THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES ON ADULT MENTAL HEALTH COURT INVOLVEMENT: A QUALITATIVE EXPLORATION

by

PORTER F. JENNINGS

(Under the Direction of Orion P. Mowbray)

ABSTRACT

There is a high rate of trauma among individuals involved in the U.S. criminal justice system in general, and especially among those with co-morbid mental illness who participate in mental health court (MHC). Additionally, while large-scale studies have identified a correlation between childhood trauma and criminal activity as an adult, few studies have explored this phenomenon from the perspective of participants. The purpose of this study was to address this gap by exploring *how* adverse childhood experiences (ACEs) impact adult MHC involvement. This research was guided by the following four research questions: a) what is the prevalence of ACEs among MHC graduates, b) how do ACEs impact participants' involvement in criminal activity and referral to MHC, c) how do ACEs impact MHC programmatic experience, and d) how do ACEs impact participants' outcomes following graduation from MHC.

Data for this qualitative inquiry was collected using the original 10-item ACEs measure and semi-structured interviews with 15 graduates of a Southeastern MHC program. Using narrative analytic techniques, data was collected in two phases: narrative analysis and analysis of narratives. Findings from narrative analysis yielded individual,

restoried narratives for each participant that chronologically depicted how ACEs impacted their MHC involvement.

In the second phase of analysis, participant's individual narratives were analyzed for thematic patterns in the data that relate to the guiding research questions. The following primary findings were generated from data analyses and interpretation: a) there is a high prevalence of ACEs among participants, b) most participants perceived their ACEs had a moderate-to-strong impact on their criminal activity and subsequent referral to MHC, c) most participants described their MHC programmatic experience as restorative and beneficial, and d) most participants described their outcomes following graduation from MHC as positive with no recidivism. Findings depict how ACEs can impact adult MHC involvement at all stages. Implications include recommendations for enhancing trauma-informed criminal just research and practice.

INDEX WORDS: Mental Health Courts, Adverse Childhood Experiences, Trauma, Trauma-Informed Criminal Justice Reform,

THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES ON ADULT MENTAL HEALTH COURT INVOLVEMENT: A QUALITATIVE EXPLORATION

by

PORTER F. JENNINGS

BA, Sewanee: The University of the South, 2010

MSW, The University of Georgia, 2012

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2019

© 2019

Porter F. Jennings

All Rights Reserved

THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES ON ADULT MENTAL HEALTH COURT INVOLVEMENT: A QUALITATIVE EXPLORATION

by

PORTER F. JENNINGS

Major Professor:	Orion Mowbray
Committee:	Jennifer Elkins
	Edwin Risler

Electronic Version Approved:

Suzanne Barbour
Dean of the Graduate School
The University of Georgia
May 2019

DEDICATION

This dissertation is dedicated to all the individuals I have worked with, all of whom have shown tremendous resilience in the face of adversity. Additionally, this dissertation is dedicated to my friends and family who have supported me along this journey, including my parents (Nan H. Newman and Jack S. Jennings), my grandparents (Victor and Joe Ann Hanson, and Richard and Luticia Jennings), and my aunts (Victoria Hunter and Tish Spearman) – all of whom have provided me with a lifetime of unconditional love and support.

Finally, this dissertation is dedicated to Stephen, my partner in life. Without you, none of this would have been possible. Seeing your kindness to others restores my faith in humanity and gives me hope, and the love you give me every day motivates me to keep moving forward. I am so grateful for our past, our present, and our future together, forever.

ACKNOWLEDGEMENTS

I am grateful to have had many amazing people who have supported me throughout my academic journey to whom I wish to express my extreme gratitude. First, I would like to thank the chair of my committee, Dr. Orion Mowbray. Dr. Mowbray, words cannot express how appreciative I am of all the amazing support you have shown me over the past several years. Your intelligence, skills, and wisdom have made me a better scholar in so many ways. Beyond acknowledging what an amazing academic mentor you are, I would like to most importantly thank you for showing me how it is possible to also remain a compassionate individual within the academy. Your integrity, grace, kindness, and sense of humor have made all of the difference in helping me to complete this process, and I can never fully express my gratitude to you. As I enter into academia, I will feel as though I have succeeded in my career if I can be at least a fraction of the mentor you have been to me. I will continue to express my gratitude to you by modeling the support you have shown me to the students I work with in the future. Thank you.

I would also like to extend my sincerest appreciation to the other members of my committee, Dr. Elkins and Dr. Risler. Dr. Elkins, thank you for your incredible support over the past several years. You have always been willing to talk with me and share your knowledge, and our conversations have helped me remain grounded. Your enthusiasm for your research area and your belief in me have had a profound and permanent impact in shaping my scholarly agenda, and I will forever be grateful for introducing me to the field of trauma and resiliency. Dr. Risler, thank you for being an amazing mentor, professor,

and person. I continue to learn from your expertise in social work practice and academia-especially as pertains to the intersection of social work and the criminal justice system. Thank you for believing in me and supporting me. Having your support gives me confidence to begin my academic career. I am so fortunate to have had the most supportive committee, and I am eternally grateful to each of them for the tremendous amount of support they have shown me (and helping me get a job!).

Additionally, I would like to thank the wonderful faculty and staff at The University of Georgia School of Social Work for their amazing support over the past decade. Kat Farlowe, Kerri Lewis, Christina Autry, Jeannel Muckle, and Mandi Albanese, thank you so much for your encouragement and support over the past several years, as well as for making logistical issues easier and more pleasant. Thank you also to the amazing professors who have gone above and beyond to educate me, mentor me, and shape me into a better scholar, social worker, and person.

I would like to especially thank the following faculty members: Dr. Alberta Ellett, thank you for believing in me from the beginning and for the experiences you have provided me; Dr. Jane McPherson, thank you for your, guidance, support, and for introducing me to the world of international social work; Dr. Rebecca Matthew, thank you for your unwavering support, positive nature, and teaching and research mentorship; Dr. Larry Nackerud, thank you for the support you have shown me over the past several years; Dr. Anna Scheyett, thank you for always going above and beyond for everyone at the School of Social Work; Dr. June Choi, thank you for your positive leadership, support, and encouragement; Dr. Sheri Miller, thank you for your guidance and instilling within me a love for theory; Dr. Leon Banks, thank you for your support over the past

decade and your unwavering enthusiasm-you always made my day brighter; Dr. Llewellyn Cornelius, thank you for the amazing amount of support you have provided me, and Dr. Rosalyn Campbell, thank you for your positive encouragement during stressful times. I would also like to thank professors from other disciplines at The University of Georgia, including Dr. Jori Hall (who solidified my passion for qualitive research), Dr. Andrew Gitlin (who empowered me to think critically), Dr. Seponski (for her amazing teaching, research, and character), as well as all my undergraduate professors from Sewanee who helped me establish a strong academic foundation.

I would also like to thank my amazing friends and colleagues at The University of Georgia School of Social Work, especially Tatiana Villarreal-Otálora, Christi Hardeman, Dr. Lauren Ricciardelli, Dr. Junior Lloyd Allen, Dr. Trasie Topple, Dr. Jennifer Benford, Yolanda Machado-Escudero, Joel Isler, and Dr. Irang Kim. Thank you to each and everyone one of you for your unwavering support and optimism over the past several years. Each have each brought me happiness and peace at difficult times and have provided me with more support than you will probably ever realize. Thank you also to my friends across other departments, including all of the Project F.R.E.E. leaders and team members, especially Stephanie Armes, Jenna Lamont, and Annika Karlsen.

Additionally, I would like to thank several individuals outside of The University of Georgia. I would like to extend my appreciation to the scholars in my area whose work has inspired me, especially Dr. Kelli Canada and Dr. Johnny Saldaña —you are both brilliant scholars, as well as kind and generous individuals. Furthermore, I would like to thank Douglas Morgan, who is an amazing social worker and person. I was so fortunate to have had you as a supervisor early in my social work career, as you instilled within me

a strong foundation for social work practice. You are truly making the world a better place through the integrity and extraordinary ethics you bring to supervision and practice. I will always be grateful for the opportunity to work with you, and I hope to be a strong a supervisor to others as you have been to me.

Finally, I would like to thank my friends that have provided me with consistent positive support and encouragement and have helped calm me down and keep me motivated along the way. A special thank you to my Athens people, especially Mary Catherine Hawks, Anna Ramminger, Stephanie Higdon, A.S, Donna Gordon, and everyone at Jittery Joes on the East Side. Thank you to my Nashville people, especially Colleen Dolan and Suzie Pfeil, who showed their amazing character in their decisions to support a new friend. And thank you to my old friends around the country, including Melissa Shipper, Sharnice Williams, and Sharetta Williams. Each of you all have shown tremendous patience by enduring many bouts of anxiety, frantic texts, and tears. I am forever indebted to each of you for your unwavering support.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS v

LIST OF TABLES xiii

LIST OF FIGURES xiv

CHAPTER

1 INTRODUCTION 1

Background of the Study 1

Statement of the Problem 4

Study Purpose and Research Questions 5

Overview of Research Method 5

Study Rationales and Significance 8

Definition of Key Terms 9

Chapter Summary 13

2 LITERATURE REVIEW 14

Introduction 14

The Intersection of Mental Health, the Criminal Justice System, and Social Work 14

Therapeutic Jurisprudence and the Emergence of Mental Health Courts 33

An Overview of Adverse Childhood Experiences 36

Theoretical Frameworks Guiding the Research..40

Chapter Summary 61

3 RESEARCH DESIGN AND METHOD 63

Introduction..63

Rationale for Qualitative Design 64

Researcher Reflexivity..68

Research Paradigm and Philosophical Assumptions 73

Basic Qualitative Inquiry 77

Study Procedures 79

Data Analysis, Synthesis, and Interpretation 87

Chapter Summary 93

4 RESEARCH FINDINGS..95

Introduction..95

Melinda's Story: "Jail was Not a Place for Me".......................................96

Claire's Story: "Change Hurts" 98

Dora's Story: "As a Little Girl, I thought Those Things were Supposed to Happen" 100

Tony's Story: At the End of the Day, We'ere All Criminals".................103

Travis's Story: "Anger Issues" 105

Jake's Story: "In Jail, They Treat You Like a Convict"..........................107

Morris's Story: "A Bunch of Things Happened" 110

Ariel's Story: "You Can't Always Be Hard on Yourself".......................112

Marcus's Story: "Wrong Place, Wrong Time".......................................115

Leonard's Story: "Life is Not About Living in the Light, It's About How You Bounce Back from the Dark" 116
Opal's Story: "This Body Ain't Made for No Jailhouse No More" 119
Christy's Story: "Maybe if Those Things Were Dealth with in Court, Things Would be Easier" 121
Denise's Story: "I Deserve a Happy, Good Life" 124
Thomas's Story: "The Losses Kept Coming" 127
Hannah's Story: "I Was Sick and Tired of Being Sick and Tired" 129
Chapter Summary 132
5 RESEARCH FINDINGS: ANALYSIS OF NARRATIVES 133
Introduction 133
Findings from Narrative Analysis: Four Themes 134
Theme 1: Prevalence of Adverse Childhood Experiences 136
Theme 2: Impact of Adverse Childhood Experiences on Mental Health Court Involvement 140
Theme 3: Impact of Adverse Childhood Experiences on Mental Health Court Programmatic Experience 144
Theme 4: Impact of Adverse Childhood Experiences on Mental Health Court Outcomes 146
Chapter Summary 150
6 CONCLUSIONS, LIMITATIONS, AND IMPLICATIONS 152
Introduction 152
Summary of Study Findings 153

Conclusions 153
Limitations 159
Implications 164
Chapter Summary 167
REFERENCES 169
APPENDICES 194
A Recruitment Script 194
B Informed Consent 196
C Interview Script 198
D ACEs Measure 200
E Semi-Structured Interview Guide 201
F Participant Handout 203
G Sample Selection of Codebook 204

LIST OF TABLES

Page

Table 1: Underlying Assumptions of Critical Theory Paradigm 42

Table 2: Underlying Assumptions of Complex Systems Theory 50

Table 3: Underlying Assumptions of Trauma Theory 59

Table 4: Origin of the Techniques Used in the Methodological Design 93

Table 5: Sociodemographic Characteristics of Respondents 134

Table 6: A Priori Themes Pertaining to Research Questions 135

Table 7: Themes, Categories, and Example Codes 136

Table 8: Cumulative ACE Scores for Participants (N = 15) 137

Table 9: Prevalence of ACEs by Category (N = 15) 139

Table 10: Prevalence of ACEs by Type (N = 15) 139

LIST OF FIGURES

Page

Figure 1: A timeline of policy and practice considerations 16

Figure 2: A trauma-informed, critical systems framework..62

CHAPTER 1

INTRODUCTION

Background of the Study

In 2019, over 2.2 million people were incarcerated in the United States (Sawyer & Wagner, 2019). Although there has been a recent decline in the national incarceration rate over the last decade (Kaeble & Cowhig, 2018), the United States continues to have one of the highest incarceration rates in the world. Despite being home to only 5% of the world's population, the United States contains about 25% of the world's prisoners (Coyle, Fair, Jacobson, & Walmsley, 2016; Travis, Western, & Redburn, 2014). Mass incarceration is associated with a number of adverse effects on individuals and society, including high economic costs (The Office of the Press Secretary, 2016), poor physical (Wildeman & Wang, 2017) and psychological health outcomes (Haney, 2012), and social injustices (Pettit & Gutierrez, 2018).

Overrepresentation of people with mental illness in the criminal justice system (CJS) is one of the many social injustices associated with mass incarceration in the United States (Canada, Markway, & Albright, 2016). Research has found that as many as 50% of individuals involved in the CJS have a diagnosed mental health issue (Bronson & Berzofsky, 2017; Canada & Gunn, 2013; Fazel & Danesh, 2002; James & Glaze, 2006), and approximately 14% have a diagnosed serious mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). Furthermore, individuals with mental illness experience a high risk for criminal recidivism after their initial involvement in the CJS. A

combination of consequences stemming from deinstitutionalization, insufficient community health care, and other factors has resulted in a return to the criminalization of mental illness with jails and prisons becoming "de facto mental health institutions" (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

One solution that has emerged in response to the mass incarceration crisis in the U.S. and the related deleterious effects is the emergence of problem-solving courts (PSCs) that provide alternative approaches to traditional punitive measures in favor of non-adversarial, treatment-based interventions (Miller, 2011). Examples of PSCs (sometimes also referred to as accountability courts), include family drug courts, domestic violence courts, co-occurring courts, and mental health courts (MHCs). The Bureau of Justice Association defines MHC as "a court with a specialized docket for certain defendants with mental illnesses" (Almquist & Dodd, 2009, p. 5). These court programs aim to improve the well-being of individuals with mental illness and their communities by providing accessible mental health treatment as alternatives to incarceration.

Though still in its nascency, research in this area has associated MHCs with reduced rates of criminal recidivism (Anestis & Carbonell, 2014; Lowder, Rade, & Desmarais, 2017) and increased utilization of mental health treatment (Han & Redlich, 2015). As such, the number of MHCs across the nation continues to increase, as does related research. Despite an increase in research on MHCs (e.g., Fisler, 2015; Lange, Rehm, & Popova, 2011; Loong, Bonato, & Dewa, 2016; Sarteschi, Vaughn, & Kim; 2011), there remain sizeable gaps in this body of literature, especially within social work. For example, scholars in this area have recommended that future related research explore

the following issues: how participants perceive their MHC experience, longitudinal outcomes associated with MHC completion, and factors associated with successful MHC completion–such as the relationship between specific types of mental health symptoms and MHC involvement (Canada et al., 2016).

As discussed by Canada and Gunn (2013), research on factors that impact MHC outcomes is scant. However, findings from the few studies conducted in this area have identified a correlation between specific mental health issues (e.g., psychotic features, dual diagnosis, and symptoms of anxiety and depression) and increased rates of recidivism and criminal activity (Canada et al., 2016; Douglas, Guy & Hart, 2009). The growing body of research on psychological trauma has increasingly identified this mental health issue as one that is correlated with several adverse effects, including involvement in criminal activity (Hilton, Ham, & Green, 2016; Reavis, Looman, Franco, & Rojas, 2013). Though research has identified a high prevalence of trauma among the general U.S. population—and especially individuals in the CJS— little is known about *how* trauma impacts MHC involvement (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017; Wolff, Frueh, Shi, Gerardi, Fabrikant, & Schumann, 2011; Wolff, Shi, & Siegal, 2009).

As a social work practitioner for nearly a decade who specialized in treatment with survivors of trauma, I repeatedly saw the pervasive, long-term effects of trauma among the individuals I worked with. One recurring phenomenon I observed was the adverse impact of childhood trauma on individuals across the lifespan, including the emergence of mental health symptoms that impacted behavior as an adult. In my social work practice experience, I repeatedly worked with survivors of childhood trauma who

experienced ongoing trauma-related symptoms as an adult that led them to engage in behaviors (e.g., disorderly conduct, substance abuse) that ultimately resulted in their arrest.

Despite recent increased attention on the need for trauma-informed care in the CJS (Council of State Governments Justice Center, 2016; Miller & Najavits, 2012; SAMHSA 2017, 2018), when I turned to the literature to explore this phenomenon, I was surprised to find a dearth of research in this area. To effectively promote the need for a trauma-informed CJS in the U.S., there needs to be a solid base of literature documenting *how* trauma impacts involvement in the CJS. Such information could advance trauma-informed CJS reform that could potentially prevent and address adverse outcomes of trauma, including chronic mental health issues, involvement in criminal behavior, arrest, and recidivism. Based on the observations from my practice experience and the above-discussed gap in literature, this research study aimed to explore how adverse childhood experiences (ACEs) impact MHC involvement, including an individual's' path to MHC involvement, programmatic experience, and outcomes following program completion.

Statement of the Problem

Previous research has identified the overrepresentation of individuals with mental health issues in the U.S. CJS (Canada & Gunn, 2013; Fazel & Danesh, 2002; James & Glaze, 2006; Steadman et al., 2009) and the need for MHCs to address this disparity (Almquist & Dodd, 2009; Anestis & Carbonell, 2014; Lowder et al., 2017). Among this population, trauma–and ACEs in particular–is a pervasive phenomenon that impacts mental health in this population (Hilton et al., 2016; Reavis et al., 2013; SAMHSA, 2017; Wolff et al., 2009; Wolff et al., 2011). Despite this knowledge, little information is

known about exactly *how* childhood trauma impacts MHC involvement. Such knowledge is needed to justify and guide trauma-informed criminal justice reform to address the criminalization of mental illness in the United States.

Study Purpose and Research Questions

The purpose of this exploratory qualitative study was to respond to the previously identified gaps in the literature by exploring how ACEs impact MHC involvement among graduates from a Southeastern MHC program. In this study, MHC involvement refers to participants' paths to involvement in MHC (i.e., criminal behavior resulting in arrest and referral to MHC), programmatic experience while enrolled in the MHC, outcomes following completion of the program, and graduation from the court. This study aimed to generate knowledge that can be used to affect positive social change, and was guided by the following four research questions:

1. What is the prevalence of ACEs among participants?
2. How do ACEs impact participants' paths to involvement in MHC?
3. How do ACEs impact participants' MHC programmatic experience?
4. How do ACEs impact MHC outcomes?

Overview of Research Methods

This basic qualitative study (Merriam, 2002) aimed to explore the prevalence and impact of ACEs among adult graduates of a Southeastern MHC program with the ultimate goal of generating knowledge to affect positive social change.

Guiding Paradigmatic and Theoretical Assumptions

The entire research process (i.e., from creation of the study questions, to methodological decisions regarding data collection and interpretation of findings) was

conducted within a transformative paradigm, which promotes utilization of research to enhance social justice (Mertens, 2009; 2010). Therefore, the overarching goal of this study was to generate knowledge that can be used to affect positive change, such as through recommendations for trauma-informed CJS reform. Maintaining consistency with these paradigmatic assumptions, three specific theoretical frameworks guided selection of the specific concepts focused on in this research: critical theory, complexity theory, and trauma theory.

Key tenants from these three theories were influential in informing my specific methodological decisions throughout the research process, as is recommended in qualitative research (Collins & Stockton, 2018). For example, guided by concepts from critical theory, I was especially interested in exploring how (if at all) participants experienced forms of oppression, marginalization, and vulnerability as a result of their mental health. These concepts led me to focus on how unmet mental health needs associated with childhood trauma may have impacted participants' arrest and subsequent isolation from society. Assumptions for complex systems theory further directed my focus to exploring how systemic factors impacted individual well-being, and how factors across system levels interact (e.g., how family relations impact a child's emotional well-being and later involvement in society as an adult). Finally, trauma-theory was influential in my choice to examine ACEs as the distinct type of mental health issue of focus in this study versus other types of mental health issues.

Sampling

Purposeful sampling (Patton, 2015) was used to identify study participants (N = 15). Purposeful sampling was selected as the sampling strategy implemented, as it allows

for intentional selection of “individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2013, p. 156). Participation was limited to individuals who had graduated from the program to allow for the exploration of the impact of ACEs on participants’ paths to MHC involvement, programmatic experience, and outcomes following graduation. Participants were recruited for the study through gatekeepers in the form of professional connections. As recommended by Glaser and Strauss (1967), data collection continued until the data were saturated (Saunders et al., 2018).

Data Collection

This study utilized two primary sources of data. One source of data consisted of participant responses to the original 10-item ACEs measure created by Felitti et al. (1998). The second (and primary) source of data consisted of semi-structured interviews with each participant ranging in length from approximately 60 to 90 minutes (Given, 2008).

Data Analysis

Using narrative analytic techniques, data analysis occurred in two primary stages: narrative analysis, followed by analysis of narratives (Polkinghorne, 1988). In stage one of analysis, interview recordings were transcribed verbatim, analyzed for major events, and placed in chronological order using restorying to create individual narratives. These provided a summarized plot depicting how ACEs impacted MHC involvement for each participant. In analysis of narratives, the second stage of analysis, these stories were then reviewed for reoccurring themes across participants that led to the identification of four central themes that corresponded with the four primary research questions that guided

this study.

Ethical Considerations and Trustworthiness

This study was approved by the University of Georgia Institutional Review Board prior to implementation. Consistent with the philosophical assumptions underlying qualitative inquiry guided by a transformative paradigm (Mertens, 2012), this study utilized a trauma-informed approach to research (SAMHSA, 2015a) to protect the well-being of participants and manage ethical considerations throughout data collection. Additionally, to enhance trustworthiness, several steps were taken, including triangulation of data, creation of an audit trail, and continuous researcher self-reflexivity to address biases (Patton, 2015).

Study Rationales and Significance

There were several rationales for this study. First, mass incarceration and the associated adverse effects continue to be a problem in the United States today. In order to address this social concern, there is a need for current research in this area to fill existing gaps in knowledge and to guide future studies addressing these dynamic issues. One specific gap in literature is the lack of research exploring how trauma—and ACEs in particular-impact adult involvement in the CJS. This study aimed to respond to expand knowledge in this area by gathering in-depth, detailed information about how ACEs impact MHC involvement.

Second, mass incarceration and its effects present social justice concerns, as these issues disproportionately impact subgroups of the population. As described by Pettit & Gutierrez (2018), "mass incarceration is characterized by its systematic targeting of particular segments of the population" (p. 1155). To date, the majority of research that

currently guides CJS reform and MHC interventions has largely been produced independently by scholars and professionals without the collaborative input of individuals within these subgroups. As such, more research is needed that incorporates the narratives of marginalized individuals and allows them to provide input in the research that shapes the future direction of CJS reform from the individuals who have experienced these issues firsthand. Guided by a transformative paradigmatic framework, this study provided graduates of a MHC a platform to share their voices and co-construct knowledge that can affect positive social change, especially as it pertains to trauma-informed CJS reform.

As the need for trauma-informed CJS reform is increasingly discussed in related literature (see for example, Levenson & Willis, 2017; Miller & Najavits, 2012; Ward & Roe-Sepowitz, 2009), numerous implications could be derived from these study findings. Specifically, knowledge from findings could be used to enhance trauma-informed policy, practice, research, and education in this area for social work and other related professions. For example, trauma narratives from the perspectives of survivors have increasingly been used in research to improve trauma-informed care (see for example, Jaeger, Lindblom, Parker-Guilbert, & Zoellner, 2014; Kallivayalil, Levitan, Brown, & Harvey, 2013; Knutsen & Jensen, 2017). From this study, participants' responses on how ACEs impacted their MHC involvement could provide information to enhance how trauma-informed care is provided to this population, as well as to identify optimal points for intervention across the lifespan.

Definition of Key Terms

Many of the terms used frequently throughout this study may be familiar to most readers. However, to ensure clarity surrounding the concepts integral to the themes of this

study, it is important to clearly define such terms as they will be used within the context of this research. Definition of the following terms were based on an extensive review of the literature:

1. *Participants* for this study were adult graduates of a Southeastern MHC program who had successfully completed and graduated from the program at the time of the study.
2. *Mental Health Court (MHC)* is defined by the Council of State Governments Justice Center as “a court with a specialized docket for certain defendants with mental illnesses” that aims to improve the well-being of individuals with mental illness and the communities in which they exist by providing accessible treatment and alternatives for incarceration (Almquist & Dodd, 2009. p. 5).
3. *Criminal Justice Reform* is a term that references efforts to improve the U.S. CJS. These efforts occur across system levels (e.g., at the state-level, at the federal level), and ultimately seek to make the CJS more just. The National Criminal Justice Association (2018) states that the overarching goals of CJS reform often involve improvements in the following areas: improving the reentry process, reducing offender recidivism, addressing mental health and substance use disorders in justice-involved populations, safely reducing prison and jail populations, and enhanced implementation of evidenced based practices in policy and practice (e.g., enhanced use of program evaluation and data sharing).

4. *Mental Illness,* also known as *any mental illness,* is defined by the National Institute of Mental Health (NIMH; 2017) as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and severe impairment (e.g., individuals with *serious mental illness* as defined below).
5. *Serious Mental Illness* is defined by NIMH (2017) "as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illness is particularly concentrated among those who experience disability due to serious mental illness."
6. *Trauma* is a term often used to refer to both an event that is perceived to be traumatic (i.e., physically and/or psychologically distressing) by an individual, as well as the adverse effects experienced by an individual following exposure to such an event. It is necessary to note that there are disagreements in related literature as to how to best conceptualize trauma (Pai, Suris, & North, 2016). For example, *The Diagnosis and Statistical Manual of Mental Disorders* (5th ed., *DSM-5*; American Psychiatric Association, 2013) provides diagnostic criteria for trauma that can be used to define this phenomenon. However, this conceptualization of trauma has been heavily critiqued for many reasons. For example, the *DSM-5* criteria for trauma does not account for subjective perceptions of events. Instead, the manual requires an event to contain "actual or threatened death, serious injury, or sexual violence" to be considered a trauma. (p. 271). Due to these limitations, the conceptualization of trauma in

this study extends beyond the criteria stated in the *DSM-5* to include psychosomatic events that may not contain actual or perceived physical harm, but that are perceived as traumatic by the individual (e.g., parental divorce).

7. *Adverse Childhood Experiences (ACEs)* are defined by SAMHSA (2018) as "stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders." The term originated from the original Kaiser Permanente ACEs study by Felitti et al. (1998), in which ten types of common childhood traumatic events were identified. It is noted that as research on ACEs has evolved over the past two decades, various definitions of ACEs have emerged that include additional categories and/or types of (e.g., poverty, community violence; Finkelhor, Shattuck, Turner, and Hamby, 2013).
8. *Trauma-Informed Care* (sometimes also referred to as *Trauma Informed Approach)* is defined using SAMHSA's (2014a) conceptualization of a framework involving four assumptions and six key principles, which is defined in the following manner: "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (p. 9).

9. *Trauma-Informed Criminal Justice Reform* refers to efforts to incorporate trauma-informed care in CJS reform given the high prevalence of trauma among this population (SAMHSA, 2015a). Such efforts are centered around ameliorating the adverse effects of trauma among this population (e.g., building resiliency), as well as efforts to prevent future traumatization and/or re-traumatization (SAMHSA, 2013a).

Chapter Summary

This chapter provided an overview of this study, including a discussion of the study background, statement of the problem, study purpose, research questions and methods, ethical considerations, and trustworthiness. This chapter concluded with a definition of key terms that will be used throughout this study. Chapter 2 will present a literature review of the study topic; Chapter 3 discusses the research design and methodology; Chapter 4 presents study findings from narrative analysis; Chapter 5 interprets the research findings using analysis of narratives; and Chapter 6 provides a discussion of the conclusions, limitations, and implications.

CHAPTER 2

LITERATURE REVIEW

Introduction

Chapter 1 provided an introductory overview of this study, which aimed to explore how ACEs impact adult MHC involvement. Additionally, the content in Chapter 1 provided a brief overview of the background to the study, the study purpose, and the research design. Chapter 2 presents an in-depth discussion of the literature related to the study topic.

The purpose of this literature review is twofold. First, it provides an overview of the current empirical literature on the study topic: ACEs and adult MHC involvement. The second purpose is to provide an overview of the theoretical frameworks used to guide this study. As discussed by Bloomberg and Volpe (2018), discussion of the theoretical assumptions adopted in this study provides insight into how the study was conceptualized, and how tenets from these theories informed decisions throughout the research process, such as the study foci on ACEs and MHC involvement.

The Intersection of Mental Health, the Criminal Justice System, and Social Work

Though mental health, criminal justice, and social work can be conceptualized as three distinct areas, they often intersect in both research and practice. For example, dating back to the Colonial Era and the establishment of American society, European settlers constructed regulations to govern social issues, which included stipulations to imprison the mentally ill if they were deemed a nuisance (Zwelling, 1985). Given U.S. society's

history of oppressing and marginalizing individuals with mental illness, social work has advocated for this population since the birth of the profession (Scheyett, Pettus-Davis, McCarter, & Brigham, 2012). To fully understand current issues within these areas and their relevance to social work, it is first necessary to establish a comprehensive understanding of how policy and practice considerations over time (e.g., major policies, and the interrelationship between the local, state, and federal CJSs) have shaped response by the field of social work.

Historical Considerations

Many theories used in social work to explain and predict phenomena related to social welfare and well-being (such as critical theory) emphasize the important role that history plays in shaping current practice considerations (Horkheimer, 1995). Such theories underscore the importance of analyzing how historical contexts have shaped both the social problems and interventions of interest to social work, as well as response efforts (Trattner, 1999; Wisner, 1960). Therefore, this section reviews four major historical movements that have significantly impacted social work practice with mentally ill individuals in the CJS, including (a) the prison reform movement, (b) the mental hygiene movement, (c) the deinstitutionalization movement, and (d) the community mental health care movement.

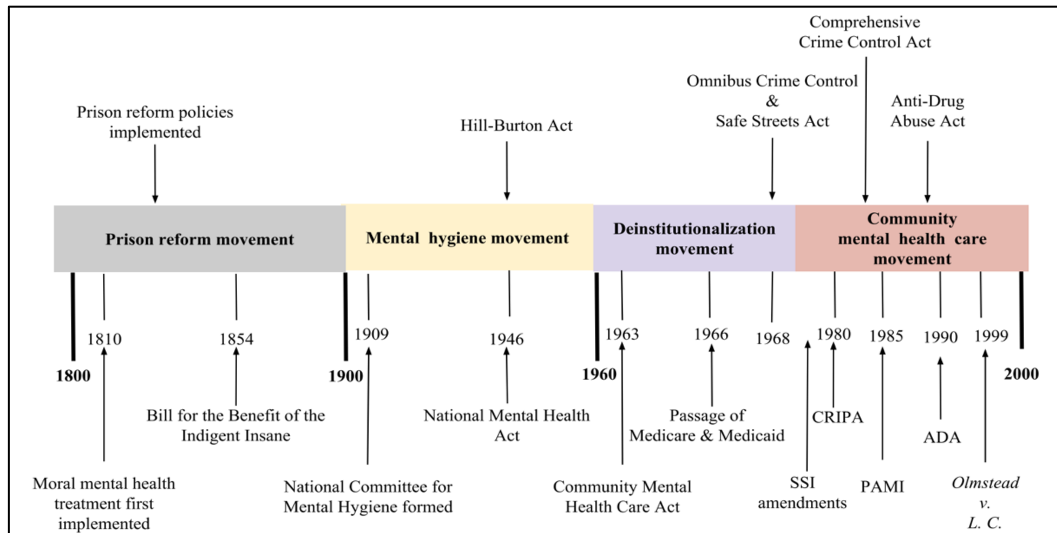

Figure 1. A timeline of policy and practice considerations. This timeline displays four historical movements and polices that have shaped social work response to the intersection of mental health and CJS.

Prison and asylum reform movement. Forms of CJSs and means of incarcerating and penalizing individuals who deviate from social norms (including the mentally ill) have been in existence in some form throughout humanity. For example, the Ur-Nammu code (which is the oldest surviving written code documenting criminalization in existence today) was created in 2112 BCE (Kimmel, 2018). Since the founding of the United States and the subsequent emergence of the American penal system, there have been concerns raised regarding how society respond to deviant behavior (Rothman, 1980; Scull, 2015).

Efforts in the late 1700s by Jeremy Bentham, John Stuart Mill, Benjamin Franklin, and the Society for Assisting Distressed Prisoners criticized the harsh treatment of prisoners. This criticism was largely inspired by early penological theorists, such as Cesarce Beccaria (1738-1794), who criticized torture and the death penalty as means of

punishment (Arrigo & Trull as cited in Trestman, Applebaum, & Metzner, 2015). Early advocacy efforts to reform the United States' penal system (by associations such as The Boston Prison Discipline to Society and The Philadelphia Society for Alleviating the Miseries of Public Prisons) marked the beginning of the prison reform movement. This movement also ignited efforts to improve the welfare of individuals with mental illness who had been housed in the CJS (Trestman et al., 2015).

This movement is especially important to the profession of social work, as Dorothea Dix–one of social work's first crusaders–played a prominent role in the prison reform movement of the 1800s by calling for reform specifically aimed at improving the treatment of the mentally ill (Parry, 2006). Dix worked to illuminate the criminalization of individuals with mental illness, describing their confinement "…*in cages, cellars, stalls, pens*! *Chained, naked, beaten with rods*, and *lashed* into obedience" (Dix, 1843 as cited in Bremmer, 1988, p. 64). Her work solidified the social injustices experienced by individuals with mental illness in the CJS as a signature practice consideration for the field of social work (Jansson, 2016). In effort to improve the well-being of this population, a period of institutionalization originated. This period was characterized by a push for public psychiatric hospitals (e.g., institutions, asylums) where those who suffered from mental illness could receive treatment in lieu of incarceration (Polizzi & Draper, 2016).

During this period, there was a push for institutional care, as providing scientific treatment to individuals in a hospital was hypothesized to be more humane than incarcerating individuals (Roberts & Kurtz, 1987; Scull, 2015). Advocacy for the construction of psychiatric hospitals was successful, as in 1880 there were a total of 75

public psychiatric hospitals to treat the nation's population of 91,959 individuals with mental illness (Torrey, 1997). At this time, individuals with mental illness only constituted .7% of the nation's total incarcerated population–a major improvement from the beginning of the 19th century when prisons and jails served as de-facto asylums.

Overall, the prison reform movement resulted in four striking practice considerations for social work with mentally ill individuals in the CJS. First, this movement solidified the treatment of individuals with mental illness involved in the CJS as a social problem of relevance to society at large, and a specific concern to the emerging field of social work (Gilligan, 2001). Concerns centered around the pervasive unjust, traumatizing conditions of incarceration (Huxter, 2013). Ironically, these very problems that were identified in the 18th and 19th century are still present today with prisons serving as de-facto mental institutions (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017; Torrey et al., 2010).

Second, the prison reform movement demarcates an influential period in the history of the treatment for mentally ill persons in the CJS, as for the first-time considerable attention was placed on identifying effective treatment models for mental illness. At this time, mental illness began to be recognized as something curable that did not intrinsically imply criminal behavior, nor merit criminalization (Polizzi & Draper, 2016; Scull, 2015). Instead, it was believed that scientific findings, such as those in the growing field of psychiatry, could be used to alleviate symptoms and rehabilitate individuals who deserved human, "moral treatment" (Roberts & Kurtz, 1987, p. 78). This movement reinforced institutionalization as a form of treatment for the mentally ill, as it

was initially believed to be more humane than the original incarceration response (Goldman & Morrissey, 1985).

Third, this movement marked the emergence of the unprecedented notion that the federal government should be tasked with providing treatment and resources to address the welfare of the mentally ill and criminals (Polizzi & Draper, 2016). Dorothea Dix's 1854 proposition of the "Bill for the Benefit of the Indignant Insane" (Brown, 1996) is one example of legislative advocacy initiated during this movement. Though this bill was eventually vetoed by President Pierce (a reflection of the social stigma towards mental health and promotion of a welfare state), this movement sparked action towards increasing the federal government's response to supporting this population–a debate still in effect today.

Fourth, the government's use of prisons and asylums to house the mentally ill during this movement has important theoretical implications for policy and practice in this area, as it symbolizes the historical pattern of the government's use of institutions to exert authoritarian control and power over vulnerable members of society to maintain the status quo (Foucault, 1977). For instance, 18th and 19th century state-run prisons (and the authorities who ran them) profited from the labor of the prisoners who were relegated to silence, solitary confinement, and hard work through penal methods such as the Auburn system (Rubin, 2017). The rise of the penal institution as a means of governmental social control at the expense of society's vulnerable individuals during this movement molded the shape of the current CJS which affects practice with this population.

The mental hygiene movement. Despite President Pierce's 1854 veto of the "Bill for the Benefit of the Indignant Insane" (which asked the federal government to

provide institutions to care for individuals with mental illness; Brown, 1996; Orlin, 1978), the institutionalization model nonetheless persevered and eventually emerged as a primary form of treatment for this population for approximately the next one hundred years (Scull, 2015). This model of care remained in effect through the mid-twentieth century (Polizzi & Draper, 2016; Rothman, 1980) with a total of 558,239 individuals with mental illness in public psychiatric hospitals by 1955 (Torrey, 1997). However, beginning at the turn of the 20th century, the increase in prevalence and discussion surrounding mental illness following the First and Second World War, combined with developments in the field of psychiatry, resulted in the emergence of the mental hygiene movement (Meyer, 1942) associated with Clifford Beers and Adolf Meyer (March & Oppenheimer, 2014), which challenged institutionalization.

Supported by reports identifying the poor conditions of public psychiatric institutions, the mental hygiene movement criticized institutional care, referencing the vast instances of inhumane care and treatment of the mentally ill (Toms, 2012). This movement maintained that emerging developments in the sciences (e.g., psychiatry, social epidemiology, psychology) could both prevent and treat mental health symptoms, and thus treatment should be readily accessible in the community. Developments from this movement greatly shaped the future of social work practice, as it set the state for asylum care reform and the idea that mental health symptoms and associated acts of criminality could be responded to in the community through interventions by professionals such as social workers (Stuart, 1997).

The deinstitutionalization movement. The emergence of the mental hygiene movement with its critique of restrictive care and new ideas for mental health treatment

set the stage for the deinstitutionalization movement (Goldman & Morrissey, 1985). Reports continued to emerge throughout the first half of the 20th century documenting the inhumane conditions of psychiatric hospitals that, ironically, had begun to resemble the deplorable conditions of earlier jails and prisons that advocates such as Dorothea Dix had tried so adamantly to improve through creation of asylums (Polizzi & Draper, 2016). These institutions were originally intended to be treatment facilities for individuals with mental illness that that provided new forms of humane, “moral treatment” associated with the physician Benjamin Rush (Scull, 2015).

Due to factors such as the Industrial Revolution and the resulting increase in poverty among immigrants and Americans alike, these facilities eventually became disproportionately populated by the poor. In contrast, the rich flocked to private mental health treatment facilities so as to avoid the perceived stigma of receiving treatment alongside immigrants and paupers (Roberts & Kurtz, 1987). Once they became inundated with the “undesired” members of society, these public mental health facilities became increasingly underfunded, understaffed, and inhumane (Holtzman, 2012).

However, by the 1950s, three primary factors contributed to deinstitutionalization, or the policy of closing state-run hospitals and moving the mentally ill (which included the intellectually disabled) out of large state institutions (Torrey, 1997). First, the financial crisis of the Great Depression, followed by the depletion of resources (both economic and intellectual in the form of physicians, nurses, etc.) resulted in the inability of state-run mental hospitals to continue functioning (Goldman & Morrissey, 1985). Second, these depletions in resources coincided with advancements in psychiatry, including the emergence of the first psychotropic drug, Thorazine (Scull, 2015). Third,

major shifts in social policy (such as the passage of Medicare and Medicaid in the late 1960s and changes to the Social Security Program in the mid-1970s) resulted in incentives for the states to rapidly discharge patients previously dependent on them who could now be sustained through federal funds.

Deinstitutionalization occurred rapidly, with the total population of public psychiatric hospitals dropping from over 555,000 to fewer than 140,000 between 1950-1980 (Goldman & Morrissey, 1985). By 1994 the total population of public psychiatric hospitals fell to 71,619 (Torrey, 1997), and then again by 50% dropping to 35,000 in 2016 (Carson, 2018). This movement resulted in a mental health crisis in which psychiatric patients were discharged with no aftercare plan, and hospitals were no longer a viable resource to future individuals requiring intensive care–individuals who now often find themselves homeless or in jail (Harris & Lurigio, 2007). The deinstitutionalization movement greatly shaped social work practice in this research area, as the needs of this population were tasked to community providers, such as social workers, throughout the community care movement (Vourlekis, Edinburg, & Knee, 1998).

The community care movement. The deinstitutionalization movement was supported by President Jimmy Carter's Committee on Mental Health, which espoused that individuals with mental illness should receive treatment in the least restrictive environment possible (Torrey, 1997). The Community Mental Health Care Act of 1963 supported denationalization policies and paved the way for the subsequent movement community care movement that has shaped the climate of social work practice today (Grob, 1994). This movement was characterized by an increase in community-based

mental health care, including preventative treatment and interdisciplinary collaboration (e.g., the integration of mental health care and primary health care) that was needed to address the many rapidly emerging social problems stemming from deinstitutionalization that became the focus of social work practice (Ambrosino, Ambrosino, Heffernan, & Shuttlesworth, 2015).

For example, while some individuals with natural support networks may have benefited from deinstitutionalization, many individuals released from hospitals did not have sufficient supports waiting following discharge, and instead were left to function under the guise of community care–a treatment model that was vastly unprepared to provide the support needed (Goldman & Morrissey, 1985; Scull, 2015). As such, many individuals released from the closed state mental hospitals either became victims of maltreatment via unlicensed and/or underfunded and inefficient community care agencies who profited off their consumers, suffered homelessness, or entered the CJS and penal institutions (Lamb, Weinberger, & Gross, 2004; Torrey, 1997). For instance, in 1995 there were a total of 1,526,800 prisoners, 10%-15% of whom were diagnosed with a mental health issues. By 2013 this total had increased to 2,300,000 (Carson, 2018) with some reports estimating that up to 50% of incarcerated individuals had a mental health issues (Torrey et al., 2010).

In addition to affecting the problems addressed by social work, this movement also drastically changed the way practice was administered. For example, Pollack and Feldman (2003) credit this movement for the following three factors: (a) training programs for community mental health professionals and patients, (b) increasing in organizations designed to treat and prevent mental illness, and (c) the emergence of the

“advocacy/consumer” movement (p. 378). Despite the emergence of such potentially positive factors, many scholars criticized the community mental health care movement for falling far short of its initial goals and promises, primarily due to factors such as insufficient funding, challenges with evidenced-based practice, and unclear federal standards of care (Goldman & Morrissey, 1985; Lamb et al., 2004; Lurigio & Harris, 2007, Scull, 2015; Torrey, 1997; Torrey et al., 2010).

Factors such as the unclear federal standards of care were especially impactful. For example, still today individual states often have the authority and liberty to determine how they apply federal policies, which leads to a decentralized system of care with complex bureaucratic details (e.g., debates on funding sources and allotments) that result in service gaps within community mental health care (Ellis, Churruca, & Braithwaite, 2017). Such factors have resulted in a mental health care system that often has inadequate resources for patients with mental illness and is frequently ineffective at addressing the broader social issues associated with mental illness and crime (e.g., poverty, lack of social supports, racial/gender injustice; Drake, 2017; Goldman, Buck, & Thompson, 2009). The current climate of community mental health care treatment has also been strongly impacted over time by social policies, which are discussed in more depth below.

Mental Health and Criminal Justice Policies

The social problems emerging from the previously discussed historical movements resulted in the emergence of new social policies. Policy is an essential component of social work and has increasingly been identified as a key area of intervention needed to address the social issues experienced by individuals with mental illness in the CJS (Sarteschi, 2013). Given the extent of their impact, several major

polices from each of the historical movements discussed above will be examined, with a focus on how they have impacted social work response in this area.

Policies from the prison and asylum reform movement. Two policy advances during the prison reform movement were especially influential in shaping the future treatment of individuals with mental illness in the CJS: (a) prison reform policies, and (b) the 1854 "Bill for the Indignant and Insane". First, in the 19th and 20th century states began to adopt new polices to govern prisons and jails that paved the way for the characteristics of penal institutions still in effect today (Pillsbury, 1989). For example, problems stemming from the Pennsylvania system, or the Auburn system, sparked polices to address penal problems related to overcrowding, inhumane treatment, and criminalization of the mentally ill (Rubin, 2017). The debate about what policies to invoke across state penal institutions were the subject of focus at the annual National Conference of Charities and Corrections attended by social workers in the late 19th and early 20th century, and such policies represented some of the first major reform efforts towards improving national and state level policies guiding how prisoners, including those with mental illness, are treated (Shumate, 2003).

While changes in policy may have initially originated in effort to evoke positive social change, the result was prison design policies and frameworks that serve as the model for the alienating institutions of social control that many American prisons are today (Pillsbury, 1989). Rather than identifying one prison reform policy as the most influential, it was this political movement as a whole that shaped future prison policies and debates pertaining to the treatment and well-being of institutionalized and incarcerated individuals. Additionally, the varying applications of policies across

individual states that emerged during this period reflect the historical presence of complex federal, state, and local government interactions in the CJS that are associated with different outcomes for those involved in this system.

A second influential policy from the prison reform era was Dorothea Dix's proposed 1854 "Bill for the Indignant and Insane" (Brown, 1996). The proposed bill asked the federal government to set aside land for the construction of institutions that could be used to treat the indigent mentally ill in lieu of incarceration. This bill represented efforts to encourage the federal government to take responsibility for the social welfare of this population and the decriminalization of mental illness. Though initially passed by Congress, this bill was ultimately vetoed by President Pierce who, citing the Constitution in his argument, ruled that the responsibility of the mentally ill should be with the local and state governments, not the federal government (Polizzi & Draper, 2016). Essentially President Pierce feared that the passing of this bill would result in the federal government assuming responsibility for all indigent or impoverished people (Scull, 2015), which thus set the stage for the ongoing debate regarding the balance between the federal and state governments' responsibility to social welfare. Today, this debate continues to impact funding for and regulation of social work practice.

Policies from the mental hygiene movement. Several policies emerging from the mental hygiene movement profoundly impacted social work practice at the intersection of mental health and the CJS, including the Mental Health Act of 1946 (Scull, 2015). This law (which was created in response to the growing investment in mental health across the country) tasked the federal government with prioritizing mental health nationwide through the establishment of the National Institute for Mental Health.

Second, the Hill-Burton Act signed by President Harry S. Truman in 1946 called for the provision of federal financial support to build hospitals nationwide, which introduced the idea of federally funded, community-based care (Trattner, 1999). This act laid the foundation for the hugely influential Community Mental Health Act of 1963 signed by President John F. Kennedy, which called for nationwide deinstitutionalization. This law had a profound impact on assigning social workers to provide community mental health services (Ambrosino et al., 2015).

Policies from the deinstitutionalization movement. Following passage of the Community Care Act of 1963 and deinstitutionalization, a multitude of new social polices emerged that significantly pertained to the welfare of mentally ill individuals involved in the CJS. First, from the 1960s to the mid-1970s, grand changes in social welfare policies originated that shaped social work practice, as responsibility of citizen welfare continued to be tasked to the federal government (Berkowitz, 2005). For instance, in the late 1960s, the passage of Medicare and Medicaid guaranteed federally funded income for institutionalized individuals (such as the elderly), thus prompting states to decrease costs by rapidly discharging these patients (Scull, 2015). Then in the 1970s, the addition of the Supplemental Security Income program to the Social Security Program provided federally funded benefits to the disabled (which included mental disabilities) if they were not institutionalized, thus resulting in another mass wave of discharge by state-run hospitals (Goldman & Morrissey, 1985). Such policy changes significantly impacted social work practice through changes in funding sources that support and regulate practice (Ambrosino et al., 2015).

Policies from the community care movement. A plethora of policies emerged during the community mental health care movement, including two categories of policies that still significantly affect practice with individuals with mental illness in the CJS today: (a) policies addressing the rights of the mentally ill, and (b) changes in policies pertaining to crime. Especially in the latter part of the 20th century, several policies emerged that are now associated with the high number of persons with mental illness involved in the CJS (Torrey, 1997). For example, the Omnibus Crime Control and Safe Streets Act of 1968, the Complete Crime Control Act of 1984, and the Anti-Drug Abuse Act of 1988 all served to strengthen the power of law enforcement and the CJS, and harshen the response to and penalties for crime, especially those related to drugs (Hinton, 2016). These policies have been associated with the rise in incarceration rates across the United States especially among people of color and low socioeconomic status.

As the incarceration rate began to rise (especially among individuals with mental illness), there was a simultaneous increase in creation of policies aimed at protecting the rights of the mentally ill. For instance, the 1980 Civil Rights of Institutionalized Persons Act (CRIPA) is a federal law that protects the rights of individuals with mental illness (including intellectual disabilities) in any public state or local institution (e.g., correctional facilities; Scull, 2015). Additionally, the Protection and Advocacy for Individuals with Mental Illness (PAMI) Act was passed in 1986, which was designed to protect this population from abuse and neglect in hospitals and other treatment facilities.

A third policy, the Americans with Disabilities Act (ADA) of 1990 is a federal law that protects people with disabilities (including mental illness) from discrimination (Scull, 2015). Following the Olmstead v. L.C. case, Title II of the ADA was passed

which specifically prohibited discrimination against this population by state and local governments and mandates the least restrictive setting of care possible. Such policies are extremely relevant to practice with individuals with mental illness in the CJS, as they protect unjust incarceration. Despite these protections, the United States still has one of the highest incarceration rates in the world. (Coyle, Fair, Jacobson, & Walmsley, 2016). Given that half of the individuals in the CJS have a mental illness (Bronson & Berzofsky, 2017), these polices thus may not ensure effective protection for this population.

Current Issues and Practice Considerations for Social Work

The major historical movements and social policies discussed in this section have culminated to create the current landscape of social problems and practice climate for social workers, and especially those specifically focused on the intersection of mental health and the CJS. As discussed above, the deinstitutionalization movement and subsequent rapid closing of many public mental health hospitals has contributed to "the decimation of the public mental health system" (Montross, 2016, p. 1407). One consequence of these historical factors has been the mass incarceration crisis in the U.S.

Mass incarceration and racial/ethnic inequalities. A 2015 report by the Bureau of Justice Statistics identified a total of 1,526,800 prisoners under federal and state jurisdiction (Carson & Anderson, 2016). Despite reports stating that this population has decreased by 2% since 2014–thus suggesting a potential downward trend in numbers–the total population remains high compared to global rates (Coyle et al., 2016). Mass incarceration has raised concerns regarding social injustices and human rights violations, thus making this area directly relevant to the field of social work.

For example, within the CJS there are a number of disparities pertaining to the characteristics of incarcerated individuals, including an overrepresentation of people of color, females, persons in poverty, and individuals with co-occurring substance use disorders in the CJS (Neill, Yusuf, & Morris, 2015). For instance, Black males have the highest imprisonment rate in comparison to any other racial or ethnic group, and are over three times more likely to be imprisoned than White or Hispanic males (Carson, 2018). Among women, Black females are four times as likely to be imprisoned compared to other racial and ethnic groups. When compared to the percentage of racial and ethnic groups in the overall U.S. population, these numbers suggest significant social disparities with an overrepresentation of people of color in the justice system (Hinton, 2016).

The prevalence of mental illness in the criminal justice system. A second major concern for social work in this area is the mass overrepresentation of mental illness in the CJS (Canada & Gunn, 2013; Collier, 2014). Due to the complexities of operationalizing mental illness and variations in methods to collect quantitative data on the prevalence of mental illness in the CJS, reports of the total number of this population vary (Prins, 2014). Despite these variations, review of literature revealed that individuals involved in the CJS were more likely to experience mental illness than individuals outside of this system. Estimates of the prevalence of mental illness in this population range from 16% to over 50% (Bronson & Berzofsky, 2017).

Trauma in the criminal justice system. In addition to the high prevalence of serious mental illness in this population, existing research has concluded that trauma is a compounding mental health issue that is disproportionately present in individuals involved with the CJS. For example, SAMHSA (2011) has acknowledged the "growing

awareness of the significant role that trauma can play in criminal justice involvement" (p. 1). One study of over 75,000 inmates found that 56% of males reported a history of trauma (Wolff et al., 2009), and another study found that over 88% of female offenders had experienced at least one traumatic event (Wolff et al., 2011). These rates were especially disproportionate among female and Black offenders (Benedict, 2014; Jäggi, Mezuk, Watkins, & Jackson, 2016).

The effects of trauma in this population were often compounded with other mental health issues, such as substance use disorders. This comorbidity makes this subpopulation especially vulnerable to experiencing a number of consequences, such as high rates of arrest and recidivism. Additionally, once involved with the CJS, offenders face a risk of experiencing re-traumatization and/or new instances of trauma during arrest(s), incarceration(s), and/or court proceedings (Wolff et al., 2009). Given the high prevalence of trauma among this population and the potential for adverse outcomes, research pertaining to trauma-informed criminal justice issues is growing.

Specific foci of research in this area has included exploration of the prevalence and outcomes of trauma among the CJS-involved population. Additionally, a growing area of interest includes exploring how specific types of trauma may impact CJS involvement. For example, recent research has identified a correlation between childhood trauma and CJS involvement as an adult (Reavis et al., 2013). Despite this identified association, there is a gap in research that explores how exactly childhood trauma impacts CJS involvement.

Consequences of the criminalization of mental illness. The criminalization of mental illness places some of the most vulnerable members of society at risk for

experiencing a number of adversities, and thus should be of grave concern to social work (Armour, 2012; Wolff & Shi, 2012). For example, persons with untreated mental illness (especially non-white individuals from low socio-economic backgrounds) are more likely to be arrested than persons without mental illness (Alegria et al., 2016; Montross, 2016). Once incarcerated, these individuals are at an increased risk for developing new or additional mental health issues, including mood disorders (e.g., depression), trauma, and suicidality (Favril, Laenen, Vandeviver, & Audenaert, 2017; Rabe, 2012).

Furthermore, the larger systems in which these individuals exist also experienced indirect effects associated with the overrepresentation of people with mental illness in the CJS including increased rates of family trauma, as well as increased civic and fiscal issues for communities, such as public health concerns, homelessness, and unemployment (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012; Freudenberg, 2001; Lynch, DeHart, Belknap, & Green, 2009). Torrey et al. (2010) have identified six specific social consequences resulting from the overrepresentation of persons with mental illness in the CJS: (a) offenders with mental illness have higher rates of recidivism; (b) it costs more to house mentally ill inmates; (c) mentally ill inmates stay incarcerated longer than persons without mental illness; (d) jails are ill-equipped to manage the behavioral symptoms of inmates with serious mental illness, resulting in management problems; (e) inmates with mental illness face a higher risk of suicide; and (f) inmates with mental illness are at risk for experiencing abuse while incarcerated. In effort to respond to these issues, social work and related disciplines have collaborated to advance criminal justice reform.

Therapeutic Jurisprudence and the Emergence of Mental Health Courts

As the number of individuals incarcerated has increased, research examining causes, consequences, and solutions pertaining to mass incarceration has expanded in social work and across disciplines. Historically, science on criminal behavior and mental illness largely considered these issues as faults of the individual that merited punitive response by society. However, as research on mental illness and criminal behavior have advanced, so too have perceptions on the etiological causes of mental health and criminality. Empirical findings have pointed to the complex causes of mental health issues that involve both biological and environmental factors (National Institutes of Health, 2007). Consequently, society's responses to behaviors related to mental illness (such as criminal behavior by someone with a mental illness) have evolved to include a focus on rehabilitation.

One such response included recent reformation of the CJS to include rehabilitative components within the system that acknowledge the impact of mental illness and other social issues (e.g., prostitution, sex trafficking, etc.) on criminal behavior. Specifically, over the past 30 years specialized courts have been created that focus on addressing the unique needs of specific types of offenders. These courts—often referred to as problem-solving courts—are led by an interdisciplinary team that takes a collaborative approach to reduce recidivism using therapeutic jurisprudence and case management (National Institute of Justice, 2018).

There are several PSCs currently in existence (including domestic violence courts, drug courts, and MHCs) that use a therapeutic jurisprudence model. First used in 1987 by Wexler (2018) in a presentation to the National Institute of Mental Health, the term

therapeutic justice was defined as the study of “law to determine its therapeutic and countertherapeutic effects” (Slobogin, 1995, p. 194). Hora, Schma, and Rosenthal (1999) clarified that this model did not imply that therapeutic considerations should always trump other social values, but rather “only suggests that the psychological and mental health aspects of a law or legal process should be examined to inform us of its potential for success in achieving its proposed goal” (p. 434).

MHCs are one specific type of PSC. As defined in Chapter 1, The Council of State Governments Justice Center defines MHC as “a court with a specialized docket for certain defendants with mental illnesses” (Almquist & Dodd, 2009, p. 5). The first MHC was established in 1997, and there are currently approximately 350 MHCs in the U.S. (Lowder et al., 2017).

These specialty courts work specifically with offenders who have a diagnosed mental illness that impacted the commission of their crime (Almquist & Dodd, 2009). The goal of these courts is not to provide mental health treatment for these individuals, but rather to connect them to community-based treatment services to address their mental health needs in effort to reduce recidivism. While each MHC program operates differently, researchers and practitioners have developed a list of ten essential elements of a MHC: (a) interdisciplinary planning and administration team, (b) clearly identified target population with inclusion criteria, (c) timely participation identification and linkage to services, (d) terms of participation, (e) informed choice, (f) treatment supports and services, (g) confidentiality, (h) court team, (i) monitoring adherence to court requirements, and (j) sustainability.

Research examining the effectiveness of MHCs is challenging given the variability in programs, thus studies have suggested mixed conclusions. Lowder et al. (2017) summarized empirical research in this area stating, “findings to date suggest considerable variability in the effectiveness of MHCs” (p. 15). For example, findings from some studies have found that MHC participation was associated with decreased recidivism (Moore & Hiday, 2006), including for extended time following completion (Hiday, Ray, & Wales, 2016). Contrastingly, other findings identified little variance in recidivism among individuals who participated in MHC in comparison to those who received treatment as usual (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005).

A recent meta-analysis was conducted to investigate the effectiveness of MHCs and concluded that there was a small impact on MHC participant recidivism, but findings highlight the need to examine variability in outcomes (Lowder et al.,2017). To summarize, existing research points to MHCs as a potential beneficial solution address the nation’s current mass incarceration problem. Given its mission and values of the discipline, social work has an opportunity and obligation to advance research and practice in this area.

Future directions for research on mental health courts. As the prevalence of MHCs has increased, so too has the research examining the process and outcomes of such programs. However, this is still a new field and much more research is needed. Scholars in this field have identified several directions for future research, especially pertaining to program design and MHC outcomes (Canada & Gunn, 2013). Additionally, as there is an increased call for trauma-informed care in the CJS in general (Miller & Najavits, 2012; SAMHSA 2018), more research is needed examining the impact of trauma on MHC

involvement given the high prevalence of trauma among this population and the risk for (re)-traumatization (Collier, 2014; CSG Justice Center, 2016; SAMSHA, 2013b). Social work's involvement in advancing trauma-informed care, combined with its historical interdisciplinary collaboration and involvement in the fields of mental health and criminal justice, positions social workers to play a prominent role in promoting trauma-informed criminal justice reform.

An Overview of Adverse Childhood Experiences

To this point, this review has provided an overview of literature pertaining to the intersection of mental health, the CJS, and social work. This study is focused on exploring how a specific type of mental health issue—ACEs—impacted adult CJS involvement among MHC participants. While an extensive discussion of the literature on childhood trauma is beyond the scope of this manuscript, a brief overview of the literature on ACEs is merited.

As research on child abuse and maltreatment has evolved over the years, the impact of childhood trauma has been of interest to researchers and practitioners who work with children across disciplines, such as social work, sociology, psychology, medicine, and public health. In the 1990s, research in this area began to grow substantially after physicians in primary care settings began noting correlations between childhood maltreatment and adverse health and lifestyle outcomes. This conversation prompted the ACEs study conducted by Felitti et al. (1998)–a monumental research project that shifted the direction of trauma research.

Based at Kaiser Permanente's San Diego Health Appraisal Clinic, the ACEs study surveyed 9,508 adults using a questionnaire that asked participants about events they had

experienced as a child (adverse experiences), as well as questions about their health and lifestyle as an adult (Felitti et al., 1998). Two major findings emerged from this study. First, findings indicated the high prevalence of ACEs among participants. Second, findings identified a correlation between these experiences and many of the leading causes of death for adults.

The measure used in the original ACEs study was created using existing items from published surveys. For example, items from the Conflicts Tactics Scale (Strauss & Gelles, 1990) and the 1988 National Health Interview Survey (Schoenborn, 1991) were used to ask participants about any child abuse or maltreatment that they experienced between the ages of zero and 18. Items from health surveys such as the Behavioral Risk Factor Surveys (Siegel, Frazier, Mariolis, Brackbill, & Smith, 2993) and the Third National Health and Nutrition Examination Survey (Crespo, Keteyian, Heath, & Sempos, 1996) were used to ask about adult health and lifestyle.

The ACEs study resulted in the development of a 10-item measure available for public use that is referred to as the ACEs Questionnaire (see Appendix D). This measure consists of 10 questions that ask participants to indicate if they experienced one or more of ten types of adverse childhood experiences that were found to be common in the ACEs study. These experiences were defined based on three types of abuse (psychological, physical, and sexual). The original questionnaire was based on four types of household dysfunctions (mental illness, violence against mother or stepmother, criminal behavior in the household, and two questions regarding exposure to substance abuse). Participants receive one point for any ACE they experienced, resulting in a cumulative score that indicates the total number of ACEs they have experienced, ranging from zero to 10.

Over time, research on ACEs has expanded, and modified versions to the original measure have been recommended (Finkelhor et al., 2013). For example, one of the more recent, amended versions of the ACEs questionnaire frequently used currently refers to the category of experiences originally titled “household dysfunctions” as “household challenges,” and includes a fifth experience: loss of a parent due to death, divorce, or other separation (CDC, 2016). One of the most common critiques of the ACEs study was that the sample was too homogenous, as participants were overwhelmingly college educated, white individuals. Following this critique, ACEs research has expanded to explore the impact of ACEs among more diverse populations. Several primary findings have emerged from this research, including disparities in the prevalence of ACEs among non-white individuals. Additionally, findings have emerged supporting an expansion of the types of ACEs inquired about, such as events including community violence and poverty.

Prevalence of Adverse Childhood Experiences

Findings from the initial ACEs study (Felitti et al, 1998) revealed that adverse experiences among children zero to 18 are common, as more than half of the participants reported have experienced at least one ACE. Specifically, the study found that 48% of participants reported zero ACEs, 25% reported one, 13% reported two, 7% reported three, and 7% reported four or more (CDC, 2016). Regarding the prevalence of child abuse, when broken down by category 11% of participants experienced psychological abuse by parents, 11% experienced physical abuse by parents, and 22% experienced sexual abuse by anyone. Regarding the prevalence of household dysfunctions, 26% of participants reported exposure to substance abuse by a household member, 19% reported

exposure to mental illness by a household member, 13% reported exposure to their mother being treated violently, and 3% reported that a household member was imprisoned.

Outcomes Associated with Adverse Childhood Experiences

In addition to revealing the high prevalence of ACEs among individuals in the United States, the ACEs study also identified a correlation between ACEs and long-term adverse outcomes on adult health and lifestyle (Felitti et al., 1998). Specifically, ACEs are associated with an increased risk for social, emotional, and cognitive impairment; adoption of health-risk behaviors; disease, disability, and social problems; and early death (CDC, 2016). Findings indicated a strong relationship between ACEs and specific types of chronic health issues in adults such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Gilbert et al., 2010). Furthermore, ACEs were found to be correlated with the ten most common risk factors for common causes of death in the United States, which include smoking, severe obesity, physical inactivity, depression, suicide attempt, alcoholism, illicit drug use, injected drug use, 50 or more sexual partners, and sexually transmitted diseases (Campbell, Walker, & Egede, 2016).

Additionally, recent research on trauma has identified an association between childhood trauma and adult criminal activity and involvement in the CJS (Garbarino, 2017; Wolff & Shi, 2012). For example, Reavis et al. (2013) found that among adult males involved in the CJS were four times as likely to endorse four or more ACEs compared to a normative group of males. Similarly, Edalati et al. (2017) found that

"results from logistic regression models indicated that exposure to ACEs had a significant effect on criminal justice involvement regardless of sociodemographic factors" (p. 1292).

While research has identified a link between childhood trauma and adult criminal behavior, researchers in this area emphasize the importance of disseminating such findings with caution so as not to erroneously suggest a false causation (Cuadra, Jaffe, Thomas, & DiLillo, 2013). Additionally, it is important to note that survivors of childhood trauma do not inevitably engage in adult criminal behavior. Scholars in this area have issued the need for future research exploring the linkage between these two factors to enhance intervention efforts.

Findings from the ACEs study indicated that higher ACE scores are associated with a higher risk of chronic toxic stress and adverse outcomes (CDC, 2016), it is important to note that while ACEs are associated with an increased potential for adverse outcomes, these consequences are not inevitable (Bellis et al., 2018). Recent ACEs literature has focused on the prevention of ACEs (e.g., parenting programs) and resiliency, including exploration of factors (e.g., positive social support) that protect individuals who have experienced ACEs from adverse outcomes (Luthar & Cicchetti, 2000; Luthar, Cicchetti, & Becker, 2000).

Theoretical Frameworks Guiding the Research

After providing a summary of the literature available on the intersection of mental health and the CJS and ACEs, I now turn to a discussion of the guiding theoretical concepts that shaped the conceptualization of this research. While several prominent social work scholars have spoken out against the essentialness of theory in social work (e.g., Thyer, 2001), many influential social work scholars such as Gomory (2001) have

concluded that theoretical inquiry is necessary to better understand, research, and respond to social work issues. Given the merging of disciplines embedded within the intersection of mental health and the CJS, a variety of theories have been applied to the understanding of this research topic including personality theories (i.e., Eysenck & Eysenck, 1977) and theories of moral development (i.e., Kohlberg, 1984). However, it is beyond the scope of this chapter to provide a comprehensive overview of all potential applicable theories that could guide research on this topic.

Based on a thorough review of the literature, critical theory, complex systems theory, and trauma theory were selected to guide this research as they were congruent with the overall philosophical assumptions of the transformative paradigm under which this qualitative inquiry was conducted (see Chapter 3 for a more extensive discussion on this paradigm). An overview of these three theories are provided below as an introduction to a novel framework that can be used to examine this topic: a trauma-informed, critical systems framework. I created this framework for this study using foundational tenets from the three existing theories. The combination of tenants included in this framework were selected for their ability to inform guide research specifically on this topic.

Critical Theory

Underlying assumptions. Critical theory is an interdisciplinary philosophical perspective developed between the First and Second World War by scholars associated with the Institute of Social Research in Frankfurt. These scholars called into question the evolving culture of authoritarian rule, instrumental rationality, and material determinism (Bronner, 2011; Held, 1980; Horkheimer, & Adorno, 1972). From its inception, critical theory has rejected the positivist, realist assumptions emerging from the Enlightenment in

favor of poststructural, postmodern, and/or a blending of these two interpretive frameworks to form a unique paradigm with a “historical realist” ontology as displayed in Table 1 (Guba & Lincoln, 1994, p. 109).

Under these ontological assumptions, critical theory views reality as the confluence of interactions between various social factors (namely social structures, power relations, and identity differences) that, over history, reified into structures that form the basis for what is considered reality (Horkheimer & Adorno, 1972). In this sense, critical theory assumes that there is a reality that is researchable through examination of power relations and social structures, though this reality is experienced and perceived differently by persons based on their identity and positionality (e.g., gender, race, economic status; Delgado & Stefancic, 2012). As such, critical theory embraces a subjective and value-laden epistemological approach to research in which both the researcher and the researched will influence the nature of questioning through a transactional and process-oriented epistemology (Guba & Lincoln, 1994, p. 109; Jaccard & Jacoby, 2010). Critical theory maintains a social justice-oriented axiology that promotes emancipatory research achieved through a method involving dialectic dialogue between the researcher and participant, in which assumptions are challenged and knowledge is generated with the intent of promoting critical consciousness in the quest for liberation (Held, 1980).

Table 1

Underlying Assumptions of Critical Theory Paradigm

Paradigm	Ontology	Epistemology	Axiology	Methodology

Post-structuralism + Post-modernism	Historical realist	Transactional, process-oriented, & subjectivist	Social justice-oriented	Subjective, dialectic dialogic, social-justice oriented, action research

Note. Underlying assumptions of critical theory paradigm adapted from Creswell (2013) and Guba & Lincoln (1994).

Major tenets. It is important to note that, as indicated by its frequent characterization as a grand theory, critical theory is a vast, complex framework that has branched into sub-theories (i.e., Frankfurt School, Habermas, critical race theory, LatCrit, legal critical theory, etc.). These sub-theories nest under the overarching umbrella of traditional critical theory with the generally widely accepted assumptions previously discussed (Delgado & Stefancic, 2012). Due to this complexity, all adherents of critical theory do not conceptualize the theory, its tenets, and key concepts the same (Held, 1980). For the present purposes, I will review the primary tenets and key concepts associated with the Frankfurt School branch of critical theory that primary refers to the work of Max Horkheimer, Theodor Adorno, Herbert Marcuse, as well as Jürgen Habermas.

The central tenet of traditional critical theory centers around the examination and critique of the past and present hierarchal workings of societal structures to better understand the social inequalities present in society, with the goal of future emancipation and liberation for the oppressed (Held, 1980; Horkheimer & Adorno, 1972). To identify and understand the power differences embedded in societal systems, critical theory calls for the challenging of underlying assumptions and false consciousness in an effort to

intentionally enhance critical consciousness through continuous critique of society. To challenge these covert assumptions supporting the workings of society, one must examine the influences of history on the present structure of society and unearth the voices of the exploited to examine how future liberation might be possible. Through this lens, for example, critical theorists seek to understand current forms of enslavement and oppression (i.e., imprisonment) that adversely affect the vulnerable members of society (i.e., persons of color with mental illness) and are supported by those in positions of power so that they might maintain the status quo.

Key concepts. A comprehensive identification and overview of all key concepts central to critical theory is beyond the scope of this dissertation. As such, five concepts that are central to understanding the application of critical theory to the present research focus will be discussed: (a) *critical consciousness*, (b) *system*, (c) *domination*, (d) *alienation*, and (e) *praxis*, though this is by no means an exhaustive list of key concepts. As applied to the social issues present at the intersection of mental health and the CJS, a critical theory approach encourages the development of *critical consciousness*, or the ability to continuously critique the covert ideological assumptions underlying society that are accepted as truths (Freire, 1973; Langer & Lietz, 2015). Critical consciousness is encouraged to challenge social injustices, such as the overrepresentation of people with mental illness in the CJS.

This social issue exemplifies how the system (Cox & Hardwick, 2002; Habermas, 1984), or the modern state/state administration (e.g.., the CJS, the prison/jail system) dominates (Habermas, 1970; Horkheimer & Adorno, 1972), or uses positions of power to control less powerful people and groups (e.g., persons labeled as mentally ill, criminals),

through alienation (Bronner, 2011; Fromm, 1941; Marcuse, 1955), or isolation from society and resources (i.e., incarceration). Through praxis (Habermas, 1973; Held, 1980), or the combination of theory and practice, knowledge can be generated to enhance critical consciousness that drives emancipatory social action aimed towards liberation.

Ability to explain the research topic. There are several strengths to using critical theory to explain the social problems present at the intersection of mental health and the CJS. First, the key themes of critical theory center around the examination of how authoritative systems (e.g., the CJS, the law, the welfare state) dominate vulnerable members of society (e.g., individuals labeled as mentally ill and/or criminals) through alienating practices (e.g., incarceration, restriction of resources and rights) to maintain social order. As such, scholars such as Groves and Sampson (1986) have used Habermas's contributions to critical theory to explain how crime and mental health issues form as the result of social inequalities (e.g., poverty, racism) that produce "sociocultural and psychological distortion" sometimes resulting in criminal behavior (p. 569; Habermas, 1984). Other scholars such as Arrigo (1996; 2001) have applied critical theory to examine how the oppression of criminals with mental illness emerges as a means of social control against individuals who violate the norms of society, and thus threaten the order of the status quo.

Second, critical theory pushes an interdisciplinary collaboration in the examination of social issues (Groves & Sampson 1986; Held, 1980; Horkheimer, 1995). This value is beneficial when examining problems such as the social issues present at the intersection of mental health and the CJS, as it calls for the integration of knowledge from all the disciplines involved (including law, criminology, psychology, mental health,

and social work) in order to ensure a comprehensive understanding of and response to the identified concerns.

A third strength in applying critical theory to this issue relates to the ability of the key concept of praxis (Habermas, 1973) discussed earlier, which perfectly situates the research issue within a social work context, as it is compatible with social work's mission for social justice (Lorenzetti, 2013). Application of critical theory's praxis concept thus drives this research to not only identify and explain the issues present in this area, but also to move a step further and address the presenting problems, in other words, the application. Therefore, the application of critical theory and concepts such as praxis underscore that it is not enough to merely explain the social issues present in this research area, which would merely serve to privilege knowledge for authoritarian purposes (Habermas, 1973; Groves & Sampson, 1986), but to engage in a continuous process of social critique and action aimed as social transformation to alleviate the injustices experienced by individuals with mental illness in the CJS.

While there are many strengths to examining this research area through the lens of critical theory, this application is not without limits. I will explore two key limitations, as a comprehensive critique of the limitations of critical theory is beyond the scope of this dissertation. The first limitation relates to the vast nature of critical theory, which includes different conceptualizations of this theory with slight variances (Held, 1980). As such, it can be challenging to apply critical theory to the examination of social issues in this research area given the lack of specificity regarding which exact major assumptions, key concepts, and tenets are inferred when doing so to guide research and intervention.

Along these lines, critical theory has been criticized for its vague critiquing "with a failure to come to terms with practical political questions" (Held, 1980, p. 25) and solutions. In other words, critical theory has been criticized for its "utopian" prescriptive solutions encouraging self-emancipation versus prescriptive resolutions (e.g., policy changes) that would more likely effect mass structural and systemic change (Groves & Sampson, 1986).

A third limitation in applying critical theory to this research area is the theory's de-emphasis of individual characteristics and the role they may play in the emergence of social issues present at the intersection of mental health and the CJS. In this sense, critical theory essentially discredits the key concepts in prominent theories, such as personality frameworks (e.g., Eysenck & Eysenck, 1977) and biomedical models (e.g., Engel, 2012). Despite these limitations, it is essential to recognize that a key component of critical theory is its continuous self-critique of its paradigm and application, which means that a dialectic dialogue surrounding these, and other limitations, is invited and embraced, as it is through critique that critical consciousness is achieved (Held, 1980).

Ability to inform qualitative research methodology. There are many strengths to the ability of critical theory to inform qualitative research methods, specifically as it applies to inquiry on the research topic discussed in this dissertation. One primary strength lies in the complementary philosophical assumptions underlying the two frameworks. Specifically, both critical theory and qualitative tradition reject positivist scientific inquiry that privileges only certain types of knowledge reached through perspective methods geared towards identifying an objective truth (Guba & Lincoln, 1994). Instead, both traditions favor research that embraces subjectivity and dialogue,

with critical theory specifically pushing for transaction, relational, process-oriented, participatory-action, social justice-oriented methodology (Horkheimer, 1995; Lorenzetti, 2013).

Additionally, application of critical theory to qualitative research allows for the generation of social work knowledge, a concern at the heart of the long-standing debate on the legitimacy of social work as a science. Critical theory influences the production of social work knowledge, as it calls for research methods that produce knowledge not valued solely for the sake of research, but rather as a means to achieve social liberation (Shaw, 2012). Through methods such as qualitative participation action research or in-depth interviews with the oppressed, critical theory influences an emancipatory, social-justice oriented research agenda.

In addition to these strengths, there are several primary limitations of the application of critical theory to this research topic. First, critical theory's rejection of positivist ontological and epistemological assumptions infers a critical hermeneutic tradition to some (Gross & Keith, 1997; Rosen, 1987), which posits that qualitative inquiry does not result in facts, but interpretations influenced by positionality. This rejection of authoritative, generalizable truth claims can lead to the de-valuation of critical theory informed qualitative research findings by key stakeholders (i.e., funding sources) who have the power to allocate the resources so often needed to evoke substantial positive social change (Shaw, 2012). Furthermore, this rejection of positivistic prescriptiveness in research methodology means that there are many ways to conceptualize and engage in a critical theory-informed approach to qualitative inquiry, which may threaten the replicability and thus trustworthiness of such research.

Ability to describe how change may occur through intervention. However, despite these identification limitations, many scholars have discussed the strength of critical theory to describe how change may occur through liberation, even at the micro level. For example, Habermas (1973) argued that is through self-reflection and action by the oppressed that liberation and social change will be achieved. In current practice with this population, self-emancipatory practices are used, such as storytelling and narrative analysis used in both the CJS and therapy to achieve liberation for oppressed individuals by providing counterstories that challenge the dominant narratives and false ideologies in a way that lends voice to and reduces alienation (Bell, 1995 as cited in Delgado & Stefancic, 2012).

Critical theory is frequently criticized for being too idealistic and failing to present systemic solutions to evoke social change beyond participant self-reflection and emancipation via critical consciousness. (Groves & Sampson, 1986). Therefore, despite identifying systemic issues as a problem in this (and other) research areas, systemic level change (e.g., penal policy changes) is not the privileged mechanism of change in critical theory. Due to these limitations, some critics argue that critical theory-informed research remains largely theoretical, utopian, and thus impractical.

Complexity Theory

Underlying assumptions. A second theory that can be used to examine social issues present at the intersection of the mental health field and the CJS is complexity theory, (also referred to as complex systems science and/or complex systems theory; Byrne & Callaghan, 2014; Walker 2007). Similar to the underlying assumptions of critical theory, complexity theory rejects positivist scientific philosophy in favor of a

paradigmatic schema that falls in between post-positivism and postmodernism (see Table 2). As encompassed by the premise of its title, complexity theory posits that life is often too "complex" to separate concepts into distinct categorical boxes versus viewing philosophical paradigms in relationship to each other. Given these beliefs, complexity theory assumes a critical realist ontology in which it is assumed there is one reality that has been socially and transactionally constructed, though there may also be multiple and varying perspectives on this reality based on unique positionality of individuals.

Complexity theorists examine the nature of reality through a transactional and process-oriented lens by analyzing factors in terms of their relationships to other systems and systemic factors, which are themselves always subject to change (Byrne & Callaghan, 2014). A subjectivist axiology rejects determinism and embraces the way in which the complexity of life means there is no one correct solution or approach to any issue, but rather the subjectivity and positionality of the systems and researchers involved will impact findings.

Table 2

Underlying Assumptions of Complex Systems Theory

Paradigm	Ontology	Epistemology	Axiology	Methodology
Postpositivism + postmodernism	Critical realist	Transaction, process-oriented	Subjectivity, complexity, non-linearity	Subjective, non-prescriptive, holistic, complex

Major tenets. The essential tenet of complexity theory is to create knowledge based on the examination and understanding of the complex relationships and interactions between individuals and the systems in which they exist. With its origins rooted in the mathematical sciences, complexity theory has increasingly been applied to the social sciences–and to social work specifically–with the ultimate aim of understanding complex social problems so that effective responses may be implemented (Finegood, 2011). More specifically, when applied to social work scientific inquiry, complexity theory drives holistic analysis of characteristics associated with the most complex problems of humanity that are both reinforced and transformed through dynamic, nonlinear, and often chaotic relations, thus adopting some tenants of chaos theory (Warren, 2013; Warren, Franklin & Streeter, 1998).

Key concepts. Arguably *the* key concept integral to complexity theory is the emphasis on complexity, which is overtly reflected in the theory's title (Woehle, 2007). In this sense, complexity refers to the principle that there is a difference between simple and complex systems, and the way in which these respective types of systems are analyzed and understood may be different. Due to the nature of complexity present in this theory, it is beyond the scope of this chapter to cover every concept underlying this theory, as each adherent may value and apply concepts differently based on their unique, individual characteristics and systemic factors.

Sanger and Giddings (2012) identified seven key concepts integral to social workers' understanding of complexity theory, and these concepts have thus been selected for review here: (a) *complexity*, (b) *subjectivity*, (c) *bio-psycho-social relations*, (d) "*intertwinglement*", (e) "*the butterfly effect*", (f) *chaos*, and (g) *transferable complexity*.

The first concept is the above referenced complexity principle, which “refers to the degree of elaboration required for a basic explanation” (Warren et al., 1998, p. 141). The second concept refers to the subjectivity, which may lead individuals to conceptualize complexity differently. The third concept refers to the notion that all systems interact with other systems so that humans are affected by their biological, psychological, and social environments (referencing the prominent biopsychosocial model prominent in social work). The fourth concept refers to the principle that all systems are both intertwined and intermingled (“intertwingled”), as systems have parts that interact with other system parts through multiple, nonlinear, dynamic feedback loops.

The remaining concepts originate out of chaos theory, with the fifth concept, “the butterfly effect”, positing that change in one system’s initial conditions may affect change in other systems and their parts. The sixth concept, chaos, refers to the principle that complexity is not synonymous with chaos, as it is possible to observe patterns and thus infer probability in complex systems, which is not thought possible in chaotic states. The seventh concept refers to the transferability of complexity to assessment of complex systems. In other words, because systems are complex, there is no one form of assessment applicable to all systems, but rather assessment and intervention should vary based on the inherent complexity of the unique, individual systems.

Ability to explain the research topic. There are several strengths to the ability of complexity theory to explain the problems of interest in this research area. First, present at the intersection of the mental health field and the CJS are the convergence of many systems, including the courts, mental health treatment providers, the police, the defendant, the community, and local/state/national policy. It is through the dynamic and

complex interactions of these systems that social issues arise across system levels. Therefore, examination of issues across systems levels requires a holistic analysis of the "big picture" as is the case of complexity theory. This comprehensive analysis avoids missing parts the systems involved in social issues evoked by too micro of a focus–a limitation of which could result in incomplete findings which are unable to truly affect major systemic change (Warren et al., 1998; Woehle, 2007).

Second, because complexity theory pushes for a holistic analysis and emphasis on nonlinear dynamic interactions not emphasized in related theories (i.e., general systems theory), this theory can provide insight into why the factors inputted into a system do not always match the factors outputted. For example, if a mental health court receives funding that does not affect the desired change, a simple analysis based on linear feedback might reach limited conclusions that the funding should have been enough to supply resources that effected change. Complexity theory would examine the non-linear relations between systems not otherwise identified as relevant, leading to a more comprehensive analysis of the system (e.g., racism, discrimination, gender bias, and other phenomena that cannot be directly alleviated through funding).

Third, a major strength of applying complexity theory to social work research on the topic of mental health and criminal justice is the compatibility in ethics between the two frameworks evidenced in several ways. For instance, complexity theory centers around the importance of analyzing systemic interactions to understand human issues, which is comparable (though different) from the general systems inquiry framework that has historically been a dominant framework in social work research (Woehle, 2007). This focus on systems is in line with social work's person-in-the-environment approach

(Sanger & Giddings, 2012) that values the worth and dignity of the individual. Additionally, complexity theory's ability to inform systemic change through a holistic understanding of nonlinear system dynamics is compatible with social work's signature solution-focused orientation geared towards affecting positive change and social justice (Finegood et al., 2012; Pycroft & Wolf-Branigin, 2015).

However, in addition to these discussed strengths, there are several limitations to the ability of complexity theory to explain the problems present in this research area. First, complexity theory is nonlinear and non-reductionist; as such, this theory does not aim to identify the specific cause and effect of the problems examined. Secondly, due to complexity theory's holistic focus on total symptom interaction, sole examination of individual person and systemic characteristics are not the focus of analysis, thus devaluing factors such as individual personality disorders or biomedical causes of psychopathology that have been key principles in frequently applied theories used to explain the problems in this research area.

Finally, there are also several discrepancies between the axiological assumptions underlying complexity theory and social work. For instance, Thyer (2008) has criticized complexity theory for its language being "too mathematical", which can make this theory difficult for social workers (who often are more interested in the social sciences) to comprehend and feel comfortable using. Furthermore, social work is an extremely value laden profession that prioritizes above all the well-being of individuals, and complexity theory originated out of the hard sciences and thus was created without an intentional humanistic drive.

Ability to inform qualitative research methodology. There are several strengths that emerge from applying complexity theory as the guiding theoretical framework for qualitative research inquiry into the social issues present at the intersection of the mental health and criminal justice fields. First, the issue of interest involves a complex interaction of multiple systems, which thus calls for an equally complex research design (Warren et al.,1998). As found by Gerrits and Verweij (2015), complexity theory calls for a methodological inquiry that is capable of homing in on analysis of entire system workings to accurately recognize the complex nature of social reality that is often underestimated in other forms of inquiry guiding analysis of only segments of the issue. In addition, the underlying, non-positivistic assumptions of qualitative inquiry and complexity theory complement each other and call for a rich, in-depth description of the phenomena examined in a non-prescriptive way. Furthermore, both frameworks maintain goals beyond mere identification of an ultimate cause and effect of the area researched, and instead recognize the complexity of human system interactions that are nonlinear and dynamic.

In addition to the previously discussed strengths of complexity theory to inform qualitative inquiry, there are also several limitations that merit noting. First, the rejection of positivism and acceptance of post-modern concepts by both complexity theory and qualitative inquiry are met with criticism for being “unscientific” by those who maintain a more positivist philosophy (Sanger & Giddings, 2012). Such critics also view the lack of focus and ability to identify deterministic cause and effect by complexity theory and qualitative inquiry as a limitation (Finegood et al., 2012). Second, both complexity theory and qualitative inquiry embrace subjectivity, which means that the concepts of the

frameworks may be defined differently by various adherents, which makes their fundamental philosophies, methodologies, and findings at times difficult to systematically conceptualize, replicate, and discuss. The fact that different language is implemented by different adherents is especially notable in complexity theory, as its origination in the mathematical sciences often results in its dismissal by social workers who criticize its language and principles as being “too mathematical” (Thyer, 2008).

Ability to describe how change may occur through intervention. There are several strengths to applying complexity theory to understanding how change may occur through intervention in response to social issues present at the intersection of the mental health and criminal justice fields. First, complexity theory is solution-oriented, as the underlying tenets of the theory are to better understand complex system interactions, and to inform effective interventions that can affect positive systems change (Finegood et al., 2012). Therefore, by looking at all levels of system involvement, complexity theory can emphasize the importance of identifying a holistic picture of the disparities faced by individuals with mental illness in the CJS across system levels (i.e., micro-level mental health symptoms, mezzo-level inadequate community resources, and macro-level institutional racism).

In addition to these strengths, there are several notable limits to the application of complexity theory to this area of research that need to be addressed. First, because complexity theory is non-linear, identifying the effectiveness of interventions (e.g., MHC) may imply a sense of linearity rejected by the theory. This could thus present challenges for research seeking to examine the causal relationships associated with ACEs.

Trauma Theory

Underlying assumptions. Trauma theory is third theoretical framework that guided this study. Unlike critical theory and complexity theory, trauma theory is a contemporary term used to reference frameworks centered around understanding and addressing psychological trauma. As this research is in its infancy, ongoing debates regarding the definition of trauma persist. Due to differences in how this phenomenon is conceptualized, there are several varying conceptual approaches used to examine this phenomenon that share some commonalities and can be included under the term "trauma theory".

This theory is distinct from the two theoretical frameworks previously discussed– critical theory and complex systems theory–in several ways. First, both critical theory and complex systems theories are typically considered to be grander in scope, as they seek to understand human behavior in general (Jaccard & Jacoby, 2010). Contrastingly, trauma theory is narrower in scope, as it focuses primarily on the specific phenomenon of trauma. While critical theory and complexity theory have been applied across varying disciplines from law to social work, trauma theory is primarily referenced in social sciences concerned with mental health.

Second, both critical theory and complexity theory are established frameworks that are commonly discussed in theoretical literature. In comparison, trauma theory may be considered a more contemporary framework that has been discussed with increasing frequency over the past decades, due primarily in part to the increased publicization of sexual abuse legal cases in the 1980s (Suleiman, 2008). A comprehensive review of the history of trauma is beyond the scope of this manuscript. However, to briefly summarize,

psychological trauma has been the topic of scientific inquiry throughout history, though it was often referred to in different terms (e.g., hysteria). Freud's work on the unconscious, hysteria, and neurosis in the 19th century is often referenced as the hallmark of social science research on trauma (Khan, 1963). However, the conceptualization of contemporary trauma theory is frequently associated with Judith Herman's *Trauma Theory and Recovery* published in 1992, and her scholarship has greatly shaped the central concepts underlying trauma-informed frameworks used today.

Given that trauma theory is in its nascency, there are yet to be clearly solidified presentations of the primary philosophical assumptions underlying this theory in the literature. Furthermore, as trauma theory can be considered a "small range" theory that focuses on the specific phenomenon of trauma, there are varying ways to conceptualize the underlying assumptions dependent upon the grander theories and paradigmatic assumptions shaping individual's understanding of trauma. As such, the identified assumptions presented in Table 3 are not taken directly from the literature, but rather reflect my individual conceptualization of trauma theory as influenced by the grander theories that guide my view of the world including critical theory and complex systems theory.

My conceptualization of trauma theory adopts postmodernist paradigmatic assumptions, which direct the focus of inquiry to restoration, understanding, and reconstructing. A historical realist ontology is applied and assumes that there is an observable and researchable reality, though this reality may be constructed and perceived differently by each individual. A transaction and process-oriented epistemology is adopted that assumes that knowledge is constructed through processing both within and

between individuals. Trauma theory embraces axiological assumptions centered around empowering and protecting individuals through a focus on healing and restoration. Finally, methodological assumptions are centered around trauma-informed practices that, in sum, are concerned with inflicting no further harm.

Table 3

Underlying Philosophical Assumptions of Trauma Theory

Paradigm	Ontology	Epistemology	Axiology	Methodology
Poststructuralism + postmodernism	Historical realist	Transactional and process-oriented	Empowering and restorative	Trauma-informed, subjective, social-justice oriented

Major tenets. My conceptualization of trauma theory centers around the three E's of trauma as identified by SAMHSA (2014): events, experience of events, and effects. Based on this, a trauma framework seeks to understand human behavior by looking at what events individuals may have experienced (e.g., maltreatment), *how* individuals experienced events (e.g., as threatening), and how individuals are affected by the impact of these events (e.g., short-term and/or long-term emotional distress).

Key concepts. The key concepts of my conceptualization of trauma theoretical frameworks include the four R's as identified by SAMHSA (2014): realize, recognize, respond, and resist re-traumatization. Realization refers to understanding of the impact of trauma and paths to recovery. Recognition refers to identifying trauma symptoms in

individuals, groups, communities, and systems. Respond and resist re-traumatization refer to action shaped by “fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization integration of knowledge” (SAMHSA, 2014, p. 9).

Ability to explain the research topic. The purpose of this study was to explore how childhood trauma impacted adult MHC involvement. As such, application of trauma theory was congruent with the study purpose since this framework calls for a focus on the phenomenon of trauma when analyzing human behavior. One significant limitation of applying a trauma framework to this study is that it may bias research by narrowing analysis of behavior to the impact of trauma while ignoring other phenomena (e.g., biological factors associated with criminal behavior).

Trauma-Informed, Critical Systems Framework

Chapter 3 presented an overview of three theoretical frameworks that influenced this study: (a) critical theory, (b) complexity theory, and (c) trauma theory. Specifically, this study used a combination of complimentary tenets from each of these respective frameworks to guide this trauma-focused study. The combination of these tenets resulted in a novel trauma-informed, critical complex systems framework that is presented below in Figure 2.

What makes this framework unique is the specific individual concepts selected for inclusion in this model, which are reflective of unique factors that impact this population. Centered around these factors, this model underscores the importance of applying an ecological systems lens when exploring social issues experienced by individuals with

mental illness in the CJS. The concepts within this framework can be used to guide foci points of trauma-informed research and practice in this area.

Chapter Summary

In summary, this chapter presented an overview of the existent body of literature related to this study topic. Additionally, three theoretical frameworks that were used to guide this study were presented. The chapter concluded with the introduction of a novel trauma-informed, critical systems framework that can be used to guide future research in this area,

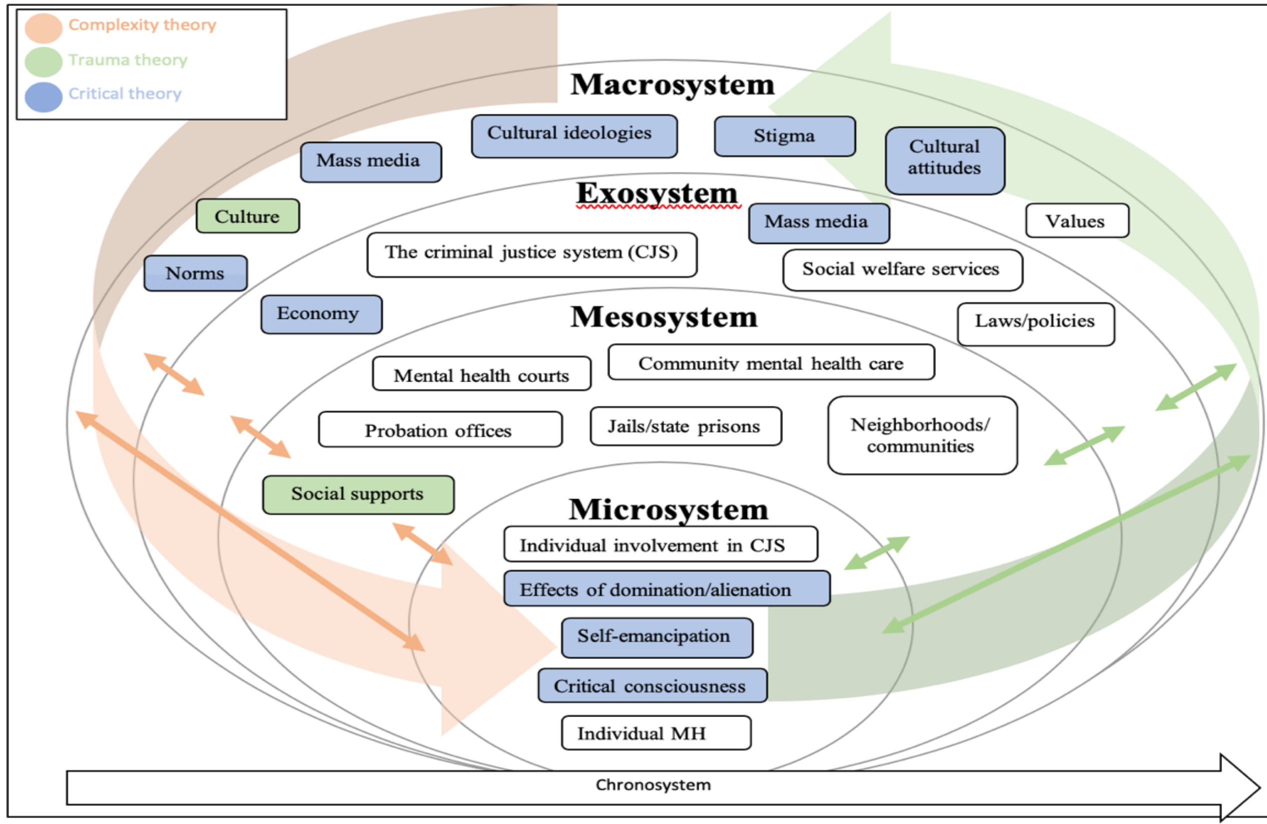

Figure 2. A trauma-informed, critical systems framework. This figure depicts a novel theoretical framework integrating concepts from critical theory (major concepts are presented in blue), complex systems theory (major concepts are presented in orange) and trauma theory (major concepts are presented in green).

CHAPTER 3

RESEARCH DESIGN AND METHOD

Introduction

The purpose of this qualitative inquiry was to examine the impact of ACEs on adult MHC involvement, including exploration of graduates' paths to involvement in the MHC system, experiences in the MHC program, and outcomes following completion of the MHC program. This study aimed to generate findings that could advance a transformative, social justice agenda by allowing the voices of MHC graduates to be heard and utilized to improve trauma-informed care efforts in the CJS. Data were collected through semi-structured interviews with 15 adult graduates of a MHC that were analyzed using narrative analytic techniques. The following four research questions guided this study:

1. What is the prevalence of ACEs?
2. How do ACEs impact participants' paths to MHC involvement?
3. How do ACEs impact MHC programmatic experience?
4. How do ACEs impact MHC outcomes?

Guided by Denzin and Lincoln's (2005) conceptualization of the phases of qualitative research, this chapter provides a thorough overview of the method implemented in this study, including discussion of the following topics: (a) rationale for qualitative methodological design, (b) researcher reflexivity, (c) research paradigm and philosophical assumptions, (d) research strategies, (e) data collection and analysis, and (f) interpretation and evaluation.

Rationale for Qualitative Design

Creswell and Creswell (2018) identified three primary approaches to research: (a) qualitative, (b) quantitative, and (c) mixed-methods. These three approaches exist on a continuum, contain differing philosophical worldviews and research methods, and are selected based on the researchers' philosophical assumptions and research questions. According to Bogdan and Biklen (1997), qualitative research consists of five key characteristics: (a) it is naturalistic, (b) it relies on descriptive data, (c) there is concern with process over outcomes, (d) data are analyzed inductively, and (e) meaning is the primary concern. Operating under an interpretive philosophical framework, this type of research uses flexible, inductive procedures to enhance understanding of social problems based on exploration of humans' lived experiences and meaning-making (Denzin & Lincoln, 2005), and is most appropriate when the aims of a study are to generate a deeper understanding of a phenomenon, to a describe context, to generate hypotheses, and/or to make new discoveries (Rubin & Babbie, 2017).

By contrast, quantitative research is characterized by the use of deductive, prescribed procedures to conduct research, and is traditionally associated with positivist philosophical assumptions (Babbie, 2013. This method is the most appropriate choice when a study aims to test hypotheses and generate precise results that are generalizable (Rubin & Babbie, 2017). Finally, mixed-methods research uses a combination of qualitative and quantitative research methods to answer research questions with the aim of generating a more complete understanding (Creswell, 2013). Integrating quantitative and qualitative data through a mixed-methods study is appropriate to answer multi-faceted, broad, and complex research questions (Tariq & Woodman, 2013).

My transformative philosophical worldview and the overarching goal of this research project led me to identify a qualitative method as the strongest approach to answer the specific research questions and address the unique aims of this study. According to qualitative scholars such as Merriam (2002) and Nicholson (1995), a qualitative research design is a strong methodological approach when the primary goal of a research project centers around understanding individuals' lived experiences through thick, rich description used to advance a transformative agenda, hence a qualitative design was selected. I determined that a quantitative design would not adequately answer the questions, and the primary goal of the study was not to produce generalizable findings, nor to establish causality.

Additionally, though the ACEs scale used in this study is a quantitative measure, I do not consider this a mixed-methods study for two primary reasons. First, the study's sample size (*N*=15) is considered low for a quantitative study and limited the ability conduct inferential statistical analysis that would generate credible results (Castro, Kellison, Boyd, & Kopak, 2010). Second is the issue of commensurability (Small, 2011), and the inherent contradictions between the philosophical assumptions underlying my conceptualizations of quantitative and qualitative methodology.

Ultimately, I selected a qualitative method for this study for three primary reasons: (a) to facilitate a detailed understanding of a complex issue, (b) to allow the voices of participants to be heard (c) through the telling of their stories (Creswell, 2013). According to Merriam (2002), qualitative research produces rich, detailed descriptions about an issue that can provide insight into the meaning and experience of the phenomenon examined (in this case the impact of ACEs on MHC experience). To

elaborate on quantitative research findings demonstrating the prevalence of trauma in the criminal-justice involved populations, a qualitative methodological approach allows for information that can help explain the processes and linkages underlying this phenomenon. Additionally, a qualitative method complimented my transformative philosophical worldview by allowing me to share the voices of a population usually silenced by telling their stories in a *literary, flexible style* that is not bound to the traditional constraints of academic writing (Creswell, 2013, p 48).

Within qualitative research, there are many ways to approach qualitative inquiry, including narrative research, phenomenological research, ground theory research, ethnographic research, case study research, or a combination of these approaches. (Creswell, 2013). Each of these approaches has distinguishing characteristics primarily centered around their philosophical, theoretical, and epistemological underpinnings. Additionally, various frameworks typically consist of common core questions and methodological procedures that aid in enhancing the rigor of qualitative research so that it can be assessed and replicated.

Qualitative inquiry recognizes the complexity of life, and thus does not specify a "single, monolithic approach to research", even within the various specific approaches mentioned above (Patton, 2015, p. 96). What this means is that qualitative research is complex, and within qualitative research there are differing (and sometimes competing) conclusions on methodological issues, and delineation of qualitative approaches. Furthermore, there is no one prescriptive way of implementing unique types of qualitative approaches, rather researchers can use existing methodological literature to guide their research process, including combining several types of approaches.

During the design of this study, multiple types of qualitative inquiry were reviewed, including the traditional five forms of qualitative inquiry: narrative, phenomenology, ground theory, ethnography, and case study (Creswell, 2013). Ultimately a basic qualitative inquiry was determined to be the best fit for this study, which is defined as research that "is not guided by an explicit or established set of philosophical assumptions in the form of one of the known [or more established] qualitative methodologies (Caelli et al., 2003, p. 4 as cited in Kahlke, 2014, p. 13). This specific qualitative approach was determined to be the best approach as it allowed for flexibility (lack of adherence to one specific approach) in procedures to best address the aims and answer the research questions of this study.

As is frequently the case with basic qualitative inquiries, the approach used in this study borrowed heavily from two specific approaches: narrative research and phenomenological research. Specifically, aspects from phenomenology were borrowed, including emphasis on phenomenon to be explored (ACEs and MHC involvement). This study deviated from traditional phenomenological inquiry as the phenomenon of interest consisted of two types of experiences: ACEs and MHC, while traditional phenomenological research emphasizes a single concept (Creswell, 2013). Furthermore, this study aimed to describe the phenomenon experienced, as opposed to engaging in an in-depth philosophical exploration of the experience.

The method implemented in this study also drew from narrative inquiry, including the use of narrative analysis and the telling of participants' stories in data presentation. However, techniques used in this study differed from traditional narrative inquiry, including the type of data collected. In traditional narrative inquiry, data often consist of

extremely detailed life stories from one or a small group of participants collected via autoethnographies, life histories, or oral histories. Contrastingly, in this study data consisted of responses to interview questions provided by 15 respondents who were not explicitly instructed to tell a story but were asked to discuss specific lived experiences.

Researcher Reflexivity

Denzin and Lincoln (2005) identified *the researcher as a multicultural subject* (or researcher reflexivity) as the first phase of qualitative research. They defined this phase as consisting of the researcher's reflection of their unique "history and research traditions, conceptions of self and the other, and the ethics and politics of research" (p. 23). Essentially, qualitative research adopts an "interpretive" approach to research (Denzin, 1989) in which it is acknowledged that research "cannot be understood without references to the ideas being concealed by the author and contexts within the author's life (Creswell, 2013, p. 214). In fact, beyond a call for researchers to "position" themselves in their research conduction, interpretation, and writings, are the axiological factors that underlie the embracement of subjectivity in research. As stated by qualitative scholars such as Czarniawksa (2004) and Gilgun (2005), purely objective research can have the impact of silencing the voices of researchers (and participants), which is antithetical to aim of qualitative research as a platform for all voices to be heard.

The concept of self-reflexivity is especially integral to research conducted under a transformative paradigm (see the below section titled *Theoretical Paradigm* for a more detailed discussion) due to the epistemological assumptions within a transformative paradigm, which posits that knowledge is constructed (in general and throughout the research process) through the same contexts of power and privilege present in social

structures resulting in equality (Mertens, 2009, p. 311). As such, it is imperative for transformative researchers to implement self-reflexivity throughout the entirety of the research process, especially as pertains to issues related to positionality, power, and bias. Guided by Charmaz (1995) and Creswell (2013), my reflexivity process consisted of three primary actions: identification and discussion of my positionality, my experiences with the phenomenon of interest in this study (ACEs and MHC involvement), and examination of how my positionality and past experiences have shaped my research interpretations.

Guided by fundamental principles from critical theory that are embedded within a transformative paradigm, identifying my positionality involves acknowledging factors that construct my identity, and then reflecting on how these factors impact my lived experience. Therefore, I began by identifying and describing my positionality as a White female who identifies with her gender assigned at birth, who has primarily experienced a privileged life in the middle class of society with access to resources. As suggested by Mabry (2010), I must acknowledge that this positionality is associated with a certain power that increases my risk of bias (regardless of whether it is intentional or unintentional), and thus I must be aware of the potential for "implicit effects of hidden or dimly perceived values" that may emerge no matter how intentionally reflective I am (p. 91). Furthermore, as recommended by Kendall (2006), research conducted within a transformative paradigm calls for me to use any power and privilege I experience to challenge oppressive systems and promote a social justice agenda through my research.

With regards to my experiences with the phenomenon in this study, I identified two primary experiences that I believed to have the strongest impact on my research

process and interpretations of findings: my professional lived experiences and my personal values. Both of these experiences have been greatly influenced by my academic and professional training as a social worker. Specifically, I have a Master of Social Work degree with a clinical specialization, and I am currently a Ph.D. candidate in social work at a school that identifies social justice as its primary mission. Due to the value-laden nature of the field of social work (whose professional code of ethics calls for social workers to be advocates of positive social change), my personal and professional ethics often blend. Mertens and Wilson (2012) advised that "the ethical principles of ethics, respect, beneficence, and justice are relevant for the transformative evaluator" (p. 164), thus suggesting that my values align well within this paradigm.

Mertens and Wilson (2012) stated that transformative researchers must have a strong knowledge of the combined interaction between their positionality and values. As described above, my values fit well within the transformative paradigm's axiological assumptions and allowed me to adhere to Mertens and Wilson's expectation that my "values in regard to social justice and human rights will influence the process and outcomes of [my] work" (p. 164). However, I must also acknowledge my propensity to face several challenges, including the ways I can be protective of vulnerable and marginalized populations due to the amazing people in these social contexts that I have had the privilege of working with in my profession over the past eight years. Based on Freirean principles related to unconscious oppression, this tendency towards protection can lead to unintentional actions of colonization that are in fact antithetical to the critical theory and social justice agenda valuing self-emancipation (Friere, 1996).

Additionally, my experience addressing some of the most extreme social problems in my practice over the past near decade has led to me to be vulnerable to the adverse effects of compassion fatigue and burnout. Such symptoms have resulted in me having the inclination to adopt what I have reflected on and identified as a somewhat cynical worldview in which I may initially assume social systems and persons in power are constricting/reinforcing of status quo and inequality before getting to know specifics of unique context. These challenges could inadvertently impact my research process and interpretation and are especially pertinent regarding my perception of the U.S. CJS.

The problem of mass incarceration in the United States has led to criticism of CJS as an oppressive institution that disproportionately marginalizes specific sub-populations based on factors such as race and social class (see for example Cole, 1999; Quinney & Shelden, 2018; Willison & O'Brien, 2017). Through my practice experience working with individuals involved in the CJS, I have observed such systemic consequences associated with mass incarceration. My professional experience in this area had the potential to bias my research, which merited intentional action.

In effort to manage such potential research biases stemming from my professional experience in this area, I followed techniques by Mertens's (2009). Such techniques included consistent self-reflection that involved identifying potential biases and actively creating strategies to manage these. Additionally, these strategies included a constant awareness of this tendency that prompted me to reflect on how these biases may be impacting my research strategies at each stage in the process, from how I formulated research questions, to how I responded to participants, and how I interpreted findings. Secondly, awareness of these potential biases led me to select a narrative analytic

approach that involved using direct participant quotes as part of the interpretation of data, as this allowed me to report the participants' verbatim words, in addition to my interpretation.

The second issue I believe merits discussion is my personal experience with trauma, and ACEs in particular. As I have used the ACE measure many times in both my practice and research experience (in this study and others), I have taken the ACE and reflected on my own score (3) for the past decade. More important than identifying my score is the reflection I continuously conducted on the impact of my score on my research and practice. My current conclusion on the impact of this score reflects the limitations of the ACEs measure in general. With a total score of a three, I have experienced several of the traumatic events and associated symptoms that my participants in this study experienced, therefore it may initially be assumed that I can relate to these experiences, and thus my participants. However, a score of a three does not tell the whole picture, including which types of ACEs I have experienced, the extent to which they impacted me, and how symptoms manifested. As research on trauma and ACEs has evolved, there is more acknowledgment and discussion of the degree of subjectivity to trauma, as the same event could be experienced differently by different individuals and result in varying symptoms (or absence of symptoms) that are impacted by one's positionality.

Therefore, I ultimately have concluded that my ACE score is just high enough to be dangerous, and thus furthers my commitment to continuous self-reflexivity to manage biases in my research. I have experienced some of the same events my participants experienced and thus theoretically could somewhat relate to my participants' experiences. However, due to the differences in our positionality, the way these events were

experienced and how they impacted me were very much mediated by my positionality and the privileges I have experienced, and thus in no way should I deem myself the expert on ACEs experienced by my participants. For example, the effects of my ACEs were mediated by the presence of one stable caregiver and access to financial and educational resources that protected me from the combined impact of forces such as poverty and lack of social support. Furthermore, as a cisgender, White, heterosexual female, I have been sheltered from the adverse consequences of racism and other forms of discrimination.

In conclusion, I believe it is important to openly identify and discuss my ACE score to be transparent about my lived experiences and specifically my personal experience with trauma. More importantly is what I *do* with the acknowledgment of my score—and that is an explicit awareness on my part that the participant is the expert on their life and trauma experience, and the fact that I may have experienced some of the same events in no way equates to me being an expert on ACEs and the resulting impact of ACEs, especially for people involved in the CJS and an MHC program. Furthermore, my understanding of the differences between what my ACE score means for me and what the same or a similar score may mean for my participants greatly solidifies my belief in the necessity of qualitative research to truly understand trauma, which is inherently subjective and cannot comprehensively be understood and addressed using numbers alone.

Research Paradigm and Philosophical Assumptions

Paradigm is a concept typically associated with Thomas Kuhn (1970), who defined this term as "accepted examples of actual scientific practice—examples which

include law, theory, application, and instrumentation together—provide models from which spring particular coherent traditions of scientific research" (p. 10; Sławecki, 2018). At its broadest level, a paradigm represents the worldview of a researcher that serves to define the ways in which the researcher views and understands the world. The importance of paradigms and philosophical assumptions within scientific research has long been the subject of debate among scholars in the social sciences (e.g., Gage, 1989), and social work specifically (e.g., .g., Thyer, 2001, Gomory, 2001, Munro, 2002).

In qualitative research, there is typically a strong value placed on paradigms (see for example Denzin & Lincoln, 2005; Guba & Lincoln, 1994; Mertens, 2009; 2012; and Patton, 2015). Within this tradition, it is commonly assumed that paradigmatic philosophical assumptions are important as they "should provide guidelines and support to the researchers who study the reality around them" (Benton & Craib, 2010 as cited in Sławecki , 2018, p. 10). Essentially, it is believed that a researcher's paradigm "has significant implications for every decision made in the research process," including the decisions researchers make regarding which method is used and how data are analyzed and synthesized to create meaning (Kivunja & Kuyini, 2017).

There are varying ways to conceptualize paradigms and their role within research. In qualitative inquiry, paradigms are frequently discussed using the five basic research orientations identified by Guba and Lincoln (2005). They defined paradigm as a "set of basic beliefs" comprised of ontological assumptions (the nature of reality), epistemological assumptions (the nature of knowledge), axiological assumptions (the nature of ethics), methodological assumptions (the appropriate method of inquiry), and theoretical assumptions (concepts from guiding theoretical frameworks. Based on these

conclusions, Guba and Lincoln identified five basic paradigms that shape all types of research: a) positivism, b) postpositivism, c) critical theory, d) constructivism, and e) the participatory paradigm (later referred to as the transformative paradigm; Mertens, 2012). Given the overwhelming historical consensus amongst qualitative researchers that paradigms have a profound impact on all phases of inquiry, this section this section will provide a detailed overview of the transformative paradigm under which I locate this study.

Transformative Theoretical Paradigm

The transformative paradigm is commonly considered one of the four major paradigmatic viewpoints that guide researchers in the examination of the belief systems that underlie their research. In addition to the positivist, postpositivist, and constructivist paradigms, the transformative paradigm was defined by Mertens (2010) as "a framework of belief systems that directly engages members of culturally diverse groups with a focus on increased social justice" (p. 470; Mertens, 2009, 2012; Harris, Holmes, & Mertens, 2009). With roots grounded in Marxism and critical theory traditions, the assumptions underlying the transformative paradigm emerged from the earlier theoretical work of Guba, Lincoln, and Denzin. Specifically, assumptions within the transformative paradigm emerge from the constructivist paradigm, a framework centered around belief in multiple realities and examination of the social construction of knowledge (Denzin, 2017; Guba & Lincoln, 2005).

As their work evolved, Guba, Lincoln, and Denzin all eventually identified the need for a fifth paradigm–separate from constructionism–to focus primarily on addressing social justice issues, or "transformational leadership" (Denzin & Lincoln,

2005). In 1994, Guba and Lincoln introduced a basic system of beliefs grounded in principles from Marxism and critical theory that was initially referred to as "critical theory and related ideological positions," and later labeled "the transformative paradigm." Mertens (2010) described the need for a fourth paradigm that was separate and distinct from the constructivist paradigm by stating, "...it is possible for researchers to situate themselves within the constructivist paradigm and not address issues of social justice. It is also possible to address issues of social justice from a set of belief systems that differ...from the constructivist paradigm" (p. 470). As alluded to in Mertens's justification for a distinct transformative paradigm, this set of beliefs is grounded in philosophical and theoretical assumptions primarily concerned with issues of power, privilege, inequalities, and the quest for social justice.

Ontological assumptions. The transformative paradigm assumes a "historical realist ontology" (Denzin & Lincoln, 2005 as cited in Mertens & Wilson, 2012, p. 164), which acknowledges multiple perspectives of reality that are shaped by evolving social contexts across history, such as by political and social issues.

Epistemological assumptions. Mertens and Wilson (2012) described the transformative paradigm as having a "transactional epistemology" (p. 163). This epistemological stance assumes that knowledge is constructed through interactions within social systems, and thus knowledge itself, the creation of knowledge, and the interpretation of knowledge are subject to the impact of power and privilege (Denzin & Lincoln, 2005).

Axiological assumptions. The transformative paradigm maintains an axiology that values human rights, positionality (especially the marginalized), and the

improvement of inequalities. According to Mertens (2010), the axiological branch of the transformative paradigm centered around social justice is perhaps the most important aspect of this set of beliefs, as this specific focus differentiates this belief system from others.

Methodological assumptions. No one method is required, but methodological assumptions typically include a dialectic, dialogic approach using qualitative methods primarily, though mixed methods can be used as well (Guba & Lincoln, 2005)**.**

Basic Qualitative Inquiry

Qualitative inquiry can be conducted in myriad ways using various methodological frameworks as guidance for conducting research. The subject of what specific approaches and methods must be used within a qualitative study has been a long-standing debate among researchers that continues today (Ormston, Spencer, Barnard, & Snape, 2014). For example, Creswell (1998) identified five "traditions" that shape the procedures used in the qualitative study research designs–biography, phenomenology, grounded theory, ethnography, and case study–while Denzin and Lincoln (2000) identified eight qualitative research strategies: case study, ethnography, phenomenology, grounded theory, biographical, historical, participatory, and clinical.

Amidst this debate, perhaps the primary point of consensus that has been reached regarding what research designs facilitate qualitative inquiry is that there is no master list of methods or practices that constitute qualitative research, but rather there are myriad approaches. While different approaches will create variations in each aspect of how a study is conducted (from how the research question is phrased, to how data is collected and interpreted), what remains common throughout varying strategies is that "all

qualitative research is characterized by the search for meaning and understanding, the researcher as the primary instrument of data collection and analysis, an inductive investigative strategy, and a richly descriptive end product" (Merriam, 2002, p. 6). Regardless of the specific type of approach used to conduct a research study, qualitative inquiries ultimately aim to generate thick, rich, detailed descriptions about lived experiences (Elliot, Fischer, Rennie, 1999).

Literature on specific approaches to qualitative research (such as those referenced above) was reviewed extensively to determine the appropriate procedures and techniques with which to investigate the phenomenon of interest. As recommended by Kahlke (2014), the study purpose and research questions drove selection of the qualitative approach used. Ultimately, a basic interpretive and descriptive qualitative design was selected to best answer the research questions posed while maintaining allegiance to the underlying transformative philosophical assumptions that shape my worldview.

Merriam (2002) defined a basic interpretive qualitative study as one that seeks to understanding a phenomenon through the worldviews of people involved, through a variety of various data collection techniques (including interviews), with the ultimate aim of "identifying recurring patterns or common themes" to create "a rich, descriptive account of the findings" (pp. 6-7). As depicted in Table 4, this qualitative approach allowed for blending of methodological techniques, including aspects of phenomenology and narrative inquiry. This blending of techniques allowed me to select techniques that were the best approaches to answer this study's research questions without being constrained by the traditions within only one approach.

Guided by the recommendations of (Kahkle, 2014), aspects of various established theoretical and methodological traditions were combined to allow for the flexibility necessary to look at the phenomenon of interest in a new way. Rigor was maintained by ensuring that methodological decisions were made to enhance the congruence between the four elements of a well-designed research framework as identified by Crotty (1998): philosophical assumptions, theoretical framework, broad research strategy, and methodological techniques. Guided by Creswell's (2007) conceptualization of research approaches, an overview of the research approach used in this study included techniques drawn from various established methodologies as depicted in Table 3.

Study Procedures

This study used a qualitative design in which semi-structured interviews with purposefully sampled program graduates served as the primary source of data. At the beginning of the interview, participants completed the ACEs questionnaire (Felitti et al., 1998) to establish the presence (or absence) of a childhood trauma history. The interview transcripts were transcribed and analyzed using narrative analysis to explore the emergence of themes between participants' childhood trauma history and their MHC outcomes and experiences.

Site of the Research

Study participants were graduates from a Southeastern MHC program in the United States. This program was part of a two-county MHC circuit in Southeastern that emerged in the past ten years under the umbrella of a larger county-level PSC system with the goal of addressing the underlying causes of criminal activity in effort to reduce criminal recidivism. Each county had a court that acted separately from the other, though

the staff members were the same for both courts. This MHC circuit adopted a non-adversarial, collaborative approach to serve individuals living in this two-county circuit on a post-adjudication basis.

Eligible participants for the MHC included individuals who had been charged with felonies or felony probation violations, and who had a diagnosed, severe, and persistent mental illness, or a co-occurring mental illness and substance use disorder. By statute, the following charges were excluded: murder, armed robbery, rape, aggravated sodomy, aggravated sexual battery, aggravated child molestation, child molestation, anything involving guns, possession with intent to distribute, sale of drugs, felony escape, residential burglary of a stranger, and any other sexual related offense. Participants may be referred to the MHC program via a number of sources, including self-referral, probation, family members, or (most commonly) the district attorney's office or the sheriff's office.

The MHC process was individualized for each participant's unique needs, but generally consisted of an 18-24-month program involving treatment for mental health and co-occurring substance use disorders (which included weekly mental health treatment under the supervision of a psychologist and paraprofessional support services), drug screening, community supervision by the sheriff's department and probation officers, transportation, and regular court attendance. The MHC circuit served 50 participants at the time of the study but anticipated expansion over the next several years.

Sample Selection

Purposeful sampling (Patton, 2015) was used to identify study participants (N = 15). Purposeful sampling was selected as the sampling strategy implemented, as it allows

for intentional selection of “individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2013, p. 156). Participation was limited to individuals who had graduated from the program to allow for the exploration of the impact of ACEs on participants’ paths to MHC involvement, programmatic experience, and outcomes following graduation. The one exception to this was a participant who was released from the MHC for violating the conditions, which served as a negative case example (Allen, 2017).

Due to the inherent mistrust of outside researchers by vulnerable populations (such as individuals involved in the criminal justice system), gatekeepers were used to access participants (McAreavey & Das, 2013). Through conversations with stakeholders of the MHC circuit examined in this study, several individual professionals in the MHC program that were highly trusted by MHC graduates were contacted and asked to sever as gatekeepers. Specifically, the following three individuals served as gatekeepers: the MHC circuit case manager, court coordinator, and a lead mental health treatment provider.

The use of gatekeepers was intended to access participants while also ethically protecting vulnerable individuals who may be hesitant to communicate with an outside researcher (Laine, 2000). However, there are potential limitations associated with use of gatekeepers that merit discussion, including a biased selection of participants selected by gatekeepers for invitation for study participation (Lavrakas, 2008). Finally, participants received a ten-dollar Walmart gift card as an incentive to participate, which were funded via an internal research award from The University of Georgia School of Social Work.

Data Collection

Guided by Patton's (2008; 2015), the primary source of data for this study consisted of transcripts from focused, semi-structured interviews with MHC graduates. This method of data collection was selected based on the aims of this study, which included analysis of program experience and outcomes to generate findings that could shape recommendations to affect positive programmatic change and social justice-oriented action (Argyris, 1982; Agyris & Schon, 1978; Schon, 1983). Additionally, secondary study measures were used for triangulation, including responses to a trauma screen administered to all participants immediately preceding the interview.

In line with data collection traditions in qualitative research, data was collected until saturation was reached. While data saturation typically is accepted to mean that no more data collection is needed, this phrase is sometimes used inconsistently and conceptualized differently (Saunders et al., 2018), thus meriting further discussion. Data saturation is a term that emerged from literature on grounded theory by Glaser and Strauss (1967), who provided the following definition: "the criterion for judging when to stop sampling the different groups pertinent to a category is the category's theoretical saturation. Saturation means that no more additional data are being found" (p. 61).

Given the complexity surrounding data saturation, Saunders et al. (2018) conclude that saturation should be operationalized "in a way that is consistent with the research question(s), and the theoretical position and analytic framework adopted" (p. 1893). They identify several saturation models that can be used, including theoretical saturation, inductive thematic saturation, and a priori thematic saturation. These models reflect the belief that there is not one universal conceptualization of saturation in qualitative

research, and thus no one way to ensure it is obtained (or whether even that should be a goal); instead, the saturation model used should be based on the specific research questions and the researcher's guiding philosophical assumptions (Malterud et al., 2016; O'Reilly & Parker, 2013).

Based on this study's research questions, which called for a priori thematic coding as the focus on themes to identify was pre-determined, an a priori thematic saturation model was used. This model suggests that the researcher may conclude saturation is reached when the pre-determined codes and themes are believed to have been satisfactorily exemplified in the data, and that further data collection would not be likely to yield new information (Francis et al. 2010). Guided by this model, I collected and analyzed data simultaneously to identify my pre-established themes (e.g., prevalence of ACEs, impact of ACEs on MHC involvement, impact of ACEs on MHC programmatic experience, and impact of ACEs on MHC outcomes) and code them (e.g., strong, weak). Therefore, I concluded data saturation was reached when the data I was collected exemplified the pre-established themes without yielding substantial new information relevant to the study purpose.

Instruments

The primary instrument used for data collection was a semi-structured interview guide. The semi-structured, focused interview guide was created using Patton's (2015) pragmatic approach to qualitative interviews, which are designed to elicit feedback on program processes and outcomes, as well as inclusion of questions focused on background/demographics, behaviors/experiences, opinions/values, feelings/emotions, and knowledge/senses (Royse, Thyer, & Padgett, 2010). To design a "focused" interview,

a semi-structured interview format was used, and the questions were conceptualized and implemented through use of an interview guide (see Appendix A).

The interview guide also served as a checklist to ensure that the major topics of inquiry were covered, while also remaining flexible enough to allow for amendments that might have been needed due to the complex nature of the research area. This flexibility was important, as not every potentially valuable topic can be predetermined. Additionally, it was not possible to preemptively account for the way in which symptoms of severe mental illness might affect some participants' response ability (Royse et al., 2010).

The secondary instrument implemented was the ACEs Questionnaire, which was used to assess the presence of a childhood trauma history among participants (see Appendix D). The ACEs Questionnaire was created by Felitti et al. (1998) and is a brief, 10-item screening measure used to retroactively assess experiences across three categories of abuse: (a) emotional and physical abuse, (b) physical abuse, and (c) abuse associated with living in a dysfunctional household. This questionnaire was designed to assess the presence of ten types of ACEs that occurred before the respondent turned 18, including the following: (a) emotional abuse, (b) physical abuse, (c) sexual abuse, (d) emotional neglect, (e) physical abuse, (f) witnessing maternal violence, (g) household substance abuse, (h) household mental illness, (i) parental separation or divorce, and (j) incarceration of a household member. The ACEs measure has strong psychometric properties with strong reliability, validity (Wingenfeld et al., 2010), and internal consistency (Cronbach's alpha = .88; Murphy et al., 2014).

Data Collection Procedures

The MHC staff provided a list of potential participants that fit the guidelines for a typical case sample and their contact information. With support from MHC staff as needed, the participants were contacted by the primary investigator of this study, and interviews were scheduled. Using guidelines from the pragmatic approach, the focused interviews were designed to last approximately one hour, with enough flexibility for amendment in response to the complexity of natural inquiry as appropriate (Padgett, 2008; Patton, 2015; Royse, et al., 2010; Weiss, 1998).

Data were obtained at either participants' homes, a public location in the community of their choosing (e.g., a restaurant), or at a site in the community where they received services during the MHC program (e.g., a community mental health center). Guided by recommendations for trauma-informed data collection, these options were provided to participants and they were able to select the location with which they were most comfortable, at times that were mutually convenient for all parties. Two interviews were conducted at participants' homes, one interview was conducted at a McDonald's, and 12 interviews were conducted in private offices at service-provision centers in the community. As the researcher, I conducted all interviews, which consisted of the following procedures.

After meeting participants at the interview location of their choosing, I engaged in brief rapport building, reiterated the study purpose, explained the interview procedure, reviewed the informed consent (which included consent for the interview to be recorded), and responded to any questions or concerns by participants. All 15 participants scheduled to complete an interview provided written informed consent and successfully completed

the interview process. The official interview procedure then began with administration of the ACEs measure, which participants could choose to complete independently by paper and pen, or to have me read the measure aloud to them and record their responses (this latter option was provided to maximize completion of the measure regardless of participants' literacy level).

Next, the participants completed a semi-structured interview with me, which lasted approximately 60 minutes. During this process, I asked participants questions about their history of ACEs and how their ACEs impacted their MHC involvement (see Appendix E: Semi-Structured Interview Guide). Because the audio from the interview was recorded for later transcription, I was able to focus my attention on actively listening to participants and was not distracted by attempting to record all responses. However, as recommended in qualitative research (e.g., Phillippi & Lauderdale, 2018), I did take brief field notes documenting thoughts, reactions, and feelings I noted during the interview. These field notes were later reviewed in the memoing process to assist with interpretation of data and research reflexivity (Birks, Chapman, & Francis, 2008).

Guided by Birt, Scott, Cavers, Campbell, and Walter (2016), I engaged in member checking efforts at several points throughout the interview process. For example, I orally clarified responses with participants as needed. Additionally, at the conclusion of the interview I briefly provided an oral summary of the responses I considered to be the key takeaway points pertaining to the study's guiding research questions. I then asked participants to confirm or correct these summaries and made field notes as necessary throughout this process.

Throughout the entirety of the study, trauma-informed research practices were implemented to remain consistent with the transformative lenses through which this study was conducted. Specifically, SAMSHA's (2014) recommendations for trauma-informed screening, interviewing and data collection were used. These recommendations included person-centered approaches to communication, relationship building, and trauma-sensitive approaches to interviewing.

All interviews were conducted by the primary investigator of this study, who was a licensed clinical social worker trained and experienced in administering trauma screening, assessment, and treatment. Per SAMHSA (2014) recommendations, at the conclusion of each interview, the interviewer ensured participants were grounded before leaving. Additionally, participants were provided a psychoeducational informational sheet about trauma, that included referral to a resource (in addition to the mental health treatment they were already receiving as graduates of the MHC program) should they experience any distress following participation (see Appendix F).

Data Analysis, Synthesis, and Interpretation

The units of analysis for this study were participants' responses to the specific interview questions posed (Patton, 2015, p. 443), as well as scores from the ACEs measure. Data were managed using qualitative data analysis (QDA) software. Specifically, NVivo 12 (QSR International, 2018), was used to store, file, and analyze data. Following the form of traditional qualitative inquiry, data analysis began at the start of data collection and was an ongoing, iterative process during the data collection and data analysis phases of the research project (Royse et al., 2010).

Narrative Analytic Techniques

Narrative analytic techniques were used to analyze the data collected. Narrative analysis was defined by Riessman (2008) as “a family of methods for interpreting texts that have in common a storied form” (p. 11). Within this analytic technique, events from participants’ descriptions of experiences are placed in temporal order to create individual stories, which are then analyzed across cases for common patterns or themes (findings) that are then interpreted to generate implications (Riessman, 1993).

The term *narrative analysis* may conjure confusion, as it is often incorrectly interchanged with similar terms, such as “narrative or narrative inquiry”. Narrative inquiry is a term used to describe a specific type of research approach that is common in qualitative research (Creswell, 2013). Researchers conducting narrative inquiry often use narrative analysis as the specific set of techniques to analyze their data, though they may use other analytic techniques. Additionally, researchers operating under other approaches besides narrative inquiry may use narrative analysis, such as in autoethnography or arts-based inquiry (Kim, 2016). Additional confusion may occur as within both the terms *narrative inquiry* and *narrative analysis*, the word *narrative* can be used to refer both to phenomenon–what is being studied–and a method–how the phenomenon is being studied (that is, narratively).

As was the case with this study, there are several reasons why narrative analysis might be chosen as an analytic technique outside of a study using narrative inquiry (Kim, 2016). First, selecting narrative analysis for use in a basic qualitative study allows for analysis focusing on placing the phenomenon described by participants in temporal order, which was important in this study given the goal of assessing the impact of a childhood

adverse experience on adult behavior. Narrative analysis allowed for a focus on chronology while analyzing findings without having to also adhere to all the other traditional stipulations associated with narrative inquiry, such as spending extensive time with each individual participant or placing emphasis on examining *how* stories are constructed (Creswell, 2013).

Similar to the previous discussion on various approaches to qualitative inquiry, there is no one set framework used to direct narrative analysis. Instead, there are a variety of frameworks that can be used to guide analysis, including: thematic analysis, structural analysis, and interactional analysis (Riessman, 2005). These frameworks are intended primarily to serve as guidelines for researchers to approach analysis as opposed to a strict set of stipulations that must be adhered to without deviation. This study utilized aspects of both of Polkinghorne's (1988) strategies for analysis: narrative analysis (or narrative mode of analysis) and analysis of narratives (or the paradigmatic mode of analysis).

Narrative analysis. Narrative mode of analysis (also referred to as narrative analysis), was defined by Polkinghorne (1988) as analysis that focuses on placing elements of the story into temporal order with the end goal of "configuration of the data into a coherent whole" (p. 15). In other words, narrative analysis involves analyzing the data (in this study transcriptions of qualitative interviews), extracting "elements that make each situation remarkable" (Polkinghorne, 1995, p. 6), and placing the data together into a storyline with a plot. To complete a whole with the data collected in this study, I utilized restorying (Ollerenshaw & Creswell, 2002) to extract parts of participants' responses and rewrite them into my own interpretation of a coherent narrative that

summarized each participant's story of trauma and MHC involvement in chronological order.

Analysis of narratives. Paradigmatic mode of analysis involves the identification of common themes across units of data (Kim, 2016). Polkinghorne (1988) described this type of analysis as "paradigmatic cognition" that "produces cognitive networks of concepts that allow people to construct experiences as familiar by emphasizing the common elements that appear over and over" (p. 10). In other words, analysis of narratives generates findings that are "arranged around descriptions of themes that are common across collected stories" (Kim, 2016, p. 196). After restorying participants' narratives into shortened stories in chronological order, I then conducted analysis of these restoried narratives to identify common themes present across participants that corresponded with the study's research questions.

According to Polkinghorne (1995), the themes identified in analysis of narratives can either emerge from the data to form a novel theory (similar to grounded theory techniques) or can be pre-established based on existing previous theories. My analysis of narratives utilized the second technique, where I utilized the key concepts from the guiding theoretical frameworks underlying my methodology as primary a priori codes when analyzing the narratives. Examples of codes included: prevalence of ACEs, impact of ACEs on MHC involvement, impact of ACEs on MHC programmatic experience, and impact of ACEs on MHC outcomes.

As Kim (2016) discussed, when using narrative analytic techniques, researchers must choose between interpretation of faith (the researcher takes the participants' words at face value) or interpretation of suspicion (the researcher attempts to find hidden

meaning in the participants' words). Consistent with the underlying concepts of the transformative paradigmatic framework guiding this research study, I selected interpretation of faith for several reasons. First, given the social justice axiology and critical theory concepts imbedded in this paradigm, it was important for me to provide participants with an opportunity to share their voices using their own words.

Second, qualitative methodology within a transformative paradigm calls researchers to be aware of and take steps to manage the impact of a researcher's subjectivity when creating meaning from data. Therefore, selecting interpretation of faith was one intentional methodological choice I made to try to manage my subjectivity by ensuring that each theme that emerged in the second stage of analysis was supported by direct quotes from participants. Of course, this attempt at managing reflexivity does not suggest that the researcher subjectivity does not impact data interpretation but rather highlights efforts to manage reflexivity (Hesse-Biber, 2007). For example, the researcher's subjectivity is still present even when using interpretation of faith, such as in the researcher's choice of what themes to present in the final write-up. Nonetheless, example quotes are provided to support each of the themes identified in the second stage of analysis and discussed throughout this chapter.

Issues of Trustworthiness

Throughout data collection and data analysis phases of research, I engaged in several purposeful actions to enhance credibility of the study. First, throughout the research process I utilized member checking, in which emerging findings from analysis were discussed and verified by respondents and stakeholders familiar with the participants to enhance trustworthiness of data interpretation. For example, both during

and following participant interviews, I clarified and confirmed initial interpretations of the data with participants. Additionally, I engaged in outside member checking following interviews by confirming interpretations with key MHC program stakeholders who were familiar with each participant and their unique circumstances.

Second, an audit trail was created throughout data collection and analysis. This trail included written descriptions of each step of the research process, as well as field notes pertaining to methodological decisions and analytic steps. These field notes were then reviewed in a memoing process, to guide reflection on researcher subjectivity to address potential research biases.

Third, to respond to potential biases, the members of the researcher team engaged in continuous self-reflexivity and analytic triangulation (or peer debriefing; Lincoln & Guba, 1985; ThễNguyịn, 2008). Specifically, triangulated reflective inquiry were used to address issues pertaining to reflexivity and voice during the analysis and report writing (Creswell, 2013; Patton, 2015). The researcher intentionally reflected on and discussed how her unique positionality informed findings, paying deliberate intention to the trauma researcher's role as both a "member of a scholarly community and a human community" (Connolly & Reilly, 2007). It is initially anticipated that the researcher's social work practice background in the area of trauma might be a strong issue that might inform research. Fourth, this study used triangulation through the collection of multiple forms of data (interviews, documents, and observations of participants) to enhance the credibility of interpretations and increase the overall trustworthiness of the study (Padgett, 2008; Royse et al., 2010).

Chapter Summary

In conclusion, this chapter provided a detailed overview of the research design and method for this study: a basic qualitative inquiry conducted within a transformative paradigm. Additionally, data analysis and interpretation was discussed, including a detailed discussion of the two phases of analysis conducted: narrative analysis and analysis of narratives. The following chapter presents findings generated from the first phase of data analysis.

Table 4

Origin of the Techniques Used in the Methodological Design.

Research Design Steps	Methodological Technique Used	Approach Technique Borrowed From
Study Focus	-Research that explores the lives of individuals -Understanding the essence of an experience -Describing an in-depth description of multiple cases	-Narrative research -Phenomenology -Case study
Data Collection Forms	-Primarily consists of using interviews and document analysis	-Narrative research
Data Analysis and Interpretation	-Analyzing data using "restorying" and development of themes -Analyzing the data for themes and patterns	-Narrative Research -Ethnography
Presentation of Findings	-Creating a narrative about individuals' lives -A description of the "essence" of an experience	-Narrative research -Phenomenology

Note. Adapted from Qualitative Research and Design, by Creswell, J., 2013, pp. 104-106, Los Angeles, CA: Sage

CHAPTER 4

RESEARCH FINDINGS

Introduction

Chapter 4 is the first of two chapters that discusses study findings. As discussed in Chapter 3, with qualitative research—and narrative analysis more specifically—findings are often thought of in two parts: (a) study findings, which consist of a summary of the data; and (b) interpretation of findings, which goes beyond summarizing the data to inferring meaning from these findings. This chapter presents findings from the first stage of data analysis (narrative analysis), which took the shape of individual narratives summarizing participants' interview responses.

As the researcher, I constructed these stories using restorying techniques, which included placing key concepts shared by participants in chronological order to create a plotline pertaining to the study foci (Creswell, 2013). Given the paradigmatic assumptions guiding this study, it merits noting that while the stories presented in this chapter are intended to present a summary of the data collected, these findings inherently involve some degree of interpretation by the researcher. Specifically, the decision of what content to include in these stories is a form of interpretation, as the content selected for inclusion in the stories reflects the researcher's interpretation of what is important, thus assigning meaning to the data.

This chapter provides my restoried accounts of each participant's interview, beginning first with a brief overview of the participant's demographic information, and

then leading into a story that follows timeline of the participant's paths to MHC involvement. Each story centers around the following four themes that correspond with the study's guiding research questions: (a) prevalence and types of ACEs experienced, (b) impact of ACEs on involvement in the CJS resulting in MHC involvement, (c) impact of ACEs on the programmatic experience, and (d) impact of ACEs on outcomes following graduation from the MHC program.

Melinda's Story: "Jail Was Not a Place for Me"

Melinda is a 55-year-old White female with a reported diagnosis of depression who was referred to MHC following multiple arrests pertaining to substance abuse, including forging false prescriptions. Melinda scored a 3 on the ACEs measure with reports of physical abuse by her father and household dysfunction, including household substance abuse and witnessing violence towards her mother. At one point, Melinda described her childhood trauma stating,

> I was beaten really bad by my dad. Um, he broke my arm seven times. I couldn't go to school I was beat up so bad because he was an alcoholic, um, and I'm sure that addiction runs in families, and I didn't know it at that time, but I probably knew that I didn't have a chance. And then seeing my mom get beat as well for her trying to take up for me. It was a traumatic experience growing up.

Melinda expressed that it was not until she was an adult that she was able to look back at her childhood and realize that her mental health issues first began then as a result of the depression she experienced following exposure to her father's chronic alcohol abuse, his physical abuse of her mother, and his physical abuse of her.

Melinda felt that she was able to function despite her depression until she was diagnosed with lung cancer in her early 50s and had to undergo major medical surgery. It appears that this medical trauma experienced as an adult re-triggered her childhood trauma experience and resulted in Melinda experiencing debilitating depression. She described these feelings as follows:

> I didn't want to get out of bed. Didn't want to eat. Couldn't sleep. Didn't want to be around people. I couldn't even watch TV. I just laid there and started up at the ceiling. I was never really suicidal, but I just had no purpose.

Her physician referred her to a psychiatrist who prescribed Melinda antidepressants and Xanax to help her. After one particularly upsetting follow-up doctor's appointment where she was told she there was a high probability her cancer would return, Melinda began to abuse her Xanax prescription until she eventually became addicted.

During her addiction, Melinda reported there was a period of several months where she would black out from abuse of prescription pills. She described the consequences of her substance abuse, including finding hundreds of dollars' worth of shoes that she bought while under the influence of Xanax that she could not remember buying. On another instance, Melinda wrecked her car in her neighborhood while intoxicated and called the police on herself. Eventually, Melinda was fired from her job as a veterinary technician after she confessed to her boss that she had been forging prescriptions for animals that she would then take for herself. Melinda was arrested after her boss pressed charges against her and she was referred to resource court.

Though she felt the MHC program was difficult at first due to the requirements, Melinda reported having a positive programmatic experience overall asserting, "this

program is absolutely wonderful if you want it. But you have to want it." She reported that the most helpful aspects of the program included the accountability provided, the amount of social support received, and the mental health treatment that included aspects of trauma-informed care, like sharing her trauma narrative as part of completing her fourth step in Alcoholics Anonymous (A.A.). Melinda described the benefit of sharing her trauma narrative:

> Once I read it and got it all out, I, I felt relieved. Very relieved, because I've never talked to anybody about it before, not even my husband. I guess I felt that I had to keep everything in because I felt shameful maybe. It was like the world was lifted off my shoulders—because I was able to tell somebody. That was a positive part of the program.

Melinda graduated from the program three months prior to our interview and reported positive outcomes, including no re-arrests, continued engagement in aftercare services to meet her mental health needs, and overall positive well-being including strong physical health and maintenance of sobriety. She maintained that she would recommend the program to others, and she attributed her positive outcomes following graduation to the skills she learned regarding how to meet her mental health needs while establishing positive social supports (such as A.A.). She defined resiliency as "just totally bouncing back...being the best that I can be," and identified being able to share her story with people as one of the primary factors contributing to her resiliency.

Claire's Story: "Change Hurts"

Claire is a 38-year-old White female with a reported history of multiple diagnoses, including panic disorder, depression, attention deficit hyperactivity disorder,

borderline personality disorder, and posttraumatic stress disorder. She was referred to the MHC program following multiple arrests related to her substance abuse, including possession of methamphetamine. Claire scored a 6 on the ACEs measure with reports of physical and sexual abuse, as well as household dysfunction pertaining to household members with substance abuse and mental illness.

Claire reported that the trauma she experienced as a child resulted in her experiencing depression that was so severe she attempted suicide for the first time at age 15. Following this failed attempt, Claire shared that she began to abuse substances to self-medicate as a teenager, and that abuse continued into adulthood, eventually resulting in substance-related arrests. Fleeing her home to escape the chronic trauma, Claire got married at the age of 17 to a husband who repeatedly physically abused her. One instance of violence resulted in the miscarriage of their first child. After 26 years of marriage, Claire's husband left her for a relative–a traumatic event that pushed Claire further into depression and substance abuse to medicate the pain.

After her divorce, Claire lost her job and experienced several medical issues (including kidney disease) that deepened her depression. With nowhere to go and limited income, Claire began living with a man who physically abused her to the point that she felt she was "living in hell" but "staying in what I was staying in because I didn't have nowhere else to go." This man introduced Claire to new substances such as morphine and methamphetamine that she began to abuse, which eventually lead to her arrest for substance-related charges and referral to MHC.

Claire described her experience in the MHC program saying, "My experience? Well, let me say this. The honest truth. There were tears at first, but you've got to be

willing to change, and change hurts." She reported that addressing the impact of her childhood trauma while in the program was helpful, as it helped her gain insight how the unhealthy relationships she observed as a child impacted her actions as an adult, including entering abusive relationships. Claire ultimately described the overall programmatic experience as positive, expressing that she was "ready to change," and the program provided her with social supports and formal mental health service that made change possible.

At the time of our interview, Claire had had been a graduate of the program for four months, was sober, taking care of her mental health needs, and overall doing well. She attributed these positive outcomes to the support she received from the court both during the program (including social support and psychoeducation on meeting her mental health needs), as well as participation in the aftercare program. Claire thinks she would recommend the MHC program to others because "it made a difference in my life. I lived all my life with a mental illness, and now I can function, and I'm okay." She defined resilience as, "Resilience today to me is what I've become–I was as low as a person can be, and now I have bloomed into a flower." She identified her relationship with God and her positive social supports (including A.A.) as factors that contribute to her resiliency.

Dora's Story: "As a Little Girl, I Thought Those Things were Supposed to Happen"

Dora is a 32-year-old White female with a reported history of substance use disorder and PTSD. She was referred to MHC following repeated arrests related to her substance misuse. Dora scored a 10 on the ACEs measure and reported experiencing all ten types of ACEs. She expressed feeling as though the trauma she experienced as a child led her to experience feelings of distress continuing into her adulthood that she would try

to “isolate from” and “suppress” by abusing substances. Additionally, Dora identified that her unhealthy relationships with her caregivers as a child resulted in her not knowing how to be a mom, so when she had four children she struggled to care for them. Her struggles to care for her children eventually resulted in their entry into foster care.

Dora described mixed feelings about her time in the MHC program. She reported that she found “the mental health treatment part of the program” helpful and healing, but experienced significant distress throughout the program when she interacted with law enforcement or the judge. She described these feelings: “the judge intimidated me a lot. It’s just his power over me, you know, being authority and stuff. I just felt like he wasn’t really in it to help us.” She described her mistrust of law enforcement by describing one deputy on the MHC team who would shake his handcuffs at her tauntingly each time he saw her.

She stated that this reoccurring action triggered her to “experience a lot of emotions” and concerns each time she saw him when she entered the courtroom. These concerns manifested as thoughts like, “oh my god, he’s just going to lock me up. Oh my god, where are my kids going to go? To foster care again?” Based on these feelings, she provided the following recommendation for the MHC:

> Having the court team like the judge and the team do a one on one session with each participant because we didn’t get that…I feel like when you have a connection with the judge as far as him taking time with you, I feel like that’s great. I feel like that makes the suspense level go more because everybody is scared of him.

Despite her negative interactions with law enforcement, she reported experiencing positive interactions with the mental health treatment providers during her time in the program. She recounted that one helpful aspect of the program was "the trauma individual session" she had with her therapist where "we kind of go over the story of my life and she helped me, you know, cope with it." She described how she thought it would have been helpful to have more time with her therapist to talk about her childhood trauma expressing,

> I didn't get it [all] out. It was kind of like I got some really deep stuff out and then it just stops. She's over-scheduled and has too many people because outside of resource court she is a counselor through [another agency]. I felt like she didn't care. Um, but I know she does. I just felt like I was put on the backburner.

At the time of our interview, Dora had been a graduate of the program for four months and reported no re-arrests and overall positive well-being. She stated that she was participating in the aftercare program and receiving ongoing mental health and supportive services (such as A.A.), was sober, and had regained custody of her children. Despite her mixed experiences while in the program, Dora reported that she would recommend the program to others, as it

> … had a major impact on my life, like for real…I really like what they're doing. Um, because I didn't, I never thought I would make it. I never thought I would make it, and now I am like, 'you made it'.

Dora identified the structure and social skills as the primary factors she gained from the MHC program that allowed her to maintain positive outcomes after re-arrest, as she is now about to "be accountable." Finally, Dora reported her definition of resiliency:

> Just knowing when I'm, I guess just knowing when I'm about to fall, and I just kind of give myself that pep talk, 'hey, you can't do this, you know this is wrong, you're gonna lose your kids, it's gonna be the same thing'.

She identified support from her A.A. sponsor as a factor that promoted her resiliency, as well as thinking about what she has experienced throughout her life and recognizing where she is now.

Tony's Story: "At the End of the Day, We're All Criminals"

Tony is a 36-year-old White male with a diagnosis of depression who was referred to MHC following multiple substance related arrests. He scored a 4 on the ACEs measure and reported experiencing emotional and physical abuse, emotional neglect, and a household member who abused substances. He expressed feeling as though the trauma he experienced as a child gave him "a tendency to self-medicate" in order to cope with feelings of depression, which ultimately led to the substance abuse and behavior (e.g., possession) that precipitated his arrest and referral to the MHC. Tony described mixed feelings about his MHC programmatic experience. He described finding the requirements of the program initially challenging:

> At first, it was, like, intimidating and overwhelming. It was so much to do, got to be here, got to be there. Multiple addiction meetings a week with no transportation. But, you know I mean, once you get into the routine of things, I mean, it's not bad. But, I don't know, I'm pretty sure at one point I actually walked up here, and I told them, 'yeah, you might as well just send me to jail because there is no way I can do this'.

He identified the mental health treatment aspects of the program as generally helpful overall, stating that therapy in particular was helpful for him as it gave him "somebody to vent to." He expressed feeling distress related to the program's required contact with law enforcement (e.g., random in-home drug screens) sharing, "the therapy end of things works great, but, like, the law enforcement side of it, like, they want you to fail is the way I feel…like they were setting you up for failure."

One recommendation Tony had for improving the MHC program would be to establish a peer support network for current participates, so they would have someone to reach out to when they were first starting the program and feeling overwhelmed. When asked what could be done to improve trust between MHC participants and team members associated with "the whole court team" (e.g., deputies, judges, probation officer), he offered,

> There's probably not because at the end of the day we're all criminals and that's just natural. They are never going to trust cops and, really, honestly, they're not to be trusted because their job is to catch someone breaking the law and our job is to break the law…Someone's always going to be trying to do something. I mean that's human nature—to get away with what you can get away with.

Tony graduated from the MHC program in February of 2017 and had not experienced any re-arrests at the time of our interview three months following his graduation. He reported overall positive well-being since graduation, stating he had remained sober and was still engaging in supportive mental health services. He also shared that he had gotten married and gained custody of his three children, which he said never would have happened if he had not participated in the MHC program, since he

would "probably still be in prison." He believes what he learned in the psychoeducational groups (e.g., Thinking for a Change) in the MHC program provided him with skills that allowed him to maintain positive outcomes following graduation. Tony described his definition of resiliency:

> Putting up with my family. That'll make you pretty resilient. If you can survive their…I don't know, I think they may just be some of the most judgmental, hypocritical assholes in the world. So, if you can survive them, you can survive anything.

Tony reported that while he was able to learn some life skills in the program (such as making better choices and decisions), he would only recommend the program to someone sentenced to more than three months in jail. He expounded on this sentiment by stating that because he believes the same mental health services offered in the program are available outside of the MHC program, he would only recommend the program (which he described as having many rigorous stipulations) to someone facing extensive jail time.

Travis's Story: "Anger Issues"

Travis is a 26-year-old White male diagnosed with schizophrenia and alcohol abuse who was referred to the MHC following "probably 30 arrests" for "anger issues" and charges such as "battery, drinking, stuff like that." He scored a 3 on the ACEs measure and reported a history of household challenges, including residing with a parent who had a mental illness, abused substances, and was incarcerated. He described how he began experiencing mental health symptoms as a child, like auditory hallucinations that began at age 13. He stated that the hallucinations began when his father went to jail, and

he first started drinking to cope. His mental health symptoms and substance abuse continued into adulthood, eventually leading him to be arrested on multiple occasions.

He described his perception of the impact of his childhood trauma on his mental health and behavior as an adult explaining,

> Yeah, I mean, my dad sold drugs when I was little, so I was raised in a household with drugs, and I started to turn to drugs, and that's when my psychosis got a little, you know, more heavy. And because the drugs would make it more, and then, which I al-, I always heard things [voices and stuff], but I never paid it no attention. And then when I'd get drunk or something, then I'll, I really hear.

Travis described his overall experience in the MHC as positive because he was able to gain skills that improved his life, though he did experience challenges while in the program, such as three re-arrests while in the program due to sanctions for refusing to take his medication and failing a drug test. He stated that what was most helpful to him during his time in the MHC program was the amount of structure provided in the program that kept his time occupied with healthy activities, as well as learning how to be accountable for his meeting his own mental health need by keeping appointments.

Additionally, Travis discussed the benefits of discussing his childhood trauma with his counselor and the impact that these childhood events had on his behavior as an adult. He reported that initially it was difficult to discuss his trauma history as he is "not a person that likes to talk about things," but was able to discuss these experiences in therapy because of the support he felt from his individual counselor while in the MHC program. He described this relationship positively: "…you know, she opens up some that gives me the opportunity to open up."

At the time of our interview, Travis reported that he had graduated from the court five months previously and was doing well overall, as evidenced by no re-arrests and remaining sober. He attributed the positive outcomes he experienced after graduation to "all of the tools [the MHC program] gave me, that, you know, the coping skills, the individual counseling, the classes." He stated that he would recommend the MHC program to others, because if he had just gone to jail instead of receiving supportive services, he would have "…just got out and, and I would've been doing the same thing I was."

Instead, he reported that his time in the MHC program helped him learn how to manage his mental health needs to the extent that several months after graduating he was still participating in aftercare services, like individual counseling and psychiatric services. Travis reported that he would define resiliency as "bouncing back after different things happen." He identified several factors has contributing to his resiliency, including his newly learned ability to be accountable for meeting his mental health needs (such as staying on his medication), as well as the social support he receives from his family, which has increased since the recent birth of his child.

Jake's Story: "In Jail, They Treat you Like a Convict"

Jake is a 30-year-old White male diagnosed with schizoaffective disorder who was referred to MHC following an initial arrest for disorderly conduct stemming from manic behavior attributed to his unmet mental health need at the time. He described his arrest sharing:

> Uh, see, most people are in there for drugs or alcohol, but I was there for mental problems that were affecting me—getting me in trouble with the law…So I got

> arrested and when I…they put me in an isolation cell when I was in jail and I tore off the padding off the wall, so they charged me with a felony, destruction of government property. And, um, they gave me the option at court to go to [MHC], so I picked that. It would take the felony off my record.

He scored a 3 on the ACEs measure and reported experiencing sexual abuse and household challenges, including a family member with mental illness and a history of incarceration. He identified a direct relationship between the trauma he experienced as a child and the mental health symptoms he exhibited as an adult that eventually led him to engage in disorderly conducting resulting in arrest:

> My [his mental health] was fine 'til I was 16 and seen my dad, who I put on there was mentally ill and stuff have an episode and was at the hospital. My mom was getting him 1013'd, but he ran out and he was in a robe, nothing but a robe, and ran into the middle of the highway and my bus just happened to stop right there and all my friends seen him and knew it was my dad. And then I had to eventually–couldn't even stay at high school, I had to go to an alternative 'cause people wouldn't leave me alone…That's when I started having more depression, anxiety, and eventually turned into mania. Well first it was depression and then they diagnosed me major depressive and then it switched to with acute schizophrenia and the bipolar one, and then schizoaffective.

Jake described his overall programmatic experience in MHC as positive due primarily to the informal and formal social support he received. He described his programmatic experience in a positive light:

> It was pretty good, I mean I wasn't a model student the whole time, but I had my ups and downs. At first, I thought I could get away with anything…that happens to most of the people. They go in thinking they can beat the system and then realize it whips them and then they straighten up, but it was– it was good I mean, it was kind of hard because I had people coming to my house every night–cops, and then everybody didn't really want to be around me because police were at my house and they thought I was police. But eventually I got to be friends with them, with the cops that came, and all the cops are cool, I still talk to some of them now.

He described how the social support from law enforcement was helpful for him, since they treated him "like an equal" while he was in the program. He explained why this was helpful stating that when someone is in jail "…they treat you like a convict, like you're less than them, most of them do anyway. And treating me like an equal makes me more open to listen to what they tell you and take it to heart." He also expressed receiving social support from the judge expressing, "he never gave up…he wouldn't give up on me, he wouldn't just be like I'm done with you–you're out of the program." He stated establishing trust with law enforcement and the judge while in the program was especially important to him because of the trauma he experienced as a child, recalling "I had to get to know the judge and the team before I started trusting anybody, just 'cause my childhood stuff, I could not trust anybody." Jake stated that he was asked about his trauma history while in the program but did not talk about his childhood trauma and the impact of it until after he had graduated as he was "ashamed."

At the time of our interview, Jake had been a graduate of the program for over a year but was still participating in outpatient mental health services and had not

experienced any re-arrests. He described how he has been since graduating from the program:

> I've been good, I mean I had some depression I had to deal with, I had to go to the hospital about that but as far as legal wise and getting in trouble like that I've been fine. I'm off probation now, have been for two months, two and half months now. And I'm just living the straight and narrow, I'm not in any other kind of trouble.

Jake attributed his positive outcomes after graduation to learning while in the program that he needed to structure his time and meet his mental health needs with consistent treatment following graduation. He also identified that learning how to meet his mental health needs (such as what services are available in the community) was helpful to him, as he was participating in psychosocial rehabilitation at the time of our interview. He reported that he would recommend the MHC to others because "it made [him] stronger and made [him] develop a pattern in [his] life that's staying successful." He concluded by defining resiliency as being "strong, and brave, and able to withstand the worst." He identified "the people behind [him]" as factors that making him resilient, including his family and the court.

Morris's Story: "A Bunch of Things Happened"

Morris is a 61-year-old White male diagnosed with schizophrenia, bipolar disorder, and substance abuse disorder who was referred to MHC after being arrested for trespassing while having "an outward experience." He was the only participant interviewed who scored a 0 on the ACEs measure and described an overall positive childhood in which he lived with his grandparents. He described the origination of his

mental health problems as an adult recalling, “My problem, my issues did not start from childhood. Well my problem came later. I had a, a bunch of things happened.”

Despite not reporting any ACEs, Morris identified a number of traumatic events that he experienced as an adult, including his parents’ divorce, the death of several close family members within a short time period (including his wife), followed by the subsequent loss of his home and his business. Morris stated that he did not have serious mental health symptoms prior to these life stressors but stated that after he “lost at least six people within that one year, within a very short period of time...it was just, it was just, boom.”

Morris described his overall experience in the MHC program as positive and identified the formal and informal social support he established with his mental health providers and peers as the most helpful aspects of the program. He described this sentiment:

> If you can get people to believe that the people that are in your group are really there for you, they can do it. They’ve got great resources and all you have to do is be willing.... I know that from going through [the MHC program] with along with all the other people that were in the group, you know, and...and caring for other people is another way to help yourself. And that’s always made me feel good to help someone else.

He also found the classes he received in the program to be beneficial saying,

> decision making skills and all that. I thought that was very helpful...because like I said, even though, you know, a lot of its just pure common sense, if you’re not aware of it...you know, once you are aware of it, it makes things a lot easier.

Despite having an overall positive experience while in the program, Morris acknowledged that he experienced some difficulties as a court participant. He recounted one incident in which he "slipped up and drank a beer one time and [he] got caught." He described his motivation to complete the program was "getting [his] freedom back," as he felt that during the program "even though we weren't in jail, we had certain restrictions that we had to go by" that he felt restricted his freedom.

At the time of our interview, Morris had been a graduate of the program for approximately one year. He reported that he had not experienced any re-arrests since graduating and described his well-being overall as positive. He attributed these positive outcomes to "what is in the program. Especially medication number one." He discussed which aspects of the program were the most helpful to him over time, including receiving psychoeducation on his mental health needs, acceptance of these needs, and the importance of identifying social supports in his life (e.g., his son) who are aware of these needs and can help him remain healthy. Morris stated that he would recommend the program because in it:

> You establish a relationship with everybody, even the judge, they're not just there to put you in jail. You've got to get past that first and realize that they are there to help you in any way they possibly can...If they will believe in their counselor and believe in the people that are running this group then they can get all the help that they ask for because they've got more resources than what we have on our own.

He described his definition of resiliency as "being strong," and stated that he is "pretty resilient because [he] doesn't let things bother me." He identified the support he receives from his son as a factor that makes him resilient.

Ariel's Story: "You Can't Always Be Hard on Yourself"

Ariel is a 27-year-old White female with a diagnosis of bipolar disorder who was referred to MHC following substance-related arrests, including possession of methamphetamine. She scored a 9 on the ACEs, indicating she experienced all ten of the traditional ACEs except for living with a household member who was incarcerated. She described the impact she felt her childhood trauma had on her mental health and behavior as an adult that eventually resulted in her arrest and referral to MHC stating,

> [The ACEs] impacted me a lot in my life and it made me who I am today, but it also, I think it put a stress on me, because before, when I was using and stuff, I used to try to hide all of that.

Ariel expounded on this sentiment stating that she began using and abusing substances at the age of 13 "like a mask, a shield, something that I felt protecting me some memories of [the ACEs]."

Ariel described her overall programmatic experience in MHC as positive, despite the fact that she was "terminated" from the program for lying on several occasions, including lying about how she quit her job (saying that she gave two weeks' notice when she in fact just walked out) and forging papers confirming that she attended an A.A. class. She elaborated on aspects of the program that led her to describe it positively despite her termination, saying that the structure of the classes (such as Seeking Safety) and the skills she learned in them (such as breathing techniques) were beneficial to her. She described how being terminated from the court impacted her:

> Um, it made me kind of upset, but I knew that it was my fault and all reality, so I had to learn to accept that. And then when I got out I did go see him [the judge],

> and he was mad because I had got kicked out, but he still said that he seen potential in me and then I could do good. It felt god. Because I know I can do good…just like he said.

Though she did not graduate from the MHC program, Ariel expressed that she felt she still experienced positive outcomes from the year she spent in the program and was doing well since her release approximately one year ago. At the time of our interview, she reported overall positive well-being, including no re-arrests, maintaining her sobriety, employment, and custody of her new baby. She attributed these positive outcomes to the support she received while in the program, stating that they helped her get away from her "crazy" mother and secure housing. Ariel reported she would recommend the program to others "because it's a good program. There is a participant in there now that I recommended, and she got in. She's doing good."

Ariel defined resiliency: "resilience to me is that you can't always be hard on yourself," but instead after experiencing shame you "pretty much bounce back and keep going." She identified "everything she has been through" and the support she has received from the courts, formal mental health treatment (which she still received following her termination), and her boyfriend as factors that promote her resiliency. Despite doing well after termination in terms of maintaining stability and meeting her mental health needs, Ariel did express that she felt she would be doing "even better" if she had been allowed to remain in the MHC program, since she thinks that she would have been able stay out of jail and regain custody of her oldest child (who was placed with a relative when Ariel was terminated and subsequently incarcerated). Ariel stated

she would recommend that the court have different teachers for each class to improve the program for future participants.

Marcus's Story: "Wrong Place, Wrong Time"

Marcus was a 45-year-old biracial (White and Black) male diagnosed with bipolar disorder, schizophrenia, and PTSD. He scored a 2 on the ACEs measure and reported physical neglect and loss of a parent. He described some of the adverse childhood events he experienced stating that one day his mother "left [him] on a couch and went her own way," so he was raised by his maternal grandmother. He recounted the worst thing that happened to him as a child was "getting [his] butt tore up" by his grandmother.

Marcus was the only participant with a history of childhood trauma that reported he did not think it impacted his mental health or behavior as an adult. He explained that his PTSD diagnosis was not related to childhood trauma, but rather was "handed down to [him] from [his] grandfather who served in Korea." Marcus reported that he was referred to MHC after being found "incompetent" following an "for being a convicted felon with a firearm. I was in the wrong place at the wrong time. Toting a shotgun around for the heck of it, and someone ratted on me."

Marcus reported mixed feelings regarding his programmatic experience in MHC. He initially described it as "nothing-a piece of cake" with no bad experiences except "having to fork out money to lawyers." He identified the social support from the judge as the most positive aspect of the program sharing,

> The best part was being in front of the judge, with five minutes where he's asking about how I'm doing, if I'm taking my meds. It was a chance to represent myself to the judge, and he treated me well.

He said that he was not asked about childhood or adult trauma while in the MHC program, but that it "would not have helped [him] anyway" as nothing "bad" has happened to him.

Marcus reported that the MHC program helped him have a more positive attitude and "made [him] a better man," which was evidenced by him "keeping his yard and house clean." Despite this, he ultimately reported that he would not recommend the program to anyone, as it is "not worth it" and he felt he "would have been better off in prison" where he would not have had to meet so many stipulations (like attending classes weekly and court monthly).

However, he reported positive outcomes following his graduation from MHC one year prior, sharing that he had not had any re-arrests and was still taking care of his mental health by receiving psychosocial rehabilitation services coordinated through the court. Marcus stated that he did not know what resiliency meant. When asked what helped him not experience any re-arrests after his graduation from the court, he stated that the judge helped him "the most" by telling him to "watch who [he] hang[s] around."

Leonard's Story: "Life is Not About Living in the Light, It's About How You Bounce Back from the Dark"

Leonard is a 22-year-old White male diagnosed with bipolar disorder and depression. He reported that he was referred to MHC after receiving charges for kicking down his parents' door and holding a knife after they passed out drunk and would not wake up when he asked them to take him to the hospital because he was experiencing suicidal ideations. He scored a 5 on the ACEs measure reporting a history of emotional and physical abuse, emotional neglect, exposure to violence against his mother, and a

residing with a household member who abused substances. He explained that following his childhood trauma, he experienced significant mental health issues include over twenty suicide attempts before his twentieth birthday. Leonard described his overall experience in MHC as positive, stating:

> Mental health court helped me so much, in so many ways. It-to be honest, I've been hospitalized 22 times, and when I came here, I went 'this is nothing new. This won't help me one bit.' I was like, 'This is going to be the same. I, I know this curriculum. I've done this before. I've done it my whole life.'…I thought this was going to be a million times worse, because it's court ordered and grant funded. And I'm used to very nice, private hospitals, you know? I was so wrong. It really-it was the best experience of my life.

He identified the aspects of the program he found most help as being the relationships he formed in the program and the ability to process his life experiences. He described that he received support not only from his peers and hearing their "stories," but also from the mental health providers. He described this sentiment saying,

> …the staff really helped me a lot. They really understood I did not want to be here, at all. And they slowly but surely worked with me and opened me up and I started listening to other people's stories. And I started having this deep reverence for life that I never had before, for everything I've had, and everything I can be-because of my experience. How can I serve now, you know?

He also described the benefits of processing events that happened in his life (such as childhood trauma) in the Seeking Safety class.

At the time of our interview, Leonard had been a graduate of the court for approximately three months and reported overall positive well-being and no re-arrests. He described his outcomes following graduation stating, "I live on my own now. I have a house, I'm taking care of myself–you know, I'm independent." He attributed this ability to achieve independence to the skills he learned in the MHC program (such as the mindfulness skills he learned in the dialectical behavioral therapy group), as well as the logistical support they provided (such as help with rent, budgeting, etc.).

Leonard stated that he would recommend the MHC program to others as he rates it a "nine out of ten." When asked what was most beneficial in helping Leonard graduate from the program and maintain positive outcomes, he responded:

> I guess you start to feel…I guess you start to feel like you matter…You start to feel like you matter. You start to see other people in distress…and they become friends…and you start to say…if you can become friends with this person, maybe you can have such deep reverence for everyone and everything. You know, maybe there is something to live for.

He stated that one recommendation he has for future programmatic improvement would be to have more process groups, such as opportunities to process events that happened in participants' lives (such as childhood and adult trauma) more deeply, especially events such as the traumatic impact of being arrested and spending time in jail.

When asked about resiliency, Leonard responded by describing his final program essay, which he wrote on resiliency:

> Um, my final essay was about referencing resilience. And, and to me, that's what this program taught me how to be. Was resilient…There's a quote that I love

> about an author…somebody asked her, 'do you live in the light,' and she says, 'no, I don't live in the light. And life is not about living in the light, it's about how best you bounce back from the dark.' And I think that's what resilient means to me. I think that quotes on death. It's about bouncing back and getting back when, when it's completely dark. It's finding the light.

Opal's Story: "This Body Ain't Made for No Jailhouse No More"

Opal is a 56-year-old Black female diagnosed with bipolar disorder and schizophrenia who was referred to the MHC program following arrests for substance related charges and disorderly conduct. She received a score of 5 on the ACEs measure and reported experiencing emotional and sexual abuse, emotional and physical neglect, and growing up with a household member who abused substances. She described some of her memories of her childhood recalling,

> My mom and dad were alcoholics. Seeing other children with things, and, had to get on to school again, but my mom in the bed, drunk, asleep, she's naked and stuff...I went in the street whooping three or four children then I went back home got in bed at night."

She described the impact that her childhood trauma had on her mental health and behavior as an adult stating that she felt hatred towards herself, and "misery, evil and miserable." She expressed that these feelings led her to have a "really hot temper" (especially towards her family), and that she began abusing substances (primarily crack) at age of 19 in effort to self-medicate. This behavior ultimately resulted in adult trauma (including having her children removed from her custody by child welfare services), as well as substance-related arrests.

Opal described an overall positive programmatic experience in the MHC, stating that the most helpful aspect was the social support she received from the entire MHC team, including the judge and mental health providers. She described this sentiment stating that the team gave her: “Love. Caring. Something that I hadn’t had…wasn’t used to. Concern. They understood me. They…they just good…I could call my team, no matter what time, when, wherever, and I mean they, they show that they care.”

Overall, Opal described the MHC program positively and said she would recommend it to others as it was “the best thing that could have ever happened to [her].” Since graduating over a year prior to our interview, Opal reported overall positive well-being, including no re-arrests, continued sobriety, and ongoing ability to meet her mental health needs. She identified that the supports she received in MHC, including logistical supports (e.g., finding an apartment, a bed), emotional support (e.g., as received in individual and group therapy), and the skills she learned (e.g., coping skills to manage distressing emotions) were the most beneficial aspects of the program that helped her maintain positive outcomes after graduation.

Additionally, Opal expressed that being able to “get up speak out and talk out our feelings” with the other participants in the program was helpful. She defined how this was helpful stating that hearing other participants stories helped her think:

> See…you not the only one having problems. You not the only one that’s going through it baby. I saw it was people up going through the same thing I went through, so it gave me a new strength, that I’m not alone.

Opal defined resiliency as being able to look in the mirror “and say ‘yeah, this me’.” Opal expressed that social support systems (such as connections she made in MHC

and her church) help promote her resiliency. She also expressed she found so much power in expressing her feelings and hearing others express theirs while in the program that she is going to write a book entitled "The Truth" that is about her life and all of the struggles she has been through (including her childhood trauma) as she hopes this will inspire others.

Christy's Story: "Maybe if Those Things Were Dealt with in Court, Things Would be Easier"

Christy is a 42-year-old White female with a diagnosis of bipolar disorder, anxiety disorder, and substance abuse disorder. She was referred to the MHC program following repeated arrests including fraud, theft, and substance-related charges. She scored a 3 on the ACEs measure and reported experiencing emotional and sexual abuse and resided with a family member with mental illness. She described how the adverse events she experienced as a child strongly impacted her mental health behavior as an adult, and subsequent arrests:

> [ACEs] affected me majorly, because, um, part of my…I mean I can't blame my parents for what I've done, but part of the reason why I got on drugs in the first place was because I was not really stable, and I was going through it by myself. But I went to my mom about being molested, but she um, she never did anything about it because it was a cousin. And so, um, nothing ever got done about it. It just, you know, was something that was handled within the family. But that had a lot do with my, um, my mental stability and the way I handled things. And, like, my dad…was verbally abusive. So yeah, it has a bearing on you when you grow up, and it determines what kind of men you put up with apparently, because I

mean I've always been with men that called me names and stuff like that. And so yeah, I'd say it has a lot to do with life and what, what you deal with. And maybe if those things were dealt with in [mental health] court, um, some type of counseling about them, maybe, um, things would be easier, you know, when you graduate and stuff.

Despite not discussing the impact of her childhood trauma (which she thinks would have helped), Christy described most of her programmatic experience as positive sharing,

> It was, um, actually a good experience. I really, um, enjoyed it. It wasn't, it wasn't hard like most people, um, think. Um, once you got into the routine of everything, it was pretty easy and pretty, um…seemed like more, more every day practice.

She described the worst part of her experience stating, "The worst part was graduating, um, because I wasn't ready to graduate, but I didn't know how to tell anybody that I wasn't ready to graduate." At the time of our interview, Christy had been a graduate of the program for three years and had experienced multiple re-arrests. Her first re-arrest was for "theft by shoplifting less than a year" after her graduation. When we spoke, Christy had recently been arrested again for violation of probation related to "a failure to report." She stated that she suspected she was in danger of relapsing immediately prior to graduation from the program but did not know how to ask for more help. She described this feeling as:

> It was like, toward the end [of the program], um, I got this attitude of, 'I've got this. I can do this on my own.' And I stopped asking for help. And I knew I was going to relapse. I could see it coming. I just didn't know it was going to be the day I graduated from [the mental health] court.

She went on to describe how her husband picked up methamphetamine on their way to her last court appearance for graduation, and she used as she was leaving the parking lot following her graduation.

Christy attributed her relapse and re-arrests to the fact that she returned to her "abusive" and drug addicted husband after graduation. She described how she hid that she was a victim of intimate partner violence from resource court because she was scared of her husband, and because she had "called the cops on him before, and they never done anything to him." Christy stated that she knew her husband was on drugs while she was in the program and that if she graduated she was "done for," but she was afraid to tell anyone that she needed more help as she was scared that she would think she "wasn't taking the program seriously" or that she would "have to go back to jail or prison."

Despite her negative outcomes following graduation, Christy stated that she would recommend the court to others. She identified the most helpful aspects of the program as the positive support she received while in the program, as well as the structure and routine it provided that gave her something to do with her time. She described how these factors were beneficial because "being in resource court mattered…It gave me something to put first."

She provided several recommendations that she felt would improve the court for future participants, including her primary recommendation that some sort of aftercare program be established. She explained this recommendation stating that at the time she graduated from court there was no aftercare program, and she thinks that if she "would've had something after resource court, [she] probably wouldn't have relapsed that day." She also recommended that the MHC program be "…more understanding as far

as…when people have outside issues, and if the court is picking up on them, for them to say something to the person…because sometimes abused people don't come out."

At the conclusion of our interview, Christy concluded "right now, as long as I stay away from men, I can stay off drugs." She defined resiliency stating "it means that I can achieve anything. I can accomplish things." She identified the support she receives from her family as something that promotes her resiliency and discussed how she planned to move in with her sister who would "keep an eye on [her]" to help her accomplish her goals.

Denise's Story: "I Deserve a Happy, Good Life"

Denise is a 35-year-old White female diagnosed with dissociative identity disorder (DID) and PTSD who was referred to MHC after multiple arrests for behavior (such as shoplifting, driving under the influence, etc.) she evidenced while in a dissociative state. She scored a 10 on the ACEs measure, reporting that she had experienced all 10 of the traditional ACEs. She described the impact her childhood trauma has had on her mental health and behavior as an adult resulting in criminal activity and entry into MHC:

> I've had this [DID] most of my life because all the trauma I've experienced as a kid...and when I deal with stress then my alternates want to come in protect me like they had to when I was going the trauma....[The ACEs] absolutely affected me, like the abuse that I suffered. I had third degree burns on my body from my dad. He was very abusive and um, we lived in the car a lot, um, you know, I've bounced around from place to place and foster care. Um, so, so yeah, I mean all that did impact, you know, with what happened, um, with getting into [mental

> health] court and my mental status. Because my mom and had mental illness and then so on and so on. And they were both addicts, so um, you know, I felt unloved, you know, even with my husband now, you know, so I turned towards drinking alcohol to cope with all everything going on, just to deal with it, just to barely survive, you know.

Denise described her overall positive programmatic experience in MHC:

> It's amazing. A lot of people think that [mental health] court or drug court or whatever program is there to hurt you or to make you not succeed-that is not true...if you're willing to help yourself, they're there to help you, but they will not do more than you.

She identified what she believed to be the most beneficial aspects of the program, including the structure and accountability (like seeing both her therapist and the judge each week), the support she received from her mental health providers, and the information she learned in treatment. The most helpful information she received in treatment included learning coping skills to manage distressing emotions without turning to substance abuse or self-injury and understanding the importance of taking her medication consistently.

Additionally, she described how the mental health treatment she received in the program helped her process the impact of her childhood trauma on her mental health and behavior as an adult sharing,

> With my therapist and all the groups we've had...that made me more aware of why I do what I do. Um, it's not that I'm weird. It's not that I'm a freak. It's not

> that I'm different. I've just been hurt. And I'm trying to cope with it. And so, um, awareness of, of what I went through and all that.

At the time of our interview, Denise had been a graduate of the program for over a year and reported a experiencing a combination of both positive and negative outcomes following graduation. She described the challenges she has experienced, including an increase in mental health symptoms (such as dissociative episodes) after the death of her mother and divorcing her husband. During this period, she reported that she was homeless for several months and was re-arrested for DUI.

Despite these challenges, Denise reported that she continued to receive aftercare services from the MHC and was doing better at the time of our interview. At this time, she stated that she had regained housing, was sober, and was in the process of getting a job. She attributed this improvement to the aftercare program stating, "If I didn't have the aftercare, if I didn't have the support, I would probably not be in a very good place right now. Thank God for the program...As [my therapist] says, I deserve a happy, good life."

Denise reported that she would highly recommend MHC to others expressing, "The [mental health] court saved my life, and, um, people need to know that the program helps." She elaborated on her well-being since graduation stating that because of her participation in the program she has been able to maintain a job, housing, and live independently for the first time in her life. She defined resiliency:

> Resilience to me means you fall down eight times, but you get up one more. Resilience means that you just, you know, live through stuff. But God does put people in your life, and you can always just never give up. No matter what. Just

> never give up. If you mess up, don't feel bad. Just [say], 'Okay. I made a bad decision' and start over.

She identified factors she feels contribute to her resiliency, including the support that she has received and continues to receive from the court.

Thomas' Story: "The Losses Kept Coming"

Thomas was a 32-year-old White male diagnosed with depression, anxiety, attention deficit hyperactivity disorder, and substance use disorder. He scored a 6 on the ACEs measure, reporting a history of emotional and physical abuse, loss of a parent, and four household challenges. He explained how his father died when he was seventeen, and this adverse experience had the most impact on his mental health and behavior as an adult, as he became depressed and "dealt with things with anger." As an adult, Thomas was arrested multiple times for substance-related charges and disorderly conduct stemming from the depression and anger he felt following his history childhood trauma:

> [The ACEs] finally caught up with me, you know what I'm saying? My emotions. And from there it went downhill like they say. Because I went straight heavily into drugs trying to kill myself. Like, not personally like kill kill myself, but I was trying to have drugs kill me.

At the time of our interview, Thomas was enrolled in the MHC program for the second time after he was re-arrested for substance-related charges (possession of methamphetamine) following his graduation from his first time enrolled in the program. He described an overall programmatic experience (both the first and second time) as positive, until he went to jail and was referred to the MHC program (both times), "the losses kept going" and life "went downhill until it went flat line and then I was just like

dead." He identified the most beneficial aspects of the program as the structure provided, the mental health treatment (including psychiatric services and therapy), and the social support provided

Thomas stated that at the time of his initial graduation from MHC, the program did not have an aftercare program. He believes that an aftercare program would have prevented him from getting re-arrested if he had had someone to reach out to. Instead, approximately six months after his first graduation he lost his job, found himself homeless and alone, began to use substances again, and was re-arrested. He reported that being isolated with no formal or informal supports was the primary factor that contributed to his relapse and subsequent arrest. He described this sentiment:

> This program has been real helpful to me though, really. You know, it's that I kinda wish I stayed a little longer the first time, you know? [If I had] the aftercare program, I kinda still [would have] had to check in... then at least, I mean, I'd have freedom all the way, you know, but at least they'd be like, hey, you alright and doing good? I'd be like I need some help and I'm stuck on, or just going through something right now and I don't know what to do.

Having now added an aftercare program, Thomas was accepted into the program for a second time. At the time of our interview, Thomas said that he had been in the program again for a year and still had several months to go. He stated that he believes he will graduate from the program and that his outcomes this time around will be different, as he will have the aftercare program and he has learned a lot, such as the importance of maintaining ongoing formal mental health services (e.g., individual therapy, A.A.) and establishing social supports.

Thomas stated he would recommend the program to others even though it is a long program explaining,

> So even though I could go to prison for two years and be out, I could still be out and do this for two years. And if I'm doing the two years in prison, I'm not going to get no help. Period.

He stated that while he was able to process how the events he experienced in his childhood and adulthood impacted his behavior and mental health, he would recommend the court add more processing to groups about how these events impact addiction stating, "Well at least we could can see where other people are coming from, see how they dealt with it." Thomas defined resiliency as "being strong," and said that he believes "owning up to [his] stuff" and learning how to ask for support when he needs it has contributed to the resiliency that fuels his desire to graduate from the program a second time.

Hanna's Story: "I was Sick and Tired of Being Sick and Tired"

Hanna is a 50-year-old White female diagnosed with depression and referred to MHC following repeated substance-related arrests, including DUI, possession of marijuana, possession of methamphetamine, and violation of probation. She scored a 2 on the ACEs measure, reporting that she experienced sexual abuse and emotional neglect. She described how the trauma impacted her life:

> I think [the trauma] affected me a lot, because, um, it was a cousin [who abused me] and [the abuse] was oral sex. So yeah, I think it affected me a lot. Just having to be shameful and hide. Not being able to tell anybody. Yeah, after that… was, like 12 years old when I started smoking pot. Then, when I was 15 I started doing cocaine. And it just led, you know, it just leads from one drug to another. I started

> self-medicating and using drugs to make me feel better. And just so I didn't have to feel. It just, it just kept me from feeling fear. It just voided it. And, like, I didn't have to think about [the trauma].

Hanna reported that following the abuse she experienced as a child, her depression persisted. As an adult she was involved in a series of unhealthy relationships characterized by intimate partner violence (IPV) and substance abuse. Hanna stated that following over six arrests and serving time in prison, she eventually asked for a referral to the MHC program after hearing about it from an inmate after her most recent arrest for possession of methamphetamine. She described how at the time of her last arrest she was homeless and decided she was ready for change:

> I knew I was ready to quit. I wasn't happy, I had walking pneumonia, I was sick as a dog...I was ready to quit, but I couldn't quit [on my own]. I was tired. I was sick and tired of being sick and tired. I was homeless. Didn't have nothing. I missed my kids. I missed my mom and dad, 'cause I shut all of them out. My boyfriend was beating me up, you know. He...he wasn't right. He was on drugs, too, and I couldn't do it anymore. I just couldn't live like that anymore.

Hanna described her overall programmatic experience as positive stating:

> Great. I think...I think it was great. But I wanted this. I wanted it. I mean, if you don't want this, if you don't want to be sober and clean and have the right life, you don't need this. It's not going to work for you. You have to want it. First and foremost, you have to want it for yourself.

She reported that the aspects of the program she found to be most helpful were the support she received, and the structure and accountability of the program, which she described:

> You know, the consequences. Having consequences to my actions.... The stability was the most important thing. The police officers coming out and drug testing us, not knowing when they're coming. Um, making sure we were in at curfew, having a curfew period. Having a curfew period...I had never had a curfew. Never in my life, you know. And, um, just the...the simple basics. Getting back to the basics helped me the most I think. Like curfew, going to bed, getting up-feeling responsible for where I have to be. My meetings, and my classes or A.A., and having to keep up with it.

Additionally, Hanna found that processing the impact of her childhood trauma on her behavior as an adult while in the program in individual therapy and in some classes (such as Shame and Resilience) was beneficial. She stated that processing these events helped to "recognize her feelings" regarding the trauma, and "not be ashamed of it." She described feeling nervous as she neared graduation saying, "I had a lot of anxiety about it."

At the time of our interview, Hanna had been a graduate of the program for three months and had several months left in the aftercare program. Following graduation, Hanna described overall positive well-being, including complying with the terms of aftercare, remaining sober, maintaining her mental health, and no re-arrests. She said she would recommend the program to others, though she recommended that the program tailor more to individual's unique needs whenever possible. For example, she had a

friend in the program who relapsed the week she graduated, and Hanna felt that if she had been mandated to stay in the program a little longer she would not have relapsed.

She attributed her success after graduation to the skills she learned in the program that were helpful to maintaining her health when she graduated, such as how to set boundaries, say no to triggers, and consistently meet her mental health needs (e.g., by attending A.A. regularly). Additionally, after completing the program Hanna reported that she had re-established a relationship with her family and left her abusive boyfriend. Finally, she defined resiliency as being able to "resist and repel" the negative. She identified support from her family and her faith in God as factors that she felt contribute to her resiliency.

Chapter Summary

Chapter 4 reported the findings from the first stage of analysis conducted—narrative—analysis, which included restoried accounts of participants' interviews. In these accounts, participants share their stories of how their any ACEs experienced impacted their MHC involvement. The following chapter—Chapter 5—presents findings from analysis of narratives, the second stage of data analysis.

CHAPTER 5

RESEARCH FINDINGS: ANALYSIS OF NARRATIVES

Introduction

The purpose of this study was to explore how ACEs impact adult MHC involvement. Chapter 5 is the second of two chapters discussing study findings, which overall suggest that ACEs can impact each stage of adult MHC involvement. While Chapter 4 presented summarized accounts of each participants' responses in the form of individual narratives, this chapter presents findings generated from analysis of the previously-presented narratives. These findings were generated using an enhanced analytic process that moved from creating narratives, to interpreting meaning from these findings through the identification of patterns present across individual cases.

Specifically, using a priori coding, participant narratives were analyzed for patterns that related to the study's four research questions: (a) what is the prevalence of ACEs, (b) how do ACEs impact participants' paths to MHC involvement, (c) how do ACEs impact MHC programmatic experience, and (d) how do ACEs impact MHC outcomes. The findings presented in this chapter describe the characteristics of these identified patterns, which in turn provide information in response to the study research questions. In congruency with the transformative paradigmatic assumptions of this study, these findings can be used to inform implications and recommendations that can affect positive social change via trauma-informed criminal justice reform.

Findings from Analysis of Narratives: Four Themes

Using a priori coding, analysis of narrative identified characteristics pertaining to the four following themes: (a) ACEs prevalence, (b) impact of ACEs on MHC involvement, (c) impact of ACEs on MHC programmatic experience, and (d) impact of ACEs on MHC outcomes. In addition to the participant profiles reported in Chapter 4, an additional summary of the demographic characteristics of each participant is presented below in Table 5. As depicted in Table 6, data was interpreted using a priori themes that were formed based on the identification of patterns in the data that pertained to the four research questions that guided this study (Strauss & Corbin, 1990). While a comprehensive overview of the coding process used in data analysis is presented in Chapter 3, Table 7 presents an additional overview of how meaning was interpreted from these findings primarily through use of magnitude coding (Saldaña, 2009).

Table 5

Sociodemographic Characteristics of Respondents (N=15)

Attributes	*n*	%
Age		
18-24	1	6.70
25-34	5	33.50
35-44	4	26.80
45-54	2	13.40
55-64	3	20.10

65+	--	--
Gender		
Male	8	53.60
Female	7	46.4
Race		
White	13	87.10
Black	1	6.70
Biracial, Black and White	1	6.70

Table 6

A Priori Themes Pertaining to Research Questions

Research Questions	Themes
1. What is the prevalence of ACEs experienced by participants?	1. PREVELENCE OF ACES
2. How do ACEs impact participants' paths to MHC involvement?	2. IMPACT OF ACES ON MHC INVOLVEMENT
3. How do ACEs impact participants' MHC programmatic experience?	3. IMPACT OF ACES ON MHC PROGRAMMATIC EXPERIENCE
4. How do ACEs impact participants' MHC outcomes?	4. IMPACT OF ACES ON MHC OUTCOMES

Table 7

Themes, Codes, Sub-Codes, and Examples

Theme	Code	Sub-Code	Example
1. PREVELENCE OF ACES	ACE Frequency	Low	-ACE score=2 (physical and sexual abuse)
2. IMPACT OF ACES ON MHC INVOLVEMENT	MHC Inv.	Moderate Impact	-Some effect (substance use to numb), but also adult trauma impacted (increased depression and drug use as self-medication)
3. IMPACT OF ACES ON MHC EXPERIENCE	MHC Exp.	Mixed Experience	-Some parts were restorative/healing (e.g., individual and group therapy), and some parts were harmful (e.g., interactions with judge and law enforcement)
4. IMPACT OF ACES ON MHC OUTCOMES	MHC Out.	Recidivated, but Resilient	-Re-arrested once, but still meeting mental health needs and maintaining sobriety

Theme 1: Prevalence of Adverse Childhood Experiences

The first theme identified in the findings relates to the first research question guiding this study: what is the prevalence of ACEs among participants? To answer this question, each participant completed the original ACEs measure (Felitti et. al, 1999).

Each participant's ACEs score was calculated according to the instructions for this quantitative instrument, and these findings are summarized below. Additionally, findings from the ACEs measure were compared across participants to identify any sub-codes that emerged pertaining to the categories and types of ACEs reported by participants. This information was later triangulated with responses to in-depth interviews to address the three additional research questions that guided this study.

Frequency of Adverse Childhood Experiences

Table 8 presents an overview of participants' ACEs scores. As depicted in this table, the mean ACE score was 4.73. Scores ranged from 0 (*n* = 1) to 10 (*n* = 2). The median score was 5 (*n* = 2), and the mode was 3 (*n* = 4). Forty percent of participants had high cumulative ACE scores (a total of 4 or more reported ACEs). One participant, Dora, commented on her cumulative ACE score of 10 stating, "As a little girl, I thought those things were supposed to happen."

Due to the homogeneity of the sample, there are very slight differences in responses by demographic. Of the few minor differences in scores according to demographics, most notable was that slightly more female participants received higher cumulative scores (4 or greater) on the measure (*n* = 5) than did males (*n* = 3).

Table 8

Cumulative ACE Scores for Participants (N = 15)

ACE Score	*N*	%	M (range)
Overall	15	100	4.7 (1-10)
None	1	6.7	0

Moderate	6	40	2.7 (1-3)
High	8	53.3	6.9 (4-10)

Categories and types of Adverse Childhood Experiences

Participants' responses to each item on the ACEs measure were then observed for patterns related to the three categories of ACEs (abuse, neglect, household challenges). As depicted in Table 9, 73% of participants reported experiencing abuse (*n* = 11), 60% reported experiencing neglect (*n* = 9), and 86% (*n* = 13) reported experienced household challenges. Household challenges (the category that contains five of the ten types of ACES) was the most common category of ACEs experienced by participants (*n* = 13).

Responses to each item on the ACEs measure were then observed for patterns among the ten potential types of ACEs experienced within each of the respective three categories. As depicted in Table 10, among participants who experienced some form of abuse as a child, emotional abuse (60%, *n* = 9) was the most commonly experienced type of abuse (in comparison to physical or sexual abuse). Additionally, among participants who reported experiencing some form of neglect, eight participants (53%) reported experiences of emotional neglect, and six (40%) reported experiences of physical neglect. Finally, among participants who reported experiencing some type of household challenge, living with a household member with substance misuse was the most common challenge experienced within this ACEs category (66%, *n* = 10).

Table 9

Prevalence of ACEs by Category (N = 15)

Category of ACE	*n*	*% of participants*
Abuse	11	73
Neglect	9	60
Household Challenges	13	86

Table 10

Prevalence of ACEs by Type (N = 15)

Type of ACE	*n*	*%*
Abuse	11	73
Q1: Emotional	9	60
Q2: Physical	8	53
Q3: Sexual	7	46
Neglect	9	60
Q4: Emotional	8	53
Q5: Physical	6	40
Household Challenges	13	86
Q6: Loss of a biological parent	5	33
Q7: Violence against mother	5	33
Q8: Lived w/ household member with substance misuse	10	66
Q9: Household member w/ mental illness	8	53
Q10: Household member incarcerated	5	33

Summary of Theme 1: Prevalence of Adverse Childhood Experiences

In summary, data pertaining to the first theme concluded that a majority of participants had experienced ACEs. Specifically, every participant but one reported experiencing at least one ACE, and 53% of participants reported high cumulative ACE

scores in which they reported having experienced four or more ACEs (Felitti et al., 1998).

Theme 2: Impact of Adverse Childhood Experiences on Mental Health Court Involvement

The second theme identified in the data pertained to the second research question that guided this study: how did ACEs impact participants' paths to MHC involvement? What emerged from the data were stories of how adverse events experienced as children led participants to experience a series of subsequent feelings, behaviors, and actions as adults that resulted in their ultimate involvement in criminal activity, arrest, and entry into the CJS. For example, when asked how Jason felt his experience of ACEs impacted his path to MHC involvement as an adult he responded,

> A lot. A lot. Yeah, I mean, my dad sold drugs when I was little, so I was raised in a household with drugs, and I started to turn to drugs, and that's when my psychosis got a little, you know, more heavy.

Similarly, Ariel described her perception of how her ACEs impacted her behavior that resulted in arrest and referral to the MHC by sharing,

> It impacted me a lot in my life and it made me who I am today, but it also, I think it put a stress on me because before, when I was using and stuff, I used to hide all of that.

Using magnitude coding (e.g., strong, moderate, weak), participants' responses pertaining to this theme were categorized based on the degree to which they perceived their ACEs impacted their paths to MHC involvement.

Strong Impact

Eleven of the 15 participants (73%) described feeling as though the ACEs had a strong impact on their mental health, behavior, arrest, and involvement in MHC as an adult. Denise described this impact expressing,

> Things that, that I dealt with as a kid. I didn't realize how much they affected me until I started doing therapy and stuff with Resource Court. Um, but they absolutely affected me, like the abuse that I suffered. I had third degree burns on my body from my dad. He was very abusive and um, we lived in the car a lot…and I felt abandoned I guess as an adult because of, you know, we got taken away and, you know, I've bounced around from place to place and foster care. All that did impact, with what happened, um, with getting into Resource Court and my mental status. I felt unloved, even with my husband now, so I turned towards drinking alcohol to cope with it all. And then that's when my alters would step in.

Similarly, Christy described the strong impact her ACEs had on her behavior as an adult that led to arrest:

> They [ACEs] affected me majorly, because, um, part of my…I mean I can't blame my parents for what I've done, but part of the reason why I got on drugs in the first place was because I was not really stable. That had a lot do with my, um, my mental stability and the way I handled things.

Moderate Impact

Two of the 15 total participants (13%) described how they thought that their ACEs had a moderate impact on their paths to MHC involvement. One of these

participants, Tony, described how the impact of his ACEs was related to his substance abuse and arrest sharing,

> Everything that happened to me (ACEs), it gave me, I don't know, a tendency to self-medicate, and I got caught. Kind of feels like I'm passing blame there, but, I don't know, I've always felt like there was little blame deserved there.

The second participant, Leonard, explained that prior to participating in the MHC program, he felt that the impact of his ACEs had a strong effect on his behavior, actions, and mental health as an adult. He stated, however, that after hearing about the frequency and severity of other participants' ACEs while in MHC, he concluded that while his ACEs did somewhat impact his mental health and behavior leading to his arrest, "it was not to the severity of other participants. I think with me it's chemical [mental health issues]."

Weak Impact

Two of the total 15 participants (13%) expressed that they did not feel their ACEs had an impact of their MHC involvement. One of these participants— Morris—was the only participant who reported that he did not experience any ACEs. He elaborated on his perception that his events from his childhood did not impact his criminal behavior as an adult espousing, "My problem, my [mental health] issues did not start from childhood…my problem came later. I didn't have a bad childhood experience."

While Morris did not report experiencing any trauma as a child, he did experience multiple traumatic events as an adult that he directly tied to his increase in mental health symptoms and subsequent criminal behavior, arrest, and involvement in the MHC. He went on to describe those feelings as follows:

> I lost at least six people within one year, within a very short period of time, including my grandmother, uh, I did have a sister that committed suicide, two weeks after my grandmother passed away, and then my wife had breast cancer. Uh, I had a cousin with breast cancer that passed away, and I had a 26-year-old niece with cervical cancer that passed away a month before my wife did. And it was just, it was just, boom.

Stanley, the other participant who believed that the ACEs he experienced as a child had little to no impact on his mental health, behavior, and arrest as an adult described these feelings, saying his mental health issues and “PTSD were handed down from me by my grandfather who served in Korea. I haven’t experienced trauma.” He described the causes of his arrest expressing, “I was in the wrong place at the wrong time.”

Summary of Theme 2: Impact of Adverse Childhood Experiences on Mental Health Court Involvement

In summary, findings pertaining to this theme suggest that the majority of participants (*n* = 11; 73%) expressed that their ACEs had a strong impact on their paths to MHC involvement. It is interesting to note that the two participants who expressed that their ACEs had a weak impact on their paths to MHC involvement both had diagnoses of serious mental illness, including schizophrenia. This observation suggests a potential difference in the perceptions of the impact of childhood trauma on MHC involvement by participants with serious mental illness and those with other diagnoses (e.g., bipolar disorder, depression, anxiety).

Theme 3: Impact of Adverse Childhood Experiences on Mental Health Court Programmatic Experience

The third theme identified relates to the third research question guiding this study: how did ACEs impact participants' programmatic experiences while enrolled in the MHC program? Participants described ways their ACEs impacted their programmatic experience. Magnitude coding was used to categorize these responses based on overall descriptions of the program as a positive, negative, or mixed experience.

Positive Experience

Findings within this theme revealed 12 of the 15 participants (80%) described their overall programmatic experience as positive. In this sense, positive is operationalized to describe how many participants perceived their programmatic experience as restorative, helpful, beneficial, and satisfying, especially regarding how the program addressed any ACE-related symptoms. For instance, Claire described her overall programmatic experience as positive, and expressed that being able to share her trauma history for the first time after feeling shame for years was one of the most beneficial aspects of the program. She described this sentiment stating,

…just taking the classes was healing. Knowing that when you go in those rooms, you're not judged. Everybody in there has some form of addiction. Most of them might have been abused, and there's just so much love in there.

Similarly, Opal described a positive programmatic experience as well, and identified the social support she received while in the program as one of the most helpful benefits. She described these feelings as follows:

> They showed, they showed love not concern. Not just coming in and do your job. They showed that they care. And you could go to them for anything…no matter what they would help you, I mean. I didn't have a bed, my sister said, ‘you can live right there, in that truck’. They brought me a bed, pillow, pillowcase, they brought it all.

Negative Experience

One of the 15 participants (7%) described his overall programmatic experience as negative, or unhelpful, and not beneficial. Marcus described how he felt that the program was a “waste of his time” and stated that he would “have been better off at home doing yardwork.”

Mixed Experience

Two of the 15 participants (13%) described their overall programmatic experience as “mixed”, or a combination of restorative and helpful aspects, and unhelpful and re-traumatizing aspects. For example, Dora identified the mental health treatment provided during the program as beneficial and healing, but described how the consistent, recurring involvement with law enforcement was re-traumatizing. She described these feelings:

> The judge intimidated me a lot; because, it’s just his power, you know, being authority and stuff. The judge and the sheriff’s department people, they scare me. I don’t think the police should be involved in it. I just felt that they are intimidating, and they really, like there was one [law enforcement officer] who would stand back by the judge and be like, you know, give you that sarcastic, you’re not going to make it look. And that just kind of brought me down.

Additionally, Tony described mixed feelings regarding his programmatic experience. He described how there were certain aspects of the program he found helpful, such as the therapy, as it allowed him to have “somebody to vent to.” He also identified aspects of the program he found to be unhelpful, sharing that he spent six months in jail waiting to enter the program and was “worse off than when [he] went in.” Ultimately, Tony expressed how he often wonders if he would have been better off serving a brief period of time in jail as opposed to participating in the program stating: “You’re pleading into the program is the same as pleading guilty…40 months of ‘freedom’ for a little bit of bullshit [jail time]”.

Summary of Theme 3: The Impact of Adverse Childhood Experiences on Mental Health Court Programmatic Experiences

In summary, the majority of participants described their overall programmatic experience as helpful, and felt that the experience was restorative, healing, and beneficial to them, especially as it helped them address the impact of their ACEs. Participants who described having a mixed or negative experience primarily identified interactions with law enforcement as the aspects of the program that they found to be unhelpful.

Theme 4: Impact of Adverse Childhood Experiences on Mental Health Court Outcomes

The fourth theme identified in these analyses relates to the fourth research question guiding this study: how did ACEs impact participants’ outcomes following graduation from the MHC? Using magnitude coding, participants responses were organized into the following three categories: recidivated but resilient, recidivated and vulnerable, and resilient and thriving.

Recidivated but Resilient

Three participants—Ariel, Thomas, and Denise—reported that they did recidivate following graduation, but each felt as though they have recovered from the setback of being rearrested and had positive well-being at the time of our interviews. For example, Ariel ultimately served time in jail after being kicked out of the MHC program for lying, thus violating the terms of her probation. However, at the time of our interview she reported that she was using the skills she learned while in MHC to meet her mental health needs and establish stability in her life. She described this sentiment by expressing, "so since this has happened to me, I mean, I have my family, I have the things I care about. I don't just say 'screw it' no more." Ariel identified receiving strength in reflecting on her ability to survive adversities and describing that what promotes her resiliency is "everything I've been through. It makes me who I am today."

Similarly, Denise was also re-arrested following graduation for DUI. Denise attributed this arrest to an incident caused by one of her alters, who is an alcoholic. However, she shared that despite being arrested, she felt healthier than she was prior to entering MHC. She attributed her successful outcomes to the fact that she continued to receive formal social support (e.g., individual therapy) after graduating MHC, which she believes helped her to her continue to thrive overall despite the re-arrest. Similarly, Thomas shared that though he was re-arrested following a relapse, he continued to receive formal mental health treatment, and the social support he received from these services helped him recover from his re-arrest and maintain positive well-being overall following graduation from MHC.

Recidivated and Vulnerable

One participant, Christy, described how she experienced negative outcomes following graduation. As described in Chapter 4, Christy shared the story of how she relapsed the day she graduated from MHC, returned to an abusive relationship, and was re-arrested multiple times following graduation. She attributed not receiving support for intimate partner violence while in the MHC program as the primary factor that contributed to her vulnerability and ultimate recidivism, as well as a lack of social supports. She expressed how her ACEs impacted the relationships she entered into as an adult, and how if she had explored the impact of her ACEs while in the MHC program, she might have "changed the way [she] looked at things and who [she] choose to be around," and thus not returned to her abusive husband after graduation, relapsed, and been re-arrested.

Resilient and Thriving

Eleven of the 15 participants (73%) described their overall outcomes following graduation from MHC as positive. Positive in this case was operationalized to refer to participants who described that they were thriving, as evidenced by not being re-arrested, continuing to meet their mental health needs, and reporting overall positive well-being.

For example, Opal described how following graduation she was able to continue meeting both her mental and physical health needs, rebuild a healthy relationship with her family, and return to school. Similarly, Tony described how he was able to join a church, become physically active, and regain custody of his children. Melinda went from abusing substances to becoming a substance abuse technician at an inpatient treatment facility.

Among participants who reported positive outcomes following MHC graduation, findings emerged regarding factors that supported resiliency among these individuals and helped them achieve and maintain positive outcomes. For example, many individuals who had positive well-being following graduation identified having strong sources of social support (both formal and informal) that they thought to be a primary factor contributing to their success. For example, Tony identified how he receives support from his church sharing, "I got involved with the church. So I do softball with the church and they'll celebrate my recovery out there."

Finally, an inductive theme that emerged from the data was participants' identification of stories as factors that helped promote their resiliency. For example, Opal described how she sometimes looks in the mirror and cannot believe that she has survived, and she plans to write a book about her experiences of childhood trauma expressing, "I'm writing a book…It's the truth. That's the name of it. *The Truth of My Life* by Opal Powers."

Opal expressed that she hopes to inspire others by telling them her story and showing them that if she can recover from the experiences she has faced, others can as well. Opal described how she thought of this idea after receiving strength from hearing other participants share their trauma stories while in the program. She described how stories promote her resiliency expressing,

> See, they helped me too. Showed me, 'You not the only one having problems. You not the only one that's going through it, baby.' I mean, it was one girl there, this lady's talking to me. And we got a chance to get up and talk, out, speak, talk

out, talk our feelings out. And I saw it was people up going through the same thing I were so, it gave me a new strength. That I'm not alone.

Melinda also identified how telling her story about the trauma she has faced promoted her resiliency by sharing,

> I basically wrote my story and then had to go back and read it, and once I read it and got it all out, I, I felt relieved, you know? I felt a sense of, um, I don't know. I felt relieved, very relieved, because I'd never talked to anybody before.

She described how she plans to continue telling her story to help others stating, "I've been sharing my story with other people, so it will help them as well."

Summary of Theme 4: The Impact of Adverse Childhood Experiences on Participants' Mental Health Court Outcomes

In summary, most participants described how they were thriving after graduation from MHC, despite experiencing any childhood trauma. They attributed their success to resiliency factors, including formal and informal social support, and addressing the impact of their childhood trauma in mental health treatment. Four of the 15 participants were re-arrested after graduation, though three of the four reported that they had recovered from their re-arrest and were beginning to thrive again. Finally, every participant was able to discuss the concept of resiliency and identify factors that they felt contribute to their ability to persevere despite adversities.

Chapter Summary

Chapter 4 presented the findings from the analysis of interview data with 15 adult graduates of MHC. In relation to the study purpose, findings suggested that ACEs have the potential to impact adult participants' paths to MHC involvement at each phase of the

journey, including behavior leading to arrest and referral to MHC court, programmatic experiences, and outcomes following graduation. Four primary conclusions were drawn from analysis of the data: (a) participants experienced a high prevalence of ACEs; (b) ACEs impacted participants' paths to MHC involvement through display of related externalizing and internalizing problems leading to arrest; (c) ACEs impacted participants' programmatic experiences in terms of how they perceived it to be beneficial, and (d) ACEs impacted participants outcomes following graduation, which varied based on individuals' resiliency factors.

These themes correspond with the aims that guided this study. In summary, findings from this research provide detailed descriptions of *how* ACEs impact participants' MHC involvement. These findings have implications for practice, policy, research, and education in social work and related disciplines, which will be discussed in the next chapter—Chapter 6.

CHAPTER 6

CONCLUSIONS, LIMITATIONS, AND IMPLICATIONS

Introduction

Chapters 4 and 5 presented study findings from narrative analysis and analysis of narrative respectively. Chapter 6 reviews these findings, presents conclusions drawn from study findings, and situates these findings and conclusions within the larger body of related research on MHC and ACEs. Finally, this chapter concludes with implications from findings, especially as pertains to the field of social work.

The purpose of this study was to explore the impact of ACEs on adult MHC involvement. Four primary research questions guided this study:

1. What is the prevalence of ACEs?
2. How do ACEs impact participants' paths to MHC involvement?
3. How do ACEs impact MHC programmatic experience?
4. How do ACEs impact MHC outcomes?

This qualitative inquiry operated within a transformative paradigm with the goal of generating findings that can be used to affect positive social change.

Additionally, the study was guided by a critical, complex, systems theoretical framework which emphasized the need to analyze how human behavior is impacted by the complex interaction between factors across micro-, mezzo-, and macro-systems. Data was collecting through administration of the ACEs measure (Felitti et al., 1998) and semi-structured interviews, which were analyzed using narrative analytic techniques.

Specifically, narrative analysis and analysis of narratives were used to generate findings, which are summarized below.

Summary of Study Findings

Findings from narrative analysis, which consisted of restoried narratives depicting the impact of ACEs on each participants' MHC involvement, were presented in Chapter 4. Findings from analysis of narratives were presented in Chapter 5. These findings centered around the four primary themes that respectively corresponded with the above-stated research questions: a) prevalence of ACEs, b) impact of ACEs on MHC involvement, c) impact of ACEs on MHC programmatic experience, and d) impact of ACEs on MHC outcomes.

The theme pertaining to the prevalence of ACEs included categories such as frequency and type of ACEs. The theme pertaining to the impact of ACEs on MHC involvement included categories such as weak impact, moderate impact, and strong impact. The theme pertaining to the impact of ACEs on MHC programmatic experience included categories such as positive experience, mixed experience, and negative experience. Lastly, the theme pertaining to the impact of ACEs on MHC outcomes consisted of categories included recidivated and vulnerable, recidivated but resilient, and resilient and thriving.

Conclusions

Guided by knowledge from the existing body of literature related to this study, as well as the assumptions underlying this study's conceptual framework, four primary conclusions were derived from the findings that relate to how graduates perceive ACEs have impacted their MHC involvement. First, findings identify a high prevalence of

ACEs among participants, and more specifically conclude that over 50% of participants reported a high cumulative ACE score of four or more. Second, findings suggest that most participants believed that their ACEs had a moderate-to-strong impact on the behavior that led to their arrest and involvement in the MHC as an adult. Third, the majority of participants described an overall positive programmatic experience that was impacted by their ACEs. Fourth, the majority of participants did not experience recidivism following MHC graduation, described their MHC outcomes as positive, and perceived that their ACEs did have an impact on their outcomes.

Conclusion 1: High Prevalence of Adverse Childhood Experiences Among Participants

The first conclusion drawn from this study is that there is a high prevalence of ACEs among participants. This conclusion is based on findings pertaining to "Prevalence of Types of ACEs" theme discussed in Chapter 5. Specifically, data revealed that every participant except one reported at least one ACE, and the majority of participants reported a history of four or more ACEs. The most common category of ACEs experienced was household challenges, and the most frequent type of ACEs reported was living with a household member with substance misuse.

This conclusion can be situated within the larger body of related literature examining the prevalence of ACEs among individuals involved in the criminal justice system, and MHCs in particular (see for example Garbarino, 2017; Roxburgh & MacArthur, 2014; Scott, Coleman-Cowger, & Funk, 2014). These findings are not surprising, as they are consistent with the generalizable findings from related literature suggesting that many individuals in the CJS have experienced some form of trauma

(Wolff & Shi, 2012). However, the most intriguing aspect of this conclusion to me was the fact that the majority of participants reported a high ACE score, as well as the identification of the most common type of ACE experienced: substance misuse by a household member.

This conclusion is interesting for several reasons. First, it contributes to identified gaps in the existent literature by providing insight into which specific types of trauma are experienced by individuals in MHCs/the CJS. Second, as guided by the theoretical assumptions pertaining to power and oppression within this study's conceptual framework, this conclusion suggests that perhaps another adverse outcome associated with trauma is the (indirect) criminalization of ACEs by society.

Conclusion 2: Adverse Childhood Experiences Can Impact Adults' Paths to Mental Health Court Involvement

The second conclusion drawn from this study is that ACEs can impact an individual's path to MHC involvement. This conclusion stems from findings pertaining to the theme entitled "Impact of ACEs on MHC Involvement," and is consistent with generalizable results from related literature that establish a correlation between trauma (including ACEs in particular) and adult criminal behavior (see for example Edalati et al., 2017; Reavis et al.; 2013). I found several aspects of this conclusion to be especially interesting.

First, of the only two participants who described the impact of ACEs on MHC involvement as "weak," both individuals had a diagnosis of schizophrenia. This observation raises questions pertaining to how participant perceptions regarding the impact of ACEs on MHC involvement may vary based on individual mental health

diagnosis (e.g., serious mental illness vs. mental illness). Second, as guided by the theoretical assumptions underlying this study's conceptual framework, this conclusion highlights the importance of how complex interactions between systemic factors (e.g., individual emotions at the micro-level stemming from family events at the mezzo-level) may impact criminal behavior.

Conclusion 3: Adverse Childhood Experiences Can Impact Mental Health Court Programmatic Experience

The third conclusion from this study is that ACEs have the potential to impact MHC programmatic experience. This conclusion stems from findings pertaining to the theme entitled "Impact of ACEs on Participants' MHC Programmatic Experiences," such as how the majority of participants described their overall MHC programmatic experience as positive and perceived their ACEs to have a moderate-to-strong impact on this experience. In general, participants seemed to describe their programmatic experience as positive primarily because while in it, they received support that helped them cope with their mental health symptoms, including those stemming from trauma and ACEs. The extent to which participants had explicitly explored the impact of childhood trauma while in the program varied, seemingly based on differences pertaining to individual MH treatