it while in the program specifically.

In the process, they can appear wanting. They are not trying hard enough to achieve self-control as they face persisting problems around which they themselves offer conflicting claims (e.g., Stevenson described her problematic reactions as rational and legitimate, but she also would claim she needed more medication as a self out of control). Moreover, while difficult to discern from the interview data here, it is reasonable to assume that participants struggle with internalizing these ideas as they question the extent to which they are to blame for their problems. Of course, most participants do not exist at either extreme, although more cluster closer to Stevenson's case given that the participant base overwhelmingly tends to be socially and economically disadvantaged.

Additionally, this analysis also draws attention to the complex task of instilling self-control through coercion. For some participants like Jenson, self-control becomes easier to pursue because they are not on the defensive and they have good reason to believe they will retain significant autonomy over their lives. However, for other participants, self-control becomes intricately tied up with other modes of control – whether control through the court, families, or other institutions – as they confront persistent and/or growing problems. Talk about self-control, then, is not figuring out ways to fine-tune themselves. It is about establishing clear boundaries around who is to blame and how they are to be regulated by external forces. Thus, even if participants might need help, it becomes more difficult to acknowledge. In fact, precisely at the moment they most need help, participants are likely actively caught up in defending themselves from the various modes of control to which they are subject.

This raises the question of what you do with the individual who is out of control (often exemplified by 'the addict'). Surely some individuals require coercion. Moreover, often individuals might later realize coercion was in their benefit. For example, while Newman did not like staying in a substance use residential treatment facility and eventually left, in her first follow-up interview she explained how it was "totally different" from her prior probation experiences (in which she was mandated only to do Alcoholics Anonymous): "I wish this would have happened when I was thirty." For her, coerced treatment finally was working (and, according to staff data across courts, this is a common refrain for participants as they were linked to various services through the court). Unfortunately, this analysis does not provide clear policy prescriptions for how to manage such tensions. Instead, it shows how this tension is differentially distributed. Some participants inevitably are positioned to struggle with it more.

Ultimately, these findings contribute a greater understanding, then, of how participants are differently situated to the court and its goals. Participants are not merely trying to figure out how to acquiesce to the court's roles and obligations from different social positioning; they also must figure out whether and how they should be reimagining themselves.

Chapter 7
Conclusion

In this dissertation, I examined the nexus of the mental health court and the mental health court participant, with a goal of complicating our understanding of how participants are engaged by and engaging in this context. This focus directly reflects years of observing staff grapple with problems of participant engagement within the courts under study here. After all, cultivating participant engagement with the court's social service goals is the mission. In principle, doing so should benefit participants, the criminal justice system, and communities through reducing the costs associated with reoffending and incarceration. Given its importance to the court, I take a closer look at what participant engagement is achieving by investigating what is being asked of participants and how they are equipped to meet and benefit from these demands.

In so doing, I make three interrelated claims about challenges facing these courts. First, participant engagement is oriented around a set of institutional standards about what participants must do to progress through the program and, in principle, make life decent and good. These standards can be presented in these contexts as universally beneficial in ways, I claim, they are not. Second, the import of these standards to the institution – and the strategies used to foster engagement with them – inevitably constrain the possibilities for participant engagement. Rather than simply instilling an internal change as intended, participants are pressured to present themselves in ways that conform to court standards regardless of whether conformity exists. In the process, engagement can remain superficial, with some of the real problems that participants face concealed. Third, participants are differently equipped to meet and benefit from this performance. As a result, the court can serve as a differentializing institution, by which I mean it reproduces pre-existing inequalities between participants rather than ameliorating them.

I review these claims below. Specifically, after discussing the need to elicit participant engagement in the court process, I revisit participant engagement in terms of the institutional standards promoted and enforced, the performance these standards tend to cultivate in this context, and the diverse capacities of participants to engage in this performance. I, then, turn to examining how broader institutional dynamics that manifest in coercion, medicalization, and

recovery shape these processes, with mixed consequences for the program's mission. Ultimately, I aim to show how the mental health court is embedded with tensions that both work to advance its mission but also undermine it, making it difficult for staff to serve the participant population as intended.

The import of participant engagement to the mental health court in practice

On the books, mental health courts are billed as helping institutions. Moreover, far from an organizational myth with which staff symbolically comply, staff are eager to deliver this help in practice. They deliberate at length over how to respond to the multidimensional challenges that participants confront, including, for example, managing troubling symptoms, difficult family dynamics, unresponsive bureaucracies, health and dental care problems, tight or nonexistent budgets, and housing instability. Further, this is not just a matter of sitting in a room talking. Staff spend significant time with participants processing difficult issues in the courtroom, their offices, and in the community. They work to find (and sometimes provide) resources from transportation to kitchenware to mentors to housing when participants have unmet needs. They attend appointments with participants to help them advocate for themselves. They make calls or write letters to advocate for participants in settings where they do not go. In some cases, they even remain in contact with participants after they have completed the program as they confront new problems and crises. In short, staff are highly committed to helping participants achieve better outcomes.

Yet, this help quickly becomes complicated in practice. Most obviously, staff must contend with the reality that participants often appear unwilling to accept or conform to the help on offer. Further, this becomes a particularly vexing problem in this context given that the court does not provide a clear-cut way for understanding and responding to detected nonconformity (noncompliance). Instead, it offers diverging approaches. On the one hand, participants face legitimate obstacles and setbacks, for example, in the form of symptoms, stressful family dynamics, and undeveloped coping skillsets, that mean the court's goals should be tailored to their specific needs and, even then, they still will have a difficult time pursuing them. On the other hand, participants are criminal offenders who might be simply trying to avoid criminal sanction and taking advantage of the goodwill of the court, requiring standardized responses. Moreover, this complexity is compounded given that the court provides imperfect tools for

assessing what is happening. Surveillance is partial and often flawed, as even mechanisms like drug tests can produce ambiguous results (see: Paik 2006) and the self-reports of participants are suspect given their potentially fraught motivations – and sometimes these reports, thus, do verge on the absurd. (For example, upon hearing one such self-report recounted by a staff member, Judge Perry, citing a late night television show sketch, joked, "We should have a top ten list of 'Most ridiculous reasons I tested positive.'")

It is in this complex and often ambiguous terrain that staff must figure out how to ply their good intentions. Staff remain dedicated to help, but they also must ensure they are helping those who benefit from their efforts and not being manipulated. This creates a pressure that tends to lead staff members to extend themselves in unanticipated ways. Thus, for example, staff members discussed the prospect of voluntarily going to eat at a restaurant in another town where a participant reported working to ensure this was the case and one staff member recounted voluntarily sitting outside of a community service placement before work to confirm the participant was attending as claimed. More commonly, staff members became pulled into games of whack-a-mole as they attempted to pin down data about participants, such as where they were doing their community service or how they had behaved at a treatment center, only to have participants introduce new information (changing community service sites or reporting a conflict such as an emergency visit to the hospital that had not yet been verified) that had to be tracked and documented. Such ongoing and dedicated surveillance efforts reflect the difficulty of the task at hand. Just as staff become invested in helping participants, they also become involved in the complex work of evaluation: Are participants really doing what they say they're doing? Are they sick and struggling or disingenuous and manipulative? Are they really trying to get better? Do they truly want the help that is being offered? As Paik (2011) shows, such determinations accumulate, shaping the ways in which participants and staff interface and thus participant trajectories through such programs.

My goal has been to take a step back from – while acknowledging the organizational importance of – this (very engrossing) sort of evaluative work that centers around how participants are engaging with the court's goals. I recognize that participants can be disengaged, oppositional, disingenuous, manipulative, and so forth, and that such modes of engagement can be incredibly frustrating to those who want nothing more than to provide help. Moreover, this is particularly the case given that other participants are (or, at the very least, successfully present

as) invested, eager for support, and ready for change. However, from a critical distance, I do not see such modes of engagement as a justification for why staff should extend or retract their efforts to help. Instead, I see them as a starting point from which to more critically examine the mental health court and its focus on participant engagement.

Reevaluating participant engagement through the lens of institutional standards

A primary claim I advance in this dissertation is that while staff are deeply invested in helping participants, they do so through a set of standards that are not uniformly beneficial to participants. To make this case, I have turned to scholarship on the institutional reproduction of inequality. As detailed in the dissertation's introduction, institutions like the criminal justice system consistently privilege ways of being represented among the dominant social classes whose members are mainly white, middle- and upper- class, in part because the people who hold the power in these institutions come from these backgrounds. It is often difficult to "see" how this happens as institutional norms and rules are cloaked in a language of neutrality – as if they are equally beneficial to all when they are not.

This became starkly apparent in key moments such as when Kent County staff members decided to graduate very early one of the more privileged participants I observed as she had, according to Judge Perry, "got off the dime," "taken advantage of opportunities," and "rocketed through the program." By their reporting, she had completed basic treatment requirements, paid off her fines and fees, had stable housing (housed by her father who was a lawyer), was privately being treated, obtained a new job at a department store, and was looking into a master's degree program. This certainly contrasted with other participants who were slow to pay off fines and fees, remained confined to the lower tiers of the job market or jobless and mandated to do community service, and often enough were caught up in substance use and (directly surveilled) treatment noncompliance. Of course, privileged participants did not simply glide through these programs without issue (I, in fact, have demonstrated they did not). However, their – often not fully visible – capacity to meet key requirements helps reveal how such requirements privilege those who are more resource rich and relatively problem free, even if this predominantly unfolds by degree, as participants might have housing and social support, but not employment or tenuous housing through a family member, but no ongoing relationship to substance use.

As I argue, staff do not sidestep the complex reality of participants' diverse lives. In fact, they often are particularly eager to help those who have had a hard lot in life. However, they face an uphill battle against a mandate in which they inevitably must draw (simplified) distinctions between participants to process cases. Ultimately, participants must exhibit the "right" conduct, which becomes rendered as natural, necessary, and beneficial for all involved. Thus, even when staff account for the ways in which participants struggle with, for example, housing instability or addiction, they increasingly tend to view such struggles in terms of individual choices and personal flaws. The complex interplay of social dynamics that shape how participants differently go about pursuing housing or using substances (and self-report their experiences) while under the surveillance of the criminal justice system is too little acknowledged, particularly across time as participants face increasingly divergent outcomes. At some point, given all the help on offer, participants, it is said, must accept accountability for their problems. Staff have limited energy and resources. They must help those who are willing to help themselves (for a critical reading of this kind of logic, see: Cruishank 1999).

Critically, I am not arguing these programs should not strive to help participants reduce undesirable symptoms or gain better housing, education, and employment. These are worthy goals that reflect fundamental human needs. However, I am drawing attention to how those goals become transformed into relatively universal standards by which participants are evaluated and judged. In the process, some distinctions become more visible than others. For example, staff become focused on whether participants are housed without adequately attending to the varied quality of housing participants can access; or whether they are pursuing jobs rather than the differential access to employment; or whether they are adhering to psychiatric medication rather than what such adherence does or does not do for them specifically. Moreover, these kinds of standards inevitably shift the focus of evaluation onto individual participants and not the social order in which they operate. This focus on the individual is, as Reiman (2014) posits, "to look away from the issue of whether [] fellow citizens have fulfilled their obligations to him or her." It is a focus on individual responsibility at the cost of social responsibility – a particularly important ideological shift within the context of urban communities characterized in part by concentrated poverty, depopulation, residential segregation, the disappearance of manufacturing and other forms of work, and criminal justice expansion.

Reevaluating participant engagement through the lens of performance

Another claim I have advanced in this dissertation is that these demands inevitably create pressures and pulls to *perform* in certain ways. By performance, I move away from thinking about who participants intrinsically are or, for example, whether they have an underlying disorder that can be identified through biological testing. Instead, I examine how participants are pressured to present themselves and their problems in this context – a type of impression management work (Goffman 1956). Importantly, I do not argue that performance is by definition inauthentic or at odds with what all participants need or desire. Still, once we can see that the court is in part producing and intervening upon performance, we can better recognize that what practitioners – and even researchers – see is the product of interactional work.

Following a social constructionist tradition (Berger and Luckman 1966), I have contended that participants have access to many images, models, and templates for understanding themselves and their problems (see also: Gubrium and Holstein 2001). However, in the court context this meaning-making process is constrained. Participants are compelled to conform to the institutional framework of the court or, what I call "perform compliance" (as discussed in chapter 4). This performance in part is intended by the court under a logic of "fake it until you make it." Ideally, through performing compliance, participants will experience and internalize the benefits of *being* compliant, pursuing social service goals long after they are compelled to do so.

However, this performative dynamic produces undesirable effects. Primarily, nonconformity becomes more difficult to see. In coercive contexts like the court, open defiance is often averted, redirected into subtler "everyday forms of resistance" (Scott 1985) such as disingenuity, feigned compliance, and foot dragging. Of course, participants advocate for themselves, state frustrations, and contest decisions they perceive as unfair at times. Still, generally participants are compelled to accommodate or acquiesce to the court, making it difficult to levy more meaningful resistance to the court. Thus, even as participants complain about certain forms of psychiatric treatment or community service requirements at times, they rarely consistently express a more fundamental disagreement about whether the program correctly diagnoses their problems or whether they belong in the program specifically, particularly at court where such resistance would result in unfavorable action from judges. Most participants are simply trying to make it through.

This dynamic makes it difficult to know the degree to which participants are engaging with and benefitting from the program generally. Moreover, it has disparate impacts on the participant base – a topic I turn to next.

Reevaluating participant engagement through the lens of participant diversity

Finally, I have argued that while staff are often evaluating variation in (perceived) behaviors, beliefs, and attitudes, we need to look more critically at the orientations and resources underlying them. Participants exist within – and have existed within – a set of social conditions that shape how they read settings like the court program and respond to them. Across time and space, they have internalized ideas about how the social world works and developed knowledge, skills, styles, and resources accordingly that shape how they pursue their interests in ways that are both conscious and unconscious. This includes, for example, being trained from an early age about what they can expect from and how they should interact with institutional actors, whether teachers, police officers, social workers, or doctors (see: Lareau 2003; 2011). It includes how they make sense of their problems and embody them through experiences of emotional distress (see: Casey and Long 2003). It also includes more broadly how they construct a sense of self and envision the kinds of life that is possible and beneficial (see: Stephens et al. 2014).

I have used in-depth case studies to illuminate some of this variation. In chapter 4, for example, I described different treatment trajectories: a working-class, but still relatively privileged white women who recounted psychiatrists being reticent to diagnose her with a stigmatizing mental illness out of concern for her status; a middleclass white man who hired a private psychiatrist upon his criminal offense but otherwise had no history with psychiatric treatment; and a lower class black woman who was channeled through the juvenile justice system and diagnosed at a young age despite her reservations. In chapter 6, I further detailed different trajectories across the program: a more privileged white man described a bipolar diagnosis as helping him make sense of and separate from deviant behavior as he returned to a middleclass trajectory and a less privileged black young woman who struggled to secure reprieve from blame and mitigate the control of others through her bipolar diagnosis.

Such cases highlight larger patterns in how participants differently experienced, made sense of, and responded to the program given their distinct positioning vis-à-vis treatment and

control (see also: Whetstone and Gowan 2017). Exploring their contours in tandem shows how the behaviors, beliefs, and attitudes of interest to the program are the outcomes of complex social dynamics that unfold very differently for participants depending on their social positioning. Most basically, for example, it becomes easier to consistently buy into – or at least acquiesce to – institutional goals when participants have experiences of institutions as working in their favor and experience this institutional setting favorably specifically. This often is shaped by the degree to which participants experience their institutional involvement as providing them with agency rather than functioning as another site of subordination, degradation, and control, as was particularly illuminated by the different cases described in chapter six. These two divergent experiences are, in turn, conditioned by the degree to which participants can meet court standards, which as described above, privilege some participants over others, ensuring only some are subject to amplifying forms of control in this setting specifically.[84]

From this analytic vantage point, I argue that the mental health court tends to serve as a differentializing institution. That is, rather than ameliorating pre-existing inequalities within the participant base, it largely tends to reinforce these pre-existing inequalities. This is not the fault of staff, but a program structure that makes it difficult for staff to meaningfully respond to the complex and diverse needs of their largely socially disadvantaged participant base. Like other public institutions that work to cultivate change in their patients, students, clients, and participants, the court does not fundamentally change the conditions in which participants operate. They remain in the same families, social networks, and communities. They remain subject to the same forces – whether, for example, poverty, job insecurity, neighborhood disadvantage, social isolation, racism, and classism. They maintain the same orientations and resources that shape how they interface with institutional settings.

This is not to minimize the many positive strides being made by public institutions and the court setting specifically. Participants, for example, can access better medications, gain jobs or housing, or finally feel like professionals are taking their concerns seriously – all of which can

[84] Privilege is relative here. For example, those who came closest to typifying buy-in often were doing well relative to their peers – having jobs or income and no trouble with substance use during the program – but they were far from economically secure. The latter was best exemplified by Strickland, who was going through a bankruptcy but was employed, and another enthusiastic participant who did well throughout the program only to be fired from her job right after her graduation (circumstances not so dissimilar from those that had led her to abuse substances in the past and become involved with the criminal justice system). Likewise, those who were most successful at strategically acquiescing came from low income backgrounds but were still equipped to meet many of the court's standards, for example, by landing a job and not using prohibited substances.

be very meaningful and are important for understanding how mental health courts are delivering in ways that the old system did not. However, recognizing this provides a foundation to more critically examine what a program can reasonably expect when it aspires for better individual outcomes and yet does not fundamentally change the larger structures through which those outcomes are being produced.

Institutional tensions embedded in the mental health court

This kind of reading of the mental health court and its participants illuminates several core tensions embedded in the mental health court model that directly reflect the institutional dynamics under which it operates. To understand the court and its outcomes – as well as the possibilities for change – it is important to outline these dynamics. In this context, this requires redrawing attention to organizational hybridity (Battilana and Dorado 2010) – the merger of multiple institutions and their accompanying logics under one organizational umbrella. Ideally, this merger can offer innovative solutions to problems currently unaddressed by any given institution alone, but it can also produce new, undesired effects, as well as reproduce some of the problems associated with traditional institutional arrangements. Below I outline both the benefits and challenges generated through this institutional configuration, which has implications for the court specifically, but also other contexts that share similar institutional forms.

The complexity of coercion in practice

Coercion – a mainstay of the criminal justice system – is fundamental to the mental health court's core helping mission. It is difficult to imagine court programming that engaged most participants in its goals without it. Participants overall, for example, would likely be less motivated to attend treatment appointments, pursue abstinence, and participate in activities like community service. Moreover, even if judges were slightly less coercive – not applying sanctions as rigorously – they would risk participants recognizing that coercion was a hollow threat, which would also likely impact participant motivation (although, as indicated in chapter 3, this already is a dynamic with which staff grapple in practice as they work to help participants and not be overly punitive).

Significantly, engaging participants through coercion can be incredibly valuable. A primary claim I have made in this dissertation is that these goals in practice do not serve

everyone equally; however, this is far from saying these goals are unimportant for many members of this population. After all, key court goals are rooted in a growing body of research that indicates their benefit for individuals with serious mental illness (for example see: Drake et al. 2001; Drake et al. 2004). Moreover, my data suggests that many participants do experience benefits. From the perspective of staff, some participants gain new mental stability, happily obtain jobs or new housing arrangements, take better care of themselves physically, and reconnect with family members in ways they would not have otherwise done without the court-mandated nudge. Likewise, from the perspective of some participants, court requirements worked to their benefit, often in not fully anticipated ways. Medication they had never tried before could level out moods. Forced (bouts of) abstinence could increase focus and drive. Even community service – in the rarer case – could be expressed as a beneficial way to gain motivation or connection with others. Finally, and perhaps most importantly, some individuals arguably are desperately in need of being coerced to engage in such goals as they are at risk of harming themselves or others (albeit in ways that are difficult to self-identify under the throes of addiction or while severely symptomatic).

Yet, despite the critical role coercion serves in the court in generating positive outcomes, it constrains what the court can achieve, and equally important, our understanding of what the court *is* achieving. This happens as coercion infuses the social service mission of the court with the fraught dynamics of control. Staff and participants are not simply working harmoniously to achieve a set of social service goals; they are often enough wrestling for the power to determine how these goals will be implemented. This power struggle reorients their relationship. Staff become increasingly invested in ensuring the recalcitrant participant conforms to their demands (eventually, in select cases, regardless of the content of those demands) and weeding out the “scammers” and those trying to “play the system.” Conversely, some participants are certain to grow increasingly recalcitrant or “shut down” as they experience control, testing out different strategies to buck this control or becoming apathetic in terms of their power to do anything about it (regardless of whether what staff are mandating is in their best interest).

Staff are aware of the deleterious impact of coercion on their relationships with participants. As such, they grapple with when and how to reveal the mechanisms of control. For example, some case managers recount struggling (at least initially when starting the position) with how transparent to be with participants about what they report at court (and, then also,

struggling on occasion with whether to report specific intimate details *to* the court). Staff also go to some lengths to conceal who is doing the controlling. For example, judges take ownership for recommendations made by case managers that are deemed unfavorable by participants, and such recommendations are almost always made behind closed doors outside of earshot of participants. Yet, regardless of their best efforts, staff cannot fully neutralize the effects of coercion. It is the foundation of the staff-participant relationship and materializes in the face of problems – shaping both how staff respond to those problems and how participants present them.

Thus, relatedly, coercion fundamentally distorts what practitioners and researchers can know about who the participants are and what they need. Coercion leads participants to experience heightened pressure to conform to the court's goals, making it harder to identify and assert nonconformity. As a result, many participants are caught up in *presenting* as conforming to these goals even when they experience nonconformity. This is neither beneficial to participants nor the institution as without an accurate understanding of the participant and her problems, it becomes impossible to identify the best solutions and, in some cases, results in expenditures on wasted resources such as unused or useless psychiatric treatments.

Further, because this concealment process is forced so far underground, it becomes difficult to systematically detect, including even in research on problem-solving courts and other similar criminal justice interventions. A key premise that informs this study is that researchers are certain to face an uphill battle in working to separate themselves from the court apparatus in the eyes of participants, particularly among those who experience nonconformity and thus view exposing this nonconformity as risky. A consequence of this is that we are likely to have richer data about participants who are benefitting – publicized in news reports and more eager research subjects – than those who are not benefitting (who are less likely to disclose their beliefs and behaviors).

Additionally, central to my analysis, the costs of coercion are unevenly distributed, reproducing inequality. This unfolds from two directions. First, following an individualized approach, staff impose varied requirements on participants that result in different forms and intensity of coercion applied across the participant base. A consequence of this inequality is that those who are already advantaged (whether in terms of lacking the problems the court regulates or having the resources to meet requirements with ease, such as obtaining employment) tend to be best positioned to experience *less* coercion. Meeting the court's goals independently, staff do

not work to impose new forms of coercion to increase their engagement. More problematically, those with the very problems the court aims to tackle (such as substance abuse and misuse and detachment from activity like employment) are likely to experience greater coercion and its associated costs. With problems that are ideally intended to be regulated, these individuals increasingly face pressures to conceal nonconformity when they fail to effectively conform and self-regulate. This pressure to conform, then, materializes in the type of lying and manipulative behavior that the court most aggressively punishes, making it more likely that those with problems the court aims to address will be at risk of being heavily punished – a claim that deserves systematic investigation.

Second, participants enter the court with distinct orientations to and experiences with coercion, ensuring they experience coercion differently. For some participants, coercion can be experienced as a form of aid, especially – as I show – among those who have more to gain materially or symbolically through their participation (for example, due to unique contingencies that allow them to access housing, favorable plea deals, or de-stigmatization), although also among those desperate for aid due to significant instability in their lives (see also: Gowan 2010; Shdaimah and Wiechelt 2012; Kaye 2012). Additionally, some participants might be better equipped to identify and navigate the blurry edges of coercion – knowing, for example, the difference between what judges say will happen (e.g., a jail sanction in the face of future noncompliance) and what actually happens in practice (e.g., a stern warning after the first act of noncompliance).

Yet, others are more likely to experience coercion negatively. This is especially true for those who hold membership in social groups marginalized in mainstream society and its institutions and thus are likely to experience acute forms of coercion as part of a broader pattern of mistreatment, subjugation, and alienation (for a discussion of this kind of group experience, see: Bell 2017). This difference in experience is important in and of itself, accumulating across time and space as participants continue to learn (and generally reaffirm) how public institutions will respond to them and people like them. However, it also contributes to other forms of difference, as these dispositions are likely to shape participant conduct in ways that influence how they are differently read and evaluated by staff.

In sum, coercion is a necessary and – in some ways and for some participants – beneficial component of the court model, but it comes with definite costs that are unevenly distributed

across the participant base. Further, given the ways in which it distorts the research process, there is still much to know about how coercion works and who it is working for and not working for.

The complexity of (coerced) medicalization in practice

Medicalization (Conrad 1992, 1997) is also fundamental to the court. Medicalization is a scholarly concept, but it refers to the empirical process that unfolds across wide-ranging settings in which problems become defined and responded to in medical terms, expanding the jurisdiction of medical experts such as physicians and psychiatrists. This process is clearly at play in the mental health court. Medical categories (i.e., mental illness) provide the legitimacy to divert participants from traditional prosecution and medical interventions (e.g., psychiatric treatment) are central to participation. It is possible to imagine a court where medicalization plays a smaller role. Already, programming exists in many forms that expand beyond a focus on medical conditions alone to a diversity of human needs, including most notably general problem-solving courts that serve a variety of defendants (BJS 2012). Moreover, Rapids County administrative staff described a desire to start a court geared at individuals with less severe mental illness, likely lessening the intensity of a medicalized approach. Still, in the mental health courts observed, medicalization remains a mainstay of court processes and thus is important to evaluate.

The medical system and its accompanying logic certainly offer a great deal to the mental health court and its participants. Prescription drugs and psychosocial treatments can help better manage symptoms and reduce substance misuse and abuse – a particularly critical intervention for those who are severely impaired by mental illness and/or substance abuse problems *and/or* for whom medication does offer some relief (although the benefits and costs of medication in this context remain debated, see: Hughes and Peak 2013). As the recovery logic indicates, the effects of such interventions can be diffuse, improving employment prospects, social relationships, and overall wellbeing. Moreover, beyond interventions geared at better controlling biochemical processes, medicalization offers many symbolic benefits (as indicated in chapter 6 and outlined by Schneider and Conrad (1980)). It can provide participants with a framework for understanding themselves, which in turn can reduce guilt and blame as problems are attributed to sickness rather than a flawed moral self. Additionally, this framework can provide a sense of optimism through identifying potential (medical) solutions to problems. Importantly, such potential benefits can be desperately desired by participants who otherwise typically struggle

with a complex array of problems such as housing instability, unemployment, social isolation, physical health problems, and/or, at the very least, criminal justice involvement.

Yet, despite the many benefits medicalization offers, it also suffers from a similar set of tensions associated with coercion. In providing a framework for understanding and responding to participants and their problems, it closes off possibilities for other kinds of social theorizing and action, distorting how we as practitioners, researchers, and even participants understand participants and their needs. This happens as the medical model focuses attention on some causes and solutions – e.g., an internal biological illness to be remedied through the medical system – and not others – e.g., social processes and contexts that contribute to dysfunction and require systemic level change. Contra to the court's mission, medicalization can conceal the root causes of many of the problems faced by its participants. Thus, as one of many examples (explored in more depth throughout my participant-based chapters), a participant recounted with frustration in an interview how he had reported at court his anger over a negative experience in another courthouse only for the judge to ask him if he needed his medication adjusted. He explained: "You know, it's like you can't get upset in this program. And I just…I don't agree with that." Such moments revealed the ways in which medicalization constrained the court, shifting its focus away from the problems that participants experienced as real and legitimate, compelling them instead to address a medical condition that might be the least of their problems.

Critically, this is amplified in the coercive setting of the court where medicalization is at risk of being applied too rigidly. By this I mean medicalization can consistently serve as the primary lens through which participants and their problems are viewed as opposed to one of many lenses available across time and space. This rigidity stems from several sources, including: (a) court staff are positioned to assume participants require external control (e.g., coerced treatment compliance); (b) court staff are wary of not following through in exerting control (e.g., treatment noncompliance ultimately must be met with admonishment and punishment); (c) key staff, such as psychiatrists and, in this case, a probate judge, routinely confront severe cases that can bias them towards seeing mental illness as a primary problem in a way it is not for all participants; and (d) eager to help participants "get better" across the duration of participation, staff might desire what seems like quick – and available – fixes in psychiatric solutions such as medication or placement in treatment facilities.

Yet, this singular emphasis conflicts with the experience of mental illness. Mental illness is variable and episodic and one of many dimensions of individual's multidimensional lives. As explored in chapter 5, participants face complex, dynamic problems that lead them to waver in enthusiasm for a medical interpretation of their problems. Thus, for example, in times of crisis it is easier to accept a mental illness as part of an optimistic outlook that life could be better through treatment (as well as, in this case, avoiding incarceration). However, this same diagnosis could feel less accurate when housing or social support crises continue despite engaging in treatment, or, alternatively, when such crises recede. In fact, I confirm a well-established finding that while treatment compliance remains a persistent concern from the standpoint of medical and legal professionals, it rarely is the primary concern of treatment recipients, who turn to treatment to the extent it helps them exert control over their lives (Conrad 1985; Shoemaker et al. 2008). Moreover, the emphasis on treatment in the mental health court specifically has also been critiqued in a growing body of empirical research (Fisher et al. 2006; Epperson et al. 2014).

Of course, for individuals who are severely impaired by medical conditions and not able to (fully) comprehend or independently respond to their impairment, the focus on psychiatric causes and solutions is highly desirable. Yet, this focus does not serve everyone equally given a diversity of treatment needs, and it can be difficult to decipher who is being served by it in practice, particularly – but not exclusively – from the judge's seat on the bench. This is because of coercion, which constrains participants to perform as ill in this context. However, this difficulty also materializes in part through the rewards tied to medicalization that can further incentivize this performance, such as reprieve from blame and access to material resources such as housing or income (distributed based on a mental illness diagnosis). Moreover, as a practical matter, participants have significant agency in determining the extent to which they feign alignment with the medical model. Staff do not have access to their internal beliefs and most participants participate in treatment (particularly in terms of taking oral psychiatric medications) outside of the observations of staff.

Finally, there is good reason to believe that the benefits and costs of medicalization are unequally distributed. This is in part because participants are differently equipped to find ways of effectively feigning alignment with the medical model (e.g., some are better than others at faking treatment compliance). However, it is also because participants stand to gain differently from buying into this model, particularly given a fundamental tension embedded in the logic. On the

one hand, medicalization promises a shift away from personal responsibility as the locus of control is located within a biological process as opposed to a moral capacity. On the other hand, personal responsibility is far from waived, as control remains firmly entrenched in the self and, in the context of coerced treatment, a self that can ideally regain control through treatment. Within the court, this is the goal: staff expect participants to increasingly regain control and take personal responsibility for their conduct (and their problems). Thus, while staff sometimes reference how they are "treading water" until participants are stabilized on psychiatric treatment (i.e., not adding many requirements), they ultimately expect participants to engage in their requirements and "take ownership of their well-being."

For some, this kind of logic helps render the positive outcomes in their life as a product of individual choice, made by a self increasingly in control (with the assistance of medical intervention) – even if these positive outcomes are largely the product of factors such as family resources and connections, prior educational and employment backgrounds, social identities, and cultural know-how. For others, medicalization misattributes negative outcomes – shaped by factors such as social marginalization and ineffective and unjust institutions – to a self that was out of control. Schneider and Conrad (1980) rightly refer to this as the "individualization of social problems," or the process by which causes and solutions to complex social problems are located in the individual as opposed to the social system. This process clearly advantages those who are positioned more favorably in the social system and face fewer problems for which they must claim personal responsibility. Meanwhile, those disadvantaged in this system are compelled to repeatedly accept personal responsibility for their lot in life as problems emerge and re-emerge and medication offers no quick fix.

In sum, responding to participants' problems through a medical lens can be incredibly useful, particularly among those who find relief through medical remedies. However, mental health courts should be wary of an overemphasis on a medical model for *all* participants and at all points across a participant's participation, as the medical model has many shortcomings when it comes to solving the complex problems of participants and these shortcomings are unevenly distributed among the participant base.

The complexity of (coerced) recovery in practice

Mental health courts are also organized around the logic of recovery. This logic – and its integration into mental health court policy and practice – was discussed in chapter 3. However, several points are important to reiterate and elaborate on here. The dominant logic of the community mental health system, recovery extends far beyond simply a medical model. In fact, it overcomes key critiques of this model raised above. It redirects attention to the multidimensional lives of individuals with mental illness, which include not only mental illness, but also housing, community, meaningful activity, and physical wellbeing. Rather than promoting a rigid framework, it demands flexible interventions, which must be tailored to the specific attributes and circumstances of each individual. Moreover, in contrast to a coercive model, this logic incorporates participants directly into the intervention, providing them with a voice in how recovery unfolds. From the vantage point of participants, this can be empowering. From the vantage point of the institution, this can increase intervention effectiveness through shifting the work of implementation onto participants and tailoring resource provision to individual need. In short, recovery is a highly desirable remedy to many of the problems generated through medicalization, as well as coercion.

Still, this logic is not without problems, particularly in this institutional context. In chapter 3, I highlighted a fundamental tension recovery generates between individualization and standardization. In some ways, I presented this tension as unique to the mental health court (in contrast to, for example, a drug court, which has greater standardization, see: BJS 2005). Yet, this tension has long plagued the criminal justice system, from the introduction of uniform punishments and, then, early versions of tailored sentencing like parole. Recovery – and the problem-solving court movement more generally – is a new iteration of this tension, providing heightened discretion to judges and other court professionals to individualize criminal justice responses. Yet, as with prior iterations of individualization, recovery does not provide a resolution to the underlying structural problems creating this tension; instead, it sidesteps them by allowing these courts – and their staff – to decide on a case-by-case basis who is deserving of special consideration within the current institutional structure. As others have argued (Petrila 2005), shifting this responsibility to problem-solving courts ultimately only helps a small number of criminal offenders given that they process a small rate of defendants overall. Moreover, it places incredible pressure on court staff members to determine who is deserving of special

consideration within their court programs, creating opportunity for individual biases to drive decision-making.

Furthermore, this logic is ultimately constrained the degree to which its principles cannot be carried out in practice. Key principles of recovery – for example, promoting social connection, meaningful life activity, and stable housing – can easily be undermined by a lack of meaningful supports in the community. Staff across both courts regularly discussed negative social dynamics of participants' families (or a lack of family support) they were not equipped to effectively overcome. They also described an ongoing struggle to find independent housing for participants, many of whom had limited to no financial resources. When independent housing was secured, problems with pest infestations, neighborhood quality, and/or sustainability were common concerns. Likewise, securing employment could be difficult given participants skills and backgrounds, as well as available employment options. In Rapids County in particular, staff became increasingly frustrated across my observations with the failure of local employment services to follow through in aiding their participants to obtain jobs. Again, this is not to cast doubt on whether these courts make positive strides along these domains. They can, and they do. Some treatment staff, in fact, reported making greater strides with certain mental health treatment recipients under court control where they could hasten the recovery process through coercion.

However, the unaltered resource landscape points to the problems of transforming recovery into an outcome to be achieved within the criminal justice system.[85] Whereas treatment recipients can continue to access treatment regardless of whether they increase medication adherence, reduce substance use, and obtain jobs, these outcomes become signifiers of whether court participants are deserving of ongoing aid or punishment. In this context, conduct such as drug use or failure to complete community service hours are not just setbacks on the road to recovery; they are punishable offenses. Whether the right supports exist to reduce and eliminate substance use or whether available forms of community service constitute the kind of "meaningful life activity" that promotes wellbeing or leads to desired outcomes such as

[85] As Braslow (2013) effectively breaks down, recovery can mean different things, sometimes concomitantly. It can refer to a process – i.e., the subjective experience by which individuals work to manage symptoms and live meaningful lives. It also can refer to an outcome – i.e., achieving a specified mental health goal. (It also refers to the logic – or system of values – that shape how the mental health system delivers care.) In the criminal justice system, arguably, recovery as outcome becomes most important.

sustainable employment in any given case[86] become less important than whether the outcome was achieved by the participant. (In fact, Braslow (2013) argues this is the ideological magic of recovery. Under its logic, the burden shifts to individuals to develop the skills and capacities to meet their needs and make "good choices," relieving the state of responsibility for their care and support).

This is not to suggest that staff are indifferent to what supports are provided. They offer to evaluate certain services and stop using those deemed ineffective, as well as adjust their expectations of participants in specific cases given the perceived inadequacy of services. However, staff, too, adjust their expectations to the resource landscape. What is available often enough becomes the best possible alternative which becomes ultimately the right thing for the participant – whether, for example, participation in inpatient treatment or community service is beneficial as intended under a recovery logic. The latter assessment, of course, is inevitably complicated by the indeterminacy and unpredictability of such interventions (see: Hasenfeld 2010), as well as the dynamics of the setting in which staff cannot trust participants to know and share what is best for them. After all, the reason participants are under staff control is that they already showed themselves to not act appropriately in their own interests or the interests of the community. Staff, thus, are often in a position of coercing recovery through whatever available resources exist, rather than actively engaging participants to make choices about their recovery (although, as other scholars have argued, there is ideological slippage between the two poles in practice, see: Donahue and Moore 2009).

Also troubling for these courts is the extension of control *through* recovery. As a flexible and expansive logic, recovery provides legitimacy to reach deeper into the lives of participants, opening their conduct inside and outside of the court to scrutiny and regulation. These courts can regulate social relationships (for example, imposing No Contact Orders and calling Child Protective Services) and housing situations (ordering where participants are to reside). They also sometimes regulate income and budgeting (incorporating budgeting into court requirements or

[86] For example, as Kaye (2012) finds of similar programming, much of the mandated community service in which participants participate (where administrators are aware of the mandated status of participants, differentiating them from "volunteers") arguably is geared at "producing a self that is capable of self-control, self-discipline, and social subordination." These skills include accepting boredom, following rules, and responding calmly to being yelled at by supervisors. Such skills surely helpful within the low-wage labor market, but they also reflect (and demand reproduction of) social status. Some participants find agency in these skills, but others reasonably reject their imposition.

ordering state payee services). They further become involved in medical and dental care and even, to some degree, legal entanglements outside of their jurisdiction as they tell participants to address them. In general, staff extend themselves in these ways to help participants through a multi-faceted approach. However, in the process, they blur the lines between aid and coercion (particularly the degree to which participants can and/or *think they can* be punished for failure to comply with court mandates across these wider domains).

Moreover, as a growing body of scholarship reveals, this often can result in a paternalistic brand of moral and behavioral discipline imposed on socially marginalized groups who are deemed responsible for their abject circumstances (Gowan and Whetstone 2012; Kaye 2012; Stuart 2016). In the court context, these disciplinary practices can be amplified among those who are particularly marginalized – having the most problems across wide-ranging domains and thus often most likely to trigger staff intervention (both in the name of help and regulation). Moreover, often enough, these problems emerge through the demands of performance. Unable to present as the ideal subject, such participants themselves introduce information about their lives – interpersonal conflict, budgeting problems, or housing instability – to justify other forms of noncompliance – e.g., the missed appointment or failure to pick up medication. In the process, they unwittingly invite the court to regulate further domains of their lives in the name of recovery.

Despite such potential concerns, it is important to reiterate that recovery serves a critical function within the mental health court – allowing staff to flexibly tailor interventions to the attributes and circumstances of participants and help them with wide-ranging needs. This certainly is very important for many participants – some are desperately in need of such aid; however, it, too, comes with definite costs, which are unevenly distributed among the participant base.

Lingering Policy Issues

This dissertation has largely focused on broader issues of interest to sociological audiences. Yet, it is important to acknowledge several policy-related issues that emerged through the data collection and analysis process not yet explicitly discussed. Given that mental health court policy is still nascent and underdeveloped and a recovery logic that demands flexibility, court staff lack highly specified policies for many important decisions they are tasked with

making. Further research attention should be paid to these important domains, which also do not have straightforward solutions given the tensions of the setting.

Individualization versus standardization: room for more standardization?

As I have argued, these courts rely heavily on a logic of individualization. Rewards and sanctions are supposed to function as a graduated response system that will shape the motivations and conduct of participants, while remaining tailored to the specific attributes and circumstances of each participant. This individualized approach rightly allows staff to adjust interventions to participants, but it also provides room for significant discrepancies to emerge in how staff decide cases. For example, in practice, when and how participants are jailed depends on many factors that extend beyond a systematic evaluation of the participant, including whether alternative options are available, but also less obvious factors such as memory of case history, the mood of (and/or presence of) staff on a given day, and the kinds of claims participants make on their feet in the court space. Recall that staff must process complex information expeditiously with constrained resources. As a result, resources, chance, and bias can shape decisions. Unsurprisingly, staff across both courts reported in private interviews that the decision-making process could be more uniform in some cases. Participants, too, sometimes complained of inconsistencies.

It is unclear the extent to which these courts can resolve this tension in practice given the competing demands of individualization and standardization. However, one possible step forward could be to more explicitly design a set of flexible guidelines for staff in each court for how key decisions – such as jail sanctions or terminations – are made. These guidelines would be based on the specific participant population and resources of the court and include key contingencies that routinely emerge. For example, courts could quantify the type and number of relapses that lead to jail sanctions, the number of jail sanctions that could result in termination, and what kinds of exceptions could reasonably be made in this decision-making process. Such guidelines could serve as a model to which cases could be compared, allowing staff to maintain discretion but also think more critically about the standards they want to impose across cases.

Ultimately, being clearer about when and how key decisions like jail sanctions are made is particularly important since they enter the court record and institutional memory, shaping future staff action towards participants, including ultimately graduation and termination.

The rules of the game: room for greater transparency?

Related to this concern with standardization is a question about the degree to which participants should be more explicitly informed about how court standards operate in practice. It would be hard to argue that participants are unaware of what they *should do* given the persistent messaging about the goals of the court (although, of course, some participants do make an argument at court that the rules were not explained to them – sometimes repeatedly across their appearances even when they are observed being told specifically what do). Still, what participants absolutely *must do* to make it through the program and avoid sanctions in specific instances is less clear. In large part, this is because of the tension between individualization and standardization in which staff differently tailor the rules to participants as they learn about their attributes and circumstances, making it seemingly impossible to provide participants with boilerplate guidelines at the outset of participation.

However, this ambiguity also seems to be bolstered by the premise that it can be beneficial for shaping participant behavior. That is, if participants are uncertain about when they might be punished, they are more likely to self-police consistently (out of fear of looming punishment, much like the effects of a panopticon). Of course, conversely, realizing punishment is not always swift, uniform, and certain, they might try to "work the system." Whether this ambiguity generates better self-policing or participants taking advantage of the program in ways that are undesired requires research, but my data suggest that participants will be differently equipped to work the ambiguity to their advantage. Hence, finding ways to reduce some ambiguity could be beneficial.

One way I could envision reducing ambiguity is through making information-sharing practices more transparent. In interviews and observations, case managers indicated they struggled with their reporting duties at times, which could damage their relationships with participants and produce tension as they determined when and how to report on participants. By the time of individual interviews, case managers frequently reported that they already developed methods of discussing their reporting duties with participants through a process of trial and error. Still, rather than relying on case managers to determine the contours of this conversation, it would be useful to create guidelines that case managers and participants reviewed about how reporting worked (not just in principle, but in practice), including in the wide-ranging contexts

surveilled by the courts, such as psychiatrist and therapist offices, hospitals, and inpatient treatment. Of course, this might lessen the capacity of the court to surveil participants, as they become more wary of what they report across these contexts, particularly the degree to which professionals reminded participants in their encounters of these information-sharing strictures (e.g.: "Anything you say may be used against you in a court of law").

Identifying the right dose of mental health court: better to limit the duration of coercion?

Staff in both courts grappled with the right dose of mental health court. One approach, carried out by Kent County, was to extend the duration of participation from 12 months to eventually 30 months with a non-reporting period where participants would no longer have to attend court. Under this approach, participants were rarely readmitted to the program after completing it (I only observed staff discuss one such case). The other approach, carried out by Rapids County, was to maintain participation at 12 months (although they contemplated extending participation to be competitive in grants with other programs with longer sentences). Under this approach, at the discretion of staff, participants could be readmitted to the program multiple times (which still included only a minority of cases). Both courts created "alumni" or "support" groups to further increase participant engagement with social service goals both during and after participation.

Extensions of court control – whether through participation extension or alumni groups – were often discussed in terms explicitly of increasing mental health treatment engagement. Yet, my data suggest such efforts are unlikely to have the intended effect – a claim that requires systematic investigation. While some participants became more invested in programming over time and/or experienced key turning points, the majority of participants interviewed maintained a stable relationship to treatment goals or became increasingly frustrated by treatment goals as they experienced regulatory burden. Thus, many participants who disconnect from treatment after program completion are likely to do so regardless of whether their participation is extended, or they are connected to support groups.

Most obviously to all involved, this includes those strategically acquiescing participants who only participate in treatment to access criminal justice reprieve and/or social service aid (for a discussion of the links between social services and mental health status, see also: Dobransky 2009; Hansen et al. 2014). However, it also includes those participants who desire treatment but

want to symbolically and materially detach from the frustrating and degrading dynamics of court control. (And, staff, too, indicated a desire to detach from specific participants after being caught up the frustrating dynamic of trying to coerce them to engage with treatment goals.) Of course, alumni and support groups certainly benefit some participants and should be used to the extent they are found to be beneficial. However, they should not be expected to rectify issues with treatment noncompliance or be uniformly beneficial to all.

In a similar vein, my data suggests that participants can find program readmittance beneficial. After all, program participation can offer definite benefits. To the extent it is deemed beneficial, it thus seems reasonable to readmit participants. This is particularly true given the fragmented social service landscape and, as Judge Ash emphasized, a broken system of mental health laws that allow some individuals to repeatedly "fall through the cracks" and end up back in jail, needing the services the court provides. Participants and staff together will have to continue to assess whether readmittance makes sense, even if this assessment process is not perfect (see: Redlich 2005, 2010).

Criminal justice relief or criminal justice amplification?

A final – but critical – policy issue that requires further attention is the degree to which participation in mental health court results in worse criminal justice outcomes than traditional prosecution. Mental health courts are presented to participants as a better alternative – one in which they will receive help as opposed to punishment. To ensure this is not a "bait and switch," several issues must be addressed.

Participants need to receive a clear understanding of the outcome of traditional prosecution before joining mental health court. Depending on their case, some would receive less intensive probation sentences or short jail stays had they not joined mental health court. Some participants are aware of such alternatives and still choose to participate in mental health court – often desperate to get out of jail – but some reported only realizing later that they would have been better served by traditional prosecution or were uncertain of the outcome they would have faced, taking a gamble on mental health court. I did not observe what was communicated to participants, but based on their reports, it is important to pay greater attention to this informed consent process (and future scholarship should explore whether this shift towards diversion is creating greater ambiguity for defendants about their legal options, and if so, to what effect).

Additionally, participants should be alerted to the possibility of facing worse criminal justice outcomes through mental health court *if this is possible*, and these courts should work to minimize this possibility, which emerges in two ways. First, under intensive supervision, participants are given more chances according to the court model, but they are more likely to have behavior detected and responded to officially at court than they otherwise would have under traditional probation. For example, in one court, a concern was raised that warrants were being written for conduct that otherwise would not have received such responses outside the mental health court. This is important because warrants affect risk scores and future treatment within the criminal justice system. Second, participants can be sentenced more harshly after participating in mental health court for their conduct *within* mental health court. I only observed this happen two times in Kent County, when Judge Perry explicitly stated he was stepping outside of sentencing guidelines due to a participant's conduct, but I rarely observed sentencing decisions. Greater research is needed to better examine the degree to which these courts extend supervision and punishment rather than solely offering a better alternative to traditional prosecution. (Moreover, in terms of transparency, it would be useful for participants to be able to learn accurately what criminal justice outcomes they faced if they quit the mental health court while still participating in it.)

Of course, if these courts are serving as a sorting mechanism within the criminal justice system to identify those deemed deserving of aid (diverting them from the criminal justice system) and those deemed deserving of punishment (cycling them back into the criminal justice system and perhaps extending their stay within it), such extensions of punishment might not be deemed problematic from the vantage point of practitioners or policymakers. Yet, if this is part of the objective of these courts, it should be made transparent to all involved, particularly defendants in the informed consent process.

Final Remarks

In ending, I turn back to the remarks of Judge Ash referred to in the introduction. Reflecting on the problems facing mental health courts she said:

> "If it was a quick fix, I think it would be done by now. …But at least with mental health courts my attitude is: Enough. The solution, who knows, right, who knows? But I'd rather try than just sit back and bitch about it."

We have spent decades responding to the problems embodied by today's mental health court participant through incarceration – a strategy that most involved recognize to be ineffective and deleterious. Moreover, for those participants who are severely ill or caught up in substance misuse and abuse, we have offered little by way of systematic solution to their persistent issues. While some engage in only minor offenses such as loitering, public urination, or drug possession, the stakes of neglecting these issues can be high. Some will overdose, commit suicide, or, as in the memorable case cited by Judge Ash in which a man sat outside until he froze to death, fundamentally fail to take care of themselves. I have observed on more than one occasion family members in moments of desperation and despair petition the court to hospitalize their brothers, daughters, and granddaughters who are engaging in behaviors that are incredibly harmful, often first and foremost to themselves. From this vantage point, it is clear that these courts are tackling an incredibly complex but important set of challenges that, as Judge Ash contends, have far from straightforward solutions.

I also want to note the efforts of those working within the courts to imagine a better future and take seriously the plight of their participants. After all, when I think of the mental health courts I observed, I tend to think about the ways in which I was regularly surprised by the kind of commitment exhibited by staff – the program coordinator who persistently chased down a recalcitrant foster care worker who was doing little to help a participant regain custody of her children, the treatment administrator who went out at night trying to track down participants whose welfare she was deeply concerned about, the case manager who talked daily to a young participant who desperately needed some consistency of care, the probation officers whose probationers kept returning to them for help after they graduated, and the judges who often enough wanted to give the participant just one more chance because they hoped he or she really could have a better outcome. These staff members were not sitting back waiting for the ideal system; they were trying to create the best possible outcomes for participants with the resources they had.

However, when I think of these mental health courts, I also think about the participants who, too, are striving to achieve better outcomes. Commonly, we see these participants – criminal offenders – in terms of bad choices and individual pathologies. Yet, I am arguing that a better way of understanding participants – and their outcomes in this context – is through more closely attending to the complex interplay between how they are equipped to navigate

institutional contexts like the court and what these contexts demand of them. These disconnects are bigger than immediately visible to the eye and disparately distributed among the participant base. Further, they reflect a more fundamental disconnect between socially marginalized groups and the state in the context of social welfare retrenchment and criminal justice expansion.

Asking participants – and, for that matter, staff – to remedy this disconnect is far from fair or just. Both deserve more.

Bibliography

Abreu, José. 1999. “Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapist,” *Journal of Consulting and Clinical Psychology* 67.3:387-393.

Alexander, Michelle. 2012. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York: The New Press.

Andersen, Ditte. 2014. “Storytelling in Drug Treatment: How Professionals Make Sense of What They Consider Inauthentic Client Claims.” Contemporary Drug Problems 41.4: 491-506.

Angermeyer, Matthias C. and Herbert Matschinger. “Public Beliefs about Schizophrenia and Depression: Similarities and Differences.” *Social Psychiatry and Psychiatric Epidemiology* 38.9: 526-534.

Anshensel, Carol S. and Jo C. Phelan. 1999. “The Sociology of Mental Health: Surveying the Field,” in *Handbook of the Sociology of Mental Health*, eds., Carol. S. Aneshensel and Jo C. Phelan. New York: Springer.

Anspach, Renee R. 2010. “Gender and Health Care” in *Handbook of Medical Sociology*, sixth edition, eds., Chloe E. Bird, Peter Conrad, Allen M. Fremont, and Stefan Timmermans. Nashville, TN: Vanderbilt University Press.

Anspach, Renee R. 2012. Preface to *Sociology of Diagnosis*, eds., P.J. McGann and David J. Hutson. Bingley, UK: Emerald Group Publishing.

Anthony, William. 1992. “A Revolution in Vision,” *Innovations & Research* 1: 18-20.

Anthony, William. 1993. “Recovery from Mental Illness: The Guiding Vision of the Mental Health Services in the 1990s. *Psychosocial Rehabilitation Journal* 16.4: 11-23.

Anthony, William. 2000. “A Recovery Oriented Service System: Setting Some System Level Standards,” *Psychiatric Rehabilitation Journal* 24.2: 159-168.

Anthony, William. 2003. “Expanding the Evidence Base in an Era of Recovery,” *Psychiatric Rehabilitation Journal* 27.1: 1-2.

Armstrong, Elizabeth M. 1998. “Diagnosing Moral Order: The Discovery and Evolution of Fetal Alcohol Syndrome.” *Social Science and Medicine* 47.12: 2025-2042.

Armstrong, Elizabeth M. 2003. *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome & the Diagnosis of Moral Disorder*. JHU Press.

Auyero, Javier. 2012. *Patients of the State: The Politics of Waiting in Argentina*. Durham: Duke University Press.

Baker, Kimberly. 2013. "Decision Making in a Hybrid Organization: A Case Study of a Southwestern Drug Court Treatment Program." *Law & Social Inquiry* 38.1: 27-54.

Barlow, Melissa Hickman. 1998. "Race and the Problem in 'Time' and 'Newsweek' Cover Stories, 1946 to 1995." *Social Justice* 25.2: 149-183.

Battilana, Julie, and Silva Dorado. 2010. Building Sustainable Hybrid Organizations: The Case of Commercial Finance Organizations. *Academy of Management Journal* 53.6: 1419–40.

Battilina, Julie and Matthew Lee. 2014. "Advancing Research on Hybrid Organizing," *The Academy of Management Annals* 8.1: 397-441.

Beckett, Katherine and Bruce Western. 2001. "Governing Social Marginality: Welfare, Incarceration, and the Transformation of State Policy." *Punishment & Society* 3: 43-59

Bell, Monica C. 2016. "Situational Trust: How Disadvantaged Mothers Reconceive Legal Cynicism." *Law & Society Review* 50.2: 314-347.

Bell, Monica C. 2017. "Police Reform and the Dismantling of Legal Estrangement." *The Yale Law Journal*: 2054-2150.

Bendelow, Gillian. 1993. "Pain Perceptions, Emotions, and Gender." *Sociology of Health and Illness* 15.3: 273-293.

Berger, Peter L. and Thomas Luckmann. 1967. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Garden City, NY: Doubleday.

Berman, Greg, and John Feinblatt. 2005. *Good Courts: The Case for Problem-Solving Justice.* New York: New Press.

Bernheim, B. Douglas, Debraj Ray, and Sevin Yeltekin. 2015. "Poverty and Self-Control." *Econometrica* 83.5: 1877-1911.

Bertrand, Marianne and Sendhil Mullainathan. 2004. "Are Emily and Greg More Employable than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination," *American Economic Review* 94.4: 991-1013.

Binder, Amy. 2007. "For Love and Money: Organizations' Creative Responses to Multiple Environmental Logics," *Theory and Society* 36.6: 547-571.

BJA (Bureau of Justice Assistance). 2005. *A Guide to Mental Health Court Design and Implementation*. A report prepared by the Council of State Governments Justice Center. New York: US Department of Justice.

BJA (Bureau of Justice Assistance). 2008a. *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court*. A report prepared by the Council of State Governments Justice Center. New York: US Department of Justice.

BJA (Bureau of Justice Assistance). 2008b. *Mental Health Courts: A Primer for Policymakers and Practitioners*. A report prepared by the Council of State Governments Justice Center. New York: US Department of Justice.

BJS (Bureau of Justice Statistics). 2016. Strong, Suzanne M., Ramona R. Rantala, and Tracey Kyckelhahn. "Census of Problem-Solving Courts, 2012." Revised 2016.

Bosk, Emily Adlin. 2013. "Between Badness and Sickness: Reconsidering Medicalization for High Risk Children and Youth." *Children and Youth Services Review* 35: 1212-1218.

Boulware, L. Ebony, Lisa A. Cooper, Lloyd E. Ratner, Thomas A. LaVeist, and Neil R. Powe. 2003. "Race and Trust in the Health Care System." *Public Health Reports* 118: 358-365.

Bourdieu, Pierre and Jean-Claude Passerson. 1977. *Reproduction in Education, Society and Cul*ture. Beverly Hills, CA: Sage.

Bourdieu, Pierre. 1986. "The Forms of Capital," in *Handbook of Theory and Research for the Sociology of Education*, ed., John G. Richardson. New York: Greenwood Press.

Bourdieu, Pierre. 1991. "On Symbolic Power" in *Language and Symbolic Power*. Cambridge, M.A.: Harvard University Press.

Bourdieu, Pierre and Loic J. Wacquant. 1992. *An Invitation to Reflexive Sociology*. Chicago: University of Chicago Press.

Braslow, Joel Tupper. 2013. "The Manufacture of Recovery," *Annual Review of Clinical Psychology* 9: 781-809.

Brayne, S. 2014. "Surveillance and System Avoidance: Criminal Justice Contact and Institutional Attachment." *American Sociological Review* 78.2: 290-314.

Brekhus, Wayne H. 2008. "Trends in the Qualitative Study of Social Identities." *Sociology Compass* 2.3: 1059-1078.

Brown, Phil. 1987. "Diagnostic Conflict and Contradiction in Psychiatry." *Journal of Health and Social Behavior* 28.1: 37-50.

Brown, Phil. 1990. "The Name Game: Toward a Sociology of Diagnosis." *The Journal of Mind and Behavior* 11: 385-406.

Brown, Phil. 1995. "Naming and Framing: The Social Construction of Diagnosis and Illness." *Journal of Health and Social Behavior* 35: 34-52.

Burns, Stacy Lee, and Mark Peyrot. 2003. "Tough Love: Nurturing and Coercing Responsibility and Recovery in California Drug Courts." *Social Problems* 50 (3): 416–38.

Campbell, Rosalyn Denise and Orion Mowbray. 2016. "The Stigma of Depression: Black American Experiences." *Journal of Ethnic & Cultural Diversity in Social Work* 25.4: 253-269.

Canada, Kelli E. and Matthew W. Epperson. 2014. "The Client-Caseworker Relationship and Its Association with Outcomes Among Mental Health Court Participants." *Community Mental Health Journal* 50: 968-973.

Canada, Kelli E. and Virginia Aldige Hiday. 2014. "Procedural Justice in Mental Health Court: An Investigation of the Relation of Perception of Procedural Justice to Non-Adherence and Termination." *The Journal of Forensic Psychiatry & Psychology* 25.3: 321-340.

Canada, Kelli E. and Amy C. Watson. 2013. "'Cause Everybody Likes to Be Treated Good': Perceptions of Procedural Justice among Mental Health Court Participants." *American Behavioral Scientist* 57.2: 209-230.

Carter, Prudence. 2005. *Keepin' It Real: School Success Beyond Black and White*. New York: Oxford University Press.

Casey, Briege and A. Long. "Meanings of Madness: A Literature Review," Journal of Psychiatric and Mental Health Nursing 10: 89-99.

Casey, Pamela M. and David B. Rottman. 2005. "Problem-Solving Courts: Models and Trends," *Justice System Journal* 26.1: 35-56.

Castellano, Ursula. 2011. "Courting Compliance: Case Managers as "Double Agents" in the Mental Health Court." *Law & Social Inquiry* 36.2: 484-514.

Chambliss, William J. 1973. "The Saints and the Roughnecks." *Society* 11.1: 24-31

Charmaz, Kathy and Linda Liska Belgrave. 2012. "Qualitative Interviewing and Grounded Theory Analysis," chpt. in *The SAGE Handbook of Interview Research: The Complexity of the Craft Second Edition*, eds., Jaber F. Gubrium, James A. Holstein, Amir B. Marvasti, and Karyn D. McKinney. Thousand Oaks, SAGE Publications: 347-366.

Chiarello, Elizabeth. 2013. "How Organizational Context Affects Bioethical Decision-Making: Pharmacists' Management of Gatekeeping Processes in Retail and Hospital Settings," *Social Science & Medicine* 98: 319-329.

Chiarello, Elizabeth. 2015. "The War on Drugs Comes to the Pharmacy Counter: Frontline Work in the Shadow of Discrepant Institutional Logics," *Law & Social Inquiry* 40.1: 86-122.

Clair, Matthew. 2018. "Resources, Navigation, and Punishment in the Criminal Courts." SocArXiv Papers.

Clark, Jack A. and Elliot G. Mishler. 1992. "Attending to Patients' Stories: Reframing the Clinical Task." *Sociology of Health & Illness* 14.3: 344- 372.

Clear, Todd R. 2009. Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Neighborhoods Worse. New York: Oxford University Press.

Clement, S. O. Schauman, T. Graham, F. Maggioni, S. Evans-Lacko, N. Bezborodovs, C. Morgan, N. Rusch, J.S.L. Brown, and G. Thornicroft. 2015. "What is the Impact of Mental Health-Related Stigma on Help-Seeking: Systematic Review of Quantitative and Qualitative Studies." *Psychological Medicine* 45.1: 11-27.

Cloutier, C. and Langely, A. 2013. "The Logic of Institutional Logics: Insights from French Pragmatist Sociology," *Journal of Management Inquiry* 22.4: 360-380.

Colyer, Corey J. 2007. "Innovation and Discretion The Drug Court as a People-Processing Institution." *Criminal Justice Review Policy* 18: 313–29.

Comfort, Megan. 2007. "Punishment Beyond the Legal Offender," *Annual Review of Law & Social Science* 3: 271-296.

Comfort, Megan. 2008. *Doing Time Together: Love and Family in the Shadow of the Prison*. The University of Chicago Press.

Conrad, Peter. 1979. "Types of Medical Social Control." *Sociology of Health & Illness* 1:1–11.

Conrad, Peter. 1985. "The Meaning of Medications: Another Look at Compliance." *Social Science & Medicine* 20.1: 29-37.

Conrad, Peter. 1987. "The Noncompliant Patient in Search of Autonomy," *The Hastings Center Report* 17.4: 15-17.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18:209–32.

Conrad, Peter, and Schneider, Joseph W. 1980. "Medicine as an Institution of Social Control: Consequences for Society" chpt 9 in *Deviance and Medicalization: From Badness to Sickness*. St. Louis: Mosby: 241-260.

Conrad, Peter and Deborah Potter. 2000. "From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories." *Social Problems* 47.4: 559-582.

Conrad, Peter and Kristin K. Barker. 2010. "The Social Construction of Illness: Key Insights and Policy Implications." *Journal of Health and Social Behavior* 511: 67-79.

Cook, Kay E. 2012. "Stigma and the Interview Encounter" in *The SAGE Handbook of Interview Research: The Complexity of the Craft*, eds. Jaber F. Gubrium, James A. Holstein, Amir B. Marvasti, and Karyn D. McKinney. Thousand Oaks, SAGE Publications: 333-345.

Corrigan, Patrick, Vetta Thompson, David Lambert, Yvette Sangster, Jeffrey G. Noel, and Jean Campbell. 2003. "Perceptions of Discrimination Among Persons with Serious Mental Illness." *Psychiatric Services* 54.8: 1105-1110.

Corrigan, Patrick W. and Amy C. Watson. 2002. "Understanding the Impact of Stigma on People with Mental Illness" *World Psychiatry* 1.1: 16-20.

Corrigan, Patrick W. and Amy C. Watson. 2007. "The Stigma of Psychiatric Disorders and the Gender, Ethnicity, and Education of the Perceiver." *Community Mental Health Journal* 43.5: 439-458.

Crenshaw, Kimberlé. 1991. "Mapping the Margins: Identity Politics, Intersectionality, and Violence Against Women," Stanford Law Review 43.6: 1241-1291.

Cruishank, Barbara. 1999. *The Will to Empower: Democratic Citizens and Other Subjects*. Ithaca, NY: Cornell University Press.

D'Aunno, Thomas, Robert I. Sutton, and Richard H. Price. 1991. "Isomorphism and External Support in Conflicting Institutional Environments: A Study of Drug Abuse Treatment Units," *The Academy of Management Journal* 34.3: 636-661.

Devine, Patricia G. and Andrew J. Elliot. 1995. "Are Racial Stereotypes *Really* Fading? The Princeton Trilogy Revisited" *Personality and Social Psychology Bulletin* 21.11: 1139-1150.

Dhalla, R. and Oliver, C. 2013. "Industry Identity in an Oligopolistic Market and Firms' Responses to Institutional Pressures," Organizational Studies 34: 1803-1834.

Dobransky, Kerry. 2009. "The Good, the Bad, and the Severely Mentally Ill: Official and Informal Labels as Organizational Resources in Community Mental Health Services," *Social Science & Medicine* 69: 722-728.

Donahue, Eric and Dawn Moore. 2009. "When is an Offender not an Offender?: Power, the Client, and Shifting Penal Subjectivities." *Punishment & Society* 11: 319-336.

Drake, Robert E., Susan M. Essock, Andrew Shander, Kate B. Carey, Kenneth Minkoff, Lenore Kola, David Lynde, Fred C. Osher, Robin E. Clark, and Lawrence Rickards. 2001. "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness." *Psychiatric Services* 52.4: 469-476.

Drake, Robert E., Kim T. Mueser, Mary F. Brunette, and Gregory J. McHugo. 2004. "A Review of Treatments for People with Severe Mental Illness and Co-Occurring Substance Use Disorders." *Psychiatric Rehabilitation Journal* 27.4: 360-374.

Duckworth, Angela L. and Martin E.P. Seligman. 2005. "Self-Discipline Outdoes IQ in Predicting Academic Performance of Adolescents." *Psychological Science* 16: 939-944.

Eberhardt, Jennifer L., Phillip Atiba Goff, Valerie J. Purdie, and Paul G. Davies. 2004. "Seeing Black: Race, Crime, and Visual Processing." *Journal of Personality and Social Psychology* 87.6: 876-893.

Edgerton, Jason D. and Lance W. Roberts. 2014. "Cultural Capital or Habitus? Bourdieu and Beyond in the Explanation of Enduring Educational Inequality." *Theory and Research in Education* 12.2: 193-220.

Edin, Kathryn and Laura Lein. 1997. "Work, Welfare, and Single Mothers' Economic Survival Strategies." *American Sociological Review* 62.2: 253-266.

Epperson, Matthew W., Nancy Wolff, Robert D. Morgan, William H. Fisher, B. Christopher Frueh, and Jessica Huening. 2014. "Envisioning the Next Generation of Behavioral Health and Criminal justice Interventions." *International Journal of Law and Psychiatry* 37.5: 427-438.

Erikson, Bonnie H. 1996. "Culture, Class, and Connections." *American Journal of Sociology* 102.1: 217-251.

Ethier, Kathleen A. and Kay Deaux. 1994. "Negotiating Social Identity When Contexts Change: Maintaining Identification and Responding to Theat." *Journal of Personality and Social Psychology* 67.2: 243-251.

Fairbanks, Robert P. 2009. *How It Works: Recovering Citizens in Post-Welfare Philadelphia*. Chicago, IL: The University of Chicago Press.

Feagin, Joe. 2006. *Systemic Racism: A Theory of Oppression*. New York: Routledge.

Fisher, William H., Eric Silver, and Nancy Wolff. 2006. "Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research." *Administration and Policy in Mental Health and Mental Health Services Research* 33.5: 544-557.

Foster, Holly and John Hagan. 2009. "The Mass Incarceration of Parents in America: Issues of Race / Ethnicity, Collateral Damage to Children, and Prisoner Reentry," *The ANNALS of the American Academy of Political and Social Science* 623: 179-194.

Fox, Kathryn J. 1999. "Changing Violent Minds: Discursive Correction and Resistance in the Cognitive Treatment of Violent Offenders in Prison." *Social Problems* 46.1: 88-103.

Frank, Richard G. and Sherry A. Glied. 2006. *Better But Not Well: Mental Health Policy in the United States since 1950*. Baltimore: The John Hopkins University Press.

Fraser, Suzanne, Kiran Pienaar, Ella Dilkes-Frayne, David Moore, Renata Kokanovic, Carla Treloar, and Andrian Dunlop. 2017. "Addiction Stigma and Biopolitics of Liberal Modernity: A Qualitative Analysis." *International Journal of Drug Policy* 44: 192-201.

Friedland, Roger, and Robert R. Alford. 1991. "Bringing Society Back In: Symbols, Practices and Institutional Contradictions." In *The New Institutionalism in Organizational Analysis,* ed. Walter J. Powell and Paul J. DiMaggio, 232–63. Chicago, IL: University of Chicago Press.

Fullagar, Simone. 2009. "Negotiating the Neurochemical Self: Anti-Depressant Consumption in Women's Recovery from Depression," *Health* 13.4: 389-406.

Gagne, Jeffrey R. 2017. "Self-Control in Childhood: A Synthesis of Perspectives and Focus on Early Development." *Child Development Perspectives* 11.2: 127-132.

Gamwell, Lynn and Nancy Tomes. 1995. *Madness in America: Cultural and Medical Perceptions of Mental Illness Before 1914*. Cornell University Press.

GAO (Government Accountability Office). 2005. *Adult Drug Courts: Evidence Indicates Recidivism and Mixed Results for Other Outcomes – Report to Congressional Committees*. Washington DC: US Government Accountability Office.

Garland, David. 2001. *The Culture of Control: Crime and Social Order in a Contemporary Society*. Chicago: University Press.

Gary, Faye A. 2005. "Stigma: Barrier to Mental Health Care Among Ethnic Minorities." *Issues in Mental Health Nursing* 26: 929-999.

Glaser, Barney G. and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative*. Chicago: Aldine.

Godderis, Rebecca. 2011. “From Talk to Action: Mapping the Diagnostic Process in Psychiatry,” chpt in *Sociology of Diagnosis*, eds., P.J. McGann and David J. Hutson. Bingley, UK: Emerald Group Publishing.

Gold, Moniqueka E. and Heraldo Richards. 2012. “To Label or Not to Label: The Special Education Question for African Americans.” *Educational Foundations* 26: 143-156.

Goffman, Alice. 2009. “On the Run: Wanted Men in a Philadelphia Ghetto.” *American Sociological Review* 74.3: 339-357.

Goffman, Alice. 2014. On the Run: Fugitive Life in an American City. Chicago: The University of Chicago Press.

Goffman, Erving. 1956. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Goffman, Erving. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Garden City, NY: Anchor Books.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.

Gottfredson, Michael R. and Travis Hirschi. 1990. *A General Theory of Crime.* Stanford, CA: Stanford University Press.

Gowan, Teresa. 2010. *Hobos, Hustlers, and Backsliders: Homeless in San Francisco*. University of Minnesota Press.

Gowan, Teresa and Sarah Whetstone. 2012. “Making the Criminal Addict: Subjectivity and Social Control in a Strong-Army Rehab.” *Punishment & Society* 14.1: 69-93.

Graham, Sandra and Brian S. Lowery. 2004. “Priming Unconscious Racial Stereotypes about Adolescent Offenders.” *Law and Human Behavior* 28.5: 483-504.

Grazian, David. 2003. *Blue Chicago: The Search for Authenticity in Urban Blues Clubs*. Chicago, IL: University of Chicago Press.

Greenwood, Royston, Mia Raynard, Farah Kodeih, Evelyn R. Micelotta, and Michael Lounsbury. 2011. “Institutional Complexity and Organizational Responses.” *The Academy of Management Annals* 5.1: 317-371.

Grinyer, Anne and Carol Thomas. 2012. “The Value of Interviewing on Multiple Occasions or Longitudinally,” chpt. in *The SAGE Handbook of Interview Research: The Complexity of the Craft Second Edition*, eds., Jaber F. Gubrium, James A. Holstein, Amir B. Marvasti, and Karyn D. McKinney. Thousand Oaks, SAGE Publications: 219-230.

Grob, Gerald N. 1994. *The Mad Among Us: A History of the Care of America’s Mentally Ill*. New York: The Free Press.

Gubrium, Jaber F. and James A. Holstein, eds. 2001a. *Institutional Selves: Troubled Identities in a Postmodern World*. New York, Oxford University Press.

Gubrium, Jaber F. and James A. Holstein. 2001b. "Trying Times, Troubled Selves," introduction to *Institutional Selves: Troubled Identities in a Postmodern World*. New York, Oxford University Press.

Gusfield, Joseph R. 1963. *Symbolic Crusade: Status Politics and the American Temperance Movement*. Chicago, IL: University of Illinois Press.

Gustafson, Kaaryn S. 2011. *Cheating Welfare: Public Assistance and the Criminalization of Poverty*. New York University Press.

Hall, John R. 1992. "The Capital(s) of Cultures: A Nonholistic Approach to Status Situations, Class, Gender, and Ethnicity," chpt 11 in *Cultivating Differences: Symbolic Boundaries and the Making of Inequality*, eds., Michelle Lamont and Marcel Fournier. The University of Chicago Press.

Hallett, Tim. 2010. "The Myth Incarnate: Recoupling Processes, Turmoil, and Inhabited Institutions in an Urban Elementary School," *American Sociological Review* 75.1: 52-74.

Haney, Lynne. 2004. "Introduction: Gender, Welfare, and States of Punishment." *Social Politics* 11.3: 333-362.

Haney, Lynne A. 2010. *Offending Women: Power, Punishment, and the Regulation of Desire*. Berkeley: University of California Press.

Hannah-Moffatt, Kelly. 2001. *Punishment in Disguise: Penal Governance and Federal Imprisonment of Women in Canada*. Toronto: University of Toronto Press.

Hannah-Moffatt, Kelly. 2004. "Losing Ground: Gendered Knowledges, Parole Risk, and Responsibility." *Social Politics* 11.3: 363-385.

Hansen, Helna, Philippe Bourgois, and Ernest Drucker. 2014. "Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma under Welfare Reform." *Social Science & Medicine* 103: 76-83.

Harding, David J. 2010. *Living the Drama: Community, Conflict, and Culture Among Inner-City Boys*. Chicago: University of Chicago Press.

Harding, David J., Jeffrey D. Morenoff, Anh P. Nguyen, and Shawn D. Bushway. 2017. "The short- and long-term effects of imprisonment on future felony convictions and prison admissions." Proceedings of the National Academy of Sciences.

Harris, Alexes, Heather Evans, and Katherine Beckett. 2010. Drawing Blood from Stones: Legal Debt and Social Inequality in the Contemporary United States. *American Journal of Sociology* 115:1753-1799.

Hasenfeld, Yeheskel. 1972. "People Processing Organizations: An Exchange Approach." *American Sociological Review* 37.3: 256-263.

Hasenfeld, Yeheskel. 2000. "Organizational Forms as Moral Practices: The Case of Welfare Departments." *Social Service Review* 74.3: 329-351.

Hasenfeld, Yeheskel. 2010. "The Attributes of Human Service Organizations" in *Human Services as Complex Organizations* (2nd ed), pp9-32. Sage Publications.

Heimer, Carol A. 1999. "Competing Institutions: Law, Medicine, and Family in Neonatal Intensive Care," *Law & Society Review* 33.1: 17-66.

Heritage, John and Douglas W. Maynard. 2006. "Problems and Prospects in the Study of Physician-Patient Interaction: 30 Years of Research." *Annual Review of Sociology* 32: 351-374.

Hiday, Virginia Alidige and Padraic J. Burns. 2010. "Mental Illness and the Criminal Justice System," chpt 24 in Teresa L. Scheid and Tony N. Brown (Eds.) *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp478-498). Second Edition. New York: Cambridge University Press.

Higgins, Paul C. and Mitchell B. Mackinem, eds. 2009. *Problem-Solving Courts: Justice for the Twenty-First Century?* Santa Barbara, CA: Praeger.

Hinshaw, Stephen P. and Richard M. Scheffler. 2014. *The ADHD Explosion: Myths, Medication, Money, and Today's Push for Performance*. New York: Oxford University Press.

Holstein, James A. 1992. "Producing People: Descriptive Practice in Human Service Work." *Current Research on Occupations and Professions* 7: 23-40.

Hoppe, Trevor. 2013. "Controlling Sex in the Name of 'Public Health': Social Control and Michigan HIV Law," *Social Problems* 60.1: 27-49.

Hoppe, Trevor. 2014. "From Sickness to Badness: The Criminalization of HIV in Michigan," *Social Science & Medicine* 101: 139-147.

Horowitz, Alan V. 1999. "The Sociological Study of Mental Illness: A Critique and Synthesis of Four Perspectives," in *Handbook of the Sociology of Mental Health*, eds., Carol. S. Aneshensel and Jo C. Phelan. New York: Springer.

Horowitz, Alan V. 2010. "An Overview of Sociological Perspectives on the Definitions, Causes and Responses to Mental Health and Illness," in *A Handbook for the Study of Mental Health*, second edition, eds., Teresa L. Scheid and Tony N. Brown. New York: Cambridge.

Hughes, Shannon and Terry Peak. 2013. "A Critical Perspective on the Role of Psychotropic Medications in Mental Health Courts." *American Behavioral Scientist* 57.2: 244-265.

Huisang, Ruth and Susan S. Silbey. 2011. "Governing the Gap: Forging Safe Science through Relational Regulation." *Regulation & Governance* 5:14-42.

Huisang, Ruth and Susan S. Silbey. 2013. "Constructing Consequences for Noncompliance: The Case of Academic Laboratories." *The ANNALS of the American Academy of Political and Social Science* 649: 157-177.

Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: The National Academies Press.

Jacobson, Nora. 2004. *In Recovery: The Making of Mental Health Policy*. Amsterdam, Netherlands: VU University Press.

Jarzabkowki, Paula, Michael Smets, Rebecca Bednarek, Gary Burke, and Paul Spee. 2013. "Institutional Ambidexterity: Leveraging Institutional Complexity in Practice," *Research in the Sociology of Organizations* 39: 37-61.

Jay, J. 2013. "Navigating Paradox as a Mechanism of Change and Innovation in Hybrid Organizations," *Academy of Management Journal* 56.1: 137-159.

Jutel, Annemarie. 2009. "Sociology of Diagnosis: A Preliminary Review." *Sociology of Health & Illness* 31.2: 278-299.

Kaufman, Nicole, Joshua Kaiser, and Cesraea Rumpf. 2018. "Beyond Punishment: The Penal State's Interventionist, Covert, and Negligent Modalities of Control." *Law & Social Inquiry* 43.2: 468-495.

Kaye, Kerwin. 2012. "Rehabilitating the 'Drugs Lifestyle': Criminal Justice, Social Control, and the Cultivation of Agency" *Ethnography*: 1-26.

Kilty, Jennifer M. 2012. "'It's Like They Don't Want You to Get Better': Psy Control of Women in the Carceral Context" *Feminism & Psychology* 22.2: 162-182.

Kim, Catherine Y., Daniel J. Losen, and Damon T. Hewitt. 2010. *The School-to-Prison Pipeline: Structuring Legal Reform*. New York: New York University Press.

Kirk, David S. and Andrew V. Papachristos. 2011. "Cultural Mechanisms and the Persistence of Neighborhood Violence," *American Journal of Sociology* 116.4: 1190-1233.

Kleinman, Arthur. 1988. "Conflicting Explanatory Models in the Care of the Chronically Ill." *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kohler-Hausman, Issa. 2013. "Misdemeanor Justice: Control without Conviction," *American Journal of Sociology* 119.2: 351-393.

Kohler-Hausman, Issa. 2014. "Managerial Justice and Mass Misdemeanors," *Stanford Law Review* 66: 611-694.

Kohler-Hausman, Issa. 2018. *Misdemeanorland: Criminal Courts and Social Control in an Age of Broken Windows Policing*. Princeton University Press.

Kopelovich, Sarah, Philip Yanos, Christina Pratt, and Joshua Koerner. 2013. "Procedural Justice in Mental Health Courts: Judicial practices, participant perceptions, and outcomes related to mental health recovery." International Journal of Law and Psychiatry 36: 113-120.

Kraatz, Matthew S. and E.S. Block. 2008. "Organizational Implications of Institutional Pluralism." In R. Greenwood, C. Oliver, K. Sahlin-Andersson, and R. Suddaby (eds.). The SAGE Handbook of Organizational Institutionalism: 243-275. Thousand Oaks, CA: Sage.

Kulesza, Magdalena, Mary E. Larimer, and Deepa Rao. 2013. "Substance Use Related Stigma: What We Know and the Way Forward." *Journal of Addictive Behaviors, Therapy, and Rehabilitation* 2.2: 997-1003.

Lara-Millan, Armando. 2014. "Public Emergency Room Overcrowding, Mass Incarceration, and the Politics of Waiting." *American Sociological Review*. 79: 866-887.

Lara-Millan, Armando and Nicole Gonzalez Van Cleve. 2017. "Interorganizational Utility of Welfare Stigma in the Criminal Justice System." *Criminology* 55.1: 59-84.

Lareau, Annette. 2003, 2011. *Unequal Childhoods: Class, Race, and Family Life*. Berkeley: University of California Press.

Lareau, Annette and Elliot B. Weininger. 2003. "Cultural Capital in Educational Research: A Critical Assessment," *Theory and Society* 32: 567-606.

Lawrence, Thomas, Roy Suddaby, and Bernard Leca. 2011. "Institutional Work: Refocusing Institutional Studies of Organization," *Journal of Management Inquiry* 20.1: 52-58.

Leon, Chrysanthi S. and Corey S. Shdaimah. 2012. "Justifying Scrutiny: State Power in Prostitution Diversion Programs." *Journal of Poverty* 16: 250-273.

Link, Bruce G. and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 35: 80-94.

Link, Bruce G., Jo C. Phelan, Michaeline Bresnahan, Ann Stueve, and Bernice A. Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89.9: 1328-1333.

Link, Bruce G. and Jo C. Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology* 27: 363-385.

Lipsky, Michael. 1980. *Street-Level Bureaucracy: Dilemmas of The Individual in Public Services*. New York: Russell Sage Foundation.

Livingston, James D. and Jennifer E. Boyd. 2010. "Correlates and Consequences of Internalized Stigma for People Living with Mental Illness: A Systematic Review and Meta-Analysis." *Social Science & Medicine* 71.12: 2150-2161.

Lorber, Judith and Lisa Jean Moore. 2002. *Gender and the Social Construction of Illness*. Lanham, MD: AltaMira Press.

Lundman, Richard J. 2003. "The Newsworthiness and Selection Bias in News About Murder: Comparative and Relative Effects of Novelty and Race and Gender Typifications on Newspaper Coverage of Homicide." *Sociological Forum* 18.3: 357-386.

Lynch, Mona. 2000. "Rehabilitation as Rhetoric: The Ideal of Reformation in Contemporary Parole Discourses and Practices." *Punishment and Society* 2.1: 40-65.

Lynch, James P. and William J. Sabol. 2004. "Assessing the Effects of Mass Incarceration on Informal Social Control in Communities," *Criminology & Public Policy* 3.2: 267-294.

Mackinem, Mitchell B., and Paul Higgins. 2007. Tell Me about the Test: The Construction of Truth and Lies in Drug Court. *Journal of Contemporary Ethnography* 36 (3): 223–51.

Malacrida, Claudia. 2004. "Medicalization, Ambivalence, and Social Control: Mothers' Descriptions of Educators and ADD/ADHD." *Health: An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine* 8.1: 61-80.

Malkin, Victoria. 2005. "The End of Welfare as We Know It: What Happens When the Judge is in Charge," *Critique of Anthropology* 25: 361-388.

McCall, Leslie. 2005. "The Complexity of Intersectionality," *Signs* 30.3: 1771-1800.

McCorkel, Jill A. 2013. *Breaking Women: Gender, Race, and the New Politics of Imprisonment*. New York: New York University Press.

McGann, P.J. and David J. Hutson 2011 *Sociology of Diagnosis*. Bingley, UK: Emerald Group Publishing.

McGuire, Thomas G. and Jeanne Miranda. 2003. "New Evidence Regarding Racial and Ethnic Disparities in Mental Health: Policy Implications," *Health Affairs* 27.2: 393-403.

McKim, Allison. 2008. "'Getting Gut-Level': Punishment, Gender, and Therapeutic Governance," Gender and Society 22.3: 303-323.

McKim, Allison. 2017. *Addicted to Rehab: Race, Gender, and Drugs in the Era of Mass Incarceration*. New Jersey: Rutgers University Press.

McPherson, Chad and Michael Sauder. 2013. "Logics in Action: Managing Institutional Complexity in a Drug Court." *Administrative Science Quarterly* 58.2: 165-196.

McNeill, Fergus and Kristen Beyens. 2013. "Introduction: Studying Mass Supervision," in *Offender Supervision in Europe*, eds. Fergus McNeill and Kristen Beyens. Basingstoke: Macmillan.

Miller, JoAnn and Donald C. Johnson. 2009. *Problem Solving Courts: A Measure of Justice*. Lanham, MD: Rowman and Littlefield.

Miller, Holly Ventura. 2005. "Self-Control and Health Outcomes in a Nationally Representative Sample." *American Journal of Health Behavior* 35.1: 15-27.

Miller, Reuben. 2014. "Devolving the Carceral State: Race, Prisoner Reentry, and the Micro Politics of Urban Poverty Management." *Punishment & Society* 16.3: 305-335.

Monahan, John, Marvin Swartz, and Richard J. Bonnie. 2003. "Mandated Treatment in the Community for People with Mental Disorders," *Health Affairs* 22.5: 28-38.

Moore, Dawn. 2007. *Criminal Artefacts: Governing Drugs and Users*. Vancouver BC: UBC Press.

NADCP (National Association of Drug Court Professionals). 1997. *Defining Drug Courts: The Key Components*. Washington, DC: US Department of Justice, Drug Court Programs Office.

Nadeem, Erum, Jane M. Lange, Dawn Edge, Marie Fonwa, Tom Belin, and Jeanne Miranda. 2007. "Does Stigma Keep Poor Young Immigrant and U.S.-Born Black and Latina Women From Seeking Mental Health Care?" *Psychiatric Services* 58.12: 1547-1554.

Natapoff, Alexandra. 2015. “Misdemeanors,” *Annual Review of Law and Social Sciences* 11: 255-267.

Neighbors, Harold W., Steven J. Trierweiler, Briggett C. Ford, and Jordana R. Muroff. 2003. “Racial Differences in DSM Diagnosis Using a Semi-Structured Instrument: The Importance of Clinical Judgement in the Diagnosis of African Americans,” *Journal of Health and Social Behavior* 43: 237-256.

New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America: Final Report*. Publication SMA-03-3832. Rockville, MD: Department of Health and Human Services.

NIMH (National Institute of Mental Health). 2019. Mental Health Information. Retrieved from: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Nippert-Eng, Christena E. 1996. *Home and Work: Negotiating Boundaries through Everyday Life*. Chicago, IL: University of Chicago Press.

Nolan, James L., Jr. 2001. *Reinventing Justice: The American Drug Court Movement*. Princeton, NJ: Princeton University Press

Nolan, James L. 2003. “Redefining Criminal Courts: Problem-Solving and the Meaning of Justice,” *American Criminal Law Review*, 40: 1541-1565.

Nolan, James. 2009. *Legal Accents, Legal Borrowing: The International Problem-Solving Court Movement* Princeton, NJ: Princeton University Press.

NRC (National Research Council). 2014. *The Growth of Incarceration in the United States: Exploring Causes and Consequences. Committee on Causes and Consequences of High Rates of Incarceration*, Jeremy Travis, Bruce Western, and S. Redburn, Editors. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

O’Malley, Pat. 1996. “Volatile and Contradictory Punishment.” *Theoretical Criminology* 3: 175-196.

Omi, Michael and Howard Winant 1994. *Racial Formation in the United States: From the 1960s to the 1990s*, second edition. New York: Routledge.

Pache, A. and Santos, F. 2010. “When Worlds Collide: The Internal Dynamics of Organizational Responses to Conflicting Institutional Demands,” *Academy of Management Review* 35: 455-476.

Paik, Leslie. 2006a. “Are You Truly a Recovering Dope Fiend? Local Interpretive Practices at a Therapeutic Community Drug Treatment Program.” *Symbolic Interaction* 29 (2): 213-234.

Paik, Leslie. 2006b. “Organizational Interpretations of Drug Test Results.” *Law and Society Review* 40.4: 931–62.

Paik, Leslie. 2011. *Discretionary Justice: Looking Inside a Juvenile Drug Court.* New Brunswick, NJ and London: Rutgers University Press.

Pager, Devah. 2003. “The Mark of a Criminal Record.” *American Journal of Sociology* 108.5: 937-975.

Pager, Devah. 2007. *Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration*. Chicago: University of Chicago Press.

Pager, Devah and Hana Shepherd. 2008. "The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets," *Annual Review of Sociology* 34: 181-209.

Pager, Devah, Bruce Western, and Bart Bonikowski. 2009. "Discrimination in Low Wage Labor Market: A Field Experiment." *American Sociological Review* 74.5: 777-799.

Parsons, Talcott. 1951. *The Social System*. Glencoe, IL: The Free Press.

Phelan, Jo C., Bruce G. Link, Ann Steve, and Bernice A. Pescosolido. 2000. "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and Is It to be Feared?" *Journal of Health and Social Behavior* 41.2: 188-207.

Phelan, Jo C. and Bruce G. Link. 2015. "Is Racism a Fundamental Cause of Inequalities in Health?" *Annual Review of Sociology* 41: 311-330.

Pollack, Shoshana. 2005. "Taming the Shrew: Regulating Prisoners Through Women-Centered Mental Health Programming." *Critical Criminology* 13: 71-87.

Pollack, Shoshana. 2006. "Therapeutic Programming as a Regulatory Practice in Women's Prisons." *Criminalizing Women: Gender and (In)justice in Neo-liberal Times*: 236-249.

Porter, Rachel, Michael Rempel, and Adam Mansky. 2010. *What Makes a Court Problem-Solving? Universal Performance Indicators for Problem-Solving Justice*. New York: Center for Court Innovation.

Pratt, Travis C. and Francis T. Cullen. 2000. "The Empirical Status of Gottfredson and Hirschi's General Theory of Crime: A Meta-Analysis." *Criminology* 38.3: 931-964.

Quillian, Lincoln, Devah Pager, Ole Hexel, and Arfinn H. Midtboen. 2017. "Meta-Analysis of Field Experiments Shows No Change in Racial Discrimination in Hiring over Time." Proceedings of the National Academy of Sciences of the United States of American. 114.41: 10870-10875.

Rajan, Valli, Ronald Kramer, and Hung-En Sung. 2014. "Changing Narrative Accounts: How Young Men Tell Different Stories When Arrested, Enduring Jail Time and Navigating Community Reentry." *Punishment & Society* 16.3: 285-304.

Ramey, David M. 2015. "The Social Structure of Criminalized and Medicalized School Discipline." *Sociology of Education* 88.3: 181-201.

Rao, Deepa, Joseph Feinglass, and Patrick Corrigan. 2007. "Racial and Ethnic Disparities in Mental Illness Stigma." *The Journal of Nervous and Mental Disease* 195.12: 1020-1023.

Ravalovich, Adam. 2001. "The Conceptual History of Attention Deficit Hyperactivity Disorder: Idiocy, Imbecility, Encephalitis, and the Child Deviant, 1877-1929." *Deviant Behavior: An Interdisciplinary Journal* 22: 93-115.

Ravalovich, Adam. 2005. "Relational Troubles and Semiofficial Suspicion: Educators and the Medicalization of 'Unruly Children'." *Symbolic Interaction* 28.1: 25-46.

Reay, Trish and Hinings, Christopher R. 2009. "Managing the Rivalry of Competing Institutional Logics," *Organization Studies* 30.6: 629-652.

Redlich, Allison D. 2005. "Voluntary, But Knowing and Intelligent?: Comprehension in Mental Health Courts." *Psychology, Public Policy, and Law* 11.4: 605-619.

Redlich, Allison D., Steven Hoover, Alicia Summers, and Henry J. Steadman. 2010. "Enrollment in Mental Health Courts: Voluntariness, Knowingness, and Adjudicative Competence." *Law and Human Behavior* 34: 91-104.

Reiman, Jeffrey. 2014. "The Implicit Ideology of Criminal Justice," in *Deviance Across Cultures: Constructions of Deviance*, second edition, ed. Robert Heiner. New York: Oxford University Press.

Reinarman, Craig. 2003. "The Social Construction of Drug Scares," chpt 14 in *Constructions of Deviance: Social Power, Context, and Interactio*n, 4th edition, eds. Patricia A. Adler and Peter Adler. Thomson Wadsworth.

Richardson, Amanda, Jane Appleyard Allen, Haijun Xiao, and Donna Vallone. 2012. "Effects of Race/Ethnicity and Socioeconomic Status on Health Information-Seeking, Confidence and Trust," *Journal of Health Care for the Poor and Underserved* 23.4: 1477-1493.

Ridgely, M. Susan, John Enberg, Michael Greenberg, Susan Turner, Christine DeMartini, and Jacob W. Dembosky. 2007. *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court*. Santa Monica, CA: RAND Corporation.

Rios, Victor M. 2009. "The Consequences of the Criminal Justice Pipeline on Black and Latino Masculinity." *The ANNALS of the American Academy of Political and Social Science 623.1*: 150-162.

Rios, Victor M. 2011. *Punished: Policing the Lives of Black and Latino Boys*. New York: New York University Press.

Rome, Dennis. 2004. Black Demons: The Media's Depiction of the African American Male Criminal Stereotype. Westport, CT: Praeger.

Room, Robin. 2005. "Stigma, Social Inequality and Alcohol and Drug Use." *Drug and Alcohol Review* 24: 143-155.

Rose, Nikolas. 1998. *Inventing Ourselves: Psychology, Power, and Personhood.* Cambridge, UK: Cambridge University Press.

Rose, Nikolas. 1999. *Governing the Soul: The Shaping of the Private Self*, second edition. New York, NY: Free Association Books.

Rose, Nikolas. 2000. "Government and Control," *British Journal of Criminology* 40: 321-339.

Sallaz, Jeffrey J. and Jane Zavisca. 2007. "Bourdieu in American Sociology, 1980-2004," *Annual Review of Sociology* 33: 21-41.

SAMHSA (Substance Abuse and Mental Health Service Administration) 2002. Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders. Substance Abuse and Mental Health Services Administration. U.S. Department of Health and Human Services.

SAMHSA (Substance Abuse and Mental Health Service Administration). 2006. National Consensus Statement on Mental Health Recovery. Washington, DC: U.S. Department of Health and Human Services. http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf

SAMHSA (Substance Abuse and Mental Health Service Administration). 2012. Working Definition of Recovery. U.S. Department of Health Services.

Sampson, Robert J. and Dawn Jeglum Bartusch. 1998. "Legal Cynicism and (Subcultural?) Tolerance of Deviance: The Neighborhood Context of Racial Differences," *Law & Society Review* 32.4: 777-804.

Sarteschi, Christine M., Michael G. Vaughn, and Kevin Kim. 2011. "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review." *Journal of Criminal Justice* 39: 12-20.

Scott, James C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.

Seo, Myeong-Gu and W.E. Douglas Creed. 2002. "Institutional Contradictions, Praxis, and Institutional Change: A Dialectical Perspective," *The Academy of Management Review* 27.2: 222-247.

Sered, Susan Starr and Maureen Norton-Hawk. 2014. *Can't Catch a Break: Gender, Jail, Drugs, and the Limits of Personal Responsibility.* Oakland, CA: University of California Press.

Shdaimah, Corey S. and Chrysanthi Leon. 2014. "'First and Foremost They're Survivors': Selective Manipulation, Resilience, and Assertion Among Prostitute Women." *Feminist Criminology* 10.4: 1-22.

Shdaimah, Corey S. and Shelly A. Weichelt. 2012. "Converging on Empathy: Perspectives on Baltimore City's Specialized Prostitution Diversion Program." *Women & Criminal Justice* 22.2: 156-173.

Shoemaker, Sarah J. and Djenane Ramalho de Oliveira. 2008. "Understanding the Meaning of Medications for Patients: The Medication Experience," *Pharmacy World & Science* 30.1: 86-91.

Simon, Jonathon. 1993. *Poor Discipline: Parole and the Social Control of the Underclass, 1890-1990*. Chicago: The University of Chicago Press.

Skeem, Jennifer L., Sarah Manchak, and Jillian K. Peterson. 2011. "Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction." *Law and Human Behavior* 35: 110-126.

Skoll, Geoffrey R. 1992. *Walk the Walk and Talk the Talk: An Ethnography of a Drug Abuse Treatment Facility*. Philadelphia, PA: Temple University Press.

Solomon, Phyllis, Leslie Alexander, and Stacey Uhl. 2010. "The Relationship of Case Managers' Expressed Emotion to Clients' Outcomes." *Social Psychiatry and Psychiatric Epidemiology* 45: 165-174.

Soss, Joe Brian. 2002. *Unwanted Claims: The Politics of Participation in the U.S. Welfare System*. Ann Arbor, MI: The University of Michigan Press.

Soss, Joe, Richard C. Fording, and Sanford F. Schram. 2011. *Disciplining the Poor.* Chicago: University of Chicago Press.

Spencer, Jack. 2001. "Self-Presentation and Organizational Processing in a Human Service Agency" in *Institutional Selves: Troubled Identities in a Postmodern World,* eds., Jaber F. Gubrium and James A. Holstein, eds. New York, Oxford University Press.

Staats, Cheryl, Kelly Capatosto, Robin A. Wright, and Danya Contractor. 2015. *State of the Science: Implicit Bias Review 2015*. Kirwan Institute for the Study of Race and Ethnicity at the Ohio State University.

Steadman, Henry J. 1992. "Boundary spanners: a key component for the effective interactions of the justice and mental health systems." *Law and Human Behavior* 16:75–87.

Steadman, Henry J., Susan Davidson, and Collie Brown. 2001. "Mental Health Courts: The Promise and Unanswered Questions." Law & Psychiatry 52.4: 457-458.

Stephens, Nicole M., Hazel Rose Markus, and L. Taylor Phillips. 2014. "Social Class Culture Cycles: How Three Gateway Contexts Shape Selves and Fuel Inequality," *Annual Review of Psychology* 65: 611-634.

Stokely, Carmichael and Charles V. Hamilton 1967. *Black Power: The Politics of Liberation in America*. New York: Vintage Books.

Stuart, Forrest. 2016. *Down, Out, and Under Arrest: Policing and Everyday Life in Skid Row*. Chicago: The University of Chicago Press.

Swartz, David. 1997. *Culture and Power: The Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.

Swidler, Ann. 1986. "Culture in Action: Symbols and Strategies." *American Sociological Review* 51.2: 273-286.

Tangney, June P., Roy F. Baumeister, and Angie Luzio Boone. 2004. "High Self-Control Predicts Good Adjustment, Less Pathology, Better Grades, and Interpersonal Success." *Journal of Personality* 72.2: 271-322.

Tausig, Mark. 2007. "Mental Disorder" in *Blackwell Encyclopedia of Sociology*, ed., George Ritzer. Blackwell Publishing.

Thornton, Patricia and William Ocasio. 2008. "Institutional Logics." *The SAGE Handbook of Organizational Institutionalism*. Royston Greenwood, Christine Oliver, Kerstin Sahlin, and Roy Suddaby, eds. London: SAGE Publications: 99-129.

Thorton, Patricia H., William Ocasio, and Michael Lounsbury. 2012. *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process*. Oxford: Oxford University Press.

Throits, Peggy A. 2010. "Sociological Approaches to Mental Illness," in *A Handbook for the Study of Mental Health*, second edition, eds., Teresa L. Scheid and Tony N. Brown. New York: Cambridge.

Throits, Peggy A. 2011. "Resisting the Stigma of Mental Illness." *Social Psychology Quarterly* 74.1: 6-28.

Tiger, Rebecca. 2012. *Judging Addicts: Drug Courts and Coercion in the Justice System*. New York: New York University Press.

Tilly, Charles. 1993. "Contentious Repertoires in Great Britain, 1758-1834." *Social Science History* 17.2: 253-280.

Travis, Jeremy. 2003. "Invisible Punishment: An Instrument of Social Exclusion" in *Invisible Punishment: The Collateral Consequences of Mass Imprisonment*, eds., Marc Mauer and Meda Chesney-Lind. New York: The New Press.

Trimbur, Lucia. 2009. "'Me and the Law is Not Friends': How Former Prisoners Make Sense of Reentry." *Qualitative Sociology* 32: 259-277.

Uggen, Christopher, Mike Vuolo, Sarah Lageson, Ebony Ruhland, and Hilary K. Whitham. 2014. "The Edge of Stigma: An Experimental Audit of the Effects of Low-Level Criminal Records on Employment," *Criminology* 52.4: 627-654.

U.S. Department of Health and Human Services. 2001. *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, M.D.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Van Cleve, Nicole Gonzalez. 2016. *Crook County: Racism and Injustice in America's Largest Criminal Court*. Stanford, California: Stanford University Press.

van Ryn, Michelle. 2002. "Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care," *Medical Care* 40.1: 140-151.

van Ryn, Michelle and Steven S. Fu. 2003. "Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?" *American Journal of Public Health* 93.2: 248-255.

Wacquant, Loic. 2000. "The New 'Peculiar Institution': On the Prison as Surrogate Ghetto," *Theoretical Criminology* 4.3: 377-389.

Wacquant, Loic. 2009. *Punishing the Poor: The Neoliberal Government of Social Inequality*. Durham: Duke University Press.

Wade, Allan. 1997. "Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression," *Contemporary Family Therapy* 19.1: 23-39.

Wald, Johanna and Daniel J. Losen. 2003. "Defining and Redirecting a School-to-Prison Pipeline." *New Directions for Youth Development* 99: 9-15.

Wales, Heathcote W., Virginia Aldige Hiday, and Bradley Ray. 2010. "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism." *International Journal of Law and Psychiatry* 33.4: 265-271.

Watkins-Hayes, Celeste. 2009. *The New Welfare Bureaucrats: Entanglements of Race, Class, and Policy Reform*. Chicago: University of Chicago Press.

Weber, Max. 1905, 1949. *The Methodology of the Social Sciences*. New York: Free Press.

Weinberg, Darin. 1996. "The Enactment and Appraisal of Authenticity in a Skid Row Therapeutic Community." *Symbolic Interaction* 19.2: 137-162.

Weinberg, Darin. 2000. "'Out There': The Ecology of Addiction in Drug Abuse Treatment Discourse." *Social Problems* 47.4: 606-621.

Welch, Kelly. 2007. "Black Criminal Stereotypes and Racial Profiling." *Journal of Contemporary Criminal Justice* 23.3: 276-288.

Western, Bruce. 2006. *Punishment and Inequality in America*. New York: Russell Sage Foundation.

Wheelock, Darren. 2005. "Collateral Consequences and Racial Inequality: Felon Status Restrictions as a System of Disadvantage," *Journal of Contemporary Criminal Justice* 21.1: 82-90.

Whetstone, Sarah and Teresa Gowan. 2017. "Carceral Rehab as Fuzzy Penality: Hybrid Technologies of Control in the New Temperance Crusade." *Social Justice* 44.2/3: 83-112.

Williams, David R. and Selina A. Mohammed. 2018. "Racism and Health" in *Handbook of Medical Sociology*, sixth edition, eds. Chloe E. Bird, Peter Conrad, Allen M. Fremont, and Stefan Timmermans. Nashville: Vanderbilt University Press.

Wilson, David B., Ojmarrh Mitchell, and Doris L. Mackenzie. 2006. "A Systematic Review of Drug Court Effects on Recidivism," *Journal of Experimental Criminology* 2: 459-487.

Winick, Bruce J. and David B. Wexler, eds. 2003. *Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts*. Durham, NC: Carolina Academic Press.

Wirth, James H. and Galen V. Vodenhausen. 2009. "The Role of Gender in Mental-Illness Stigma: A National Experiment." *Psychological Science* 20.2: 169-173.

Wolf, Robert V. 2007. Principles of Problem-Solving Justice. New York: The Center for Court Innovation.

Xie, Huiting. 2013. "Strengths-Based Approach for Mental Health Recovery," *Iranian Journal of Psychiatry and Behavioral Sciences* 7.2: 5-10.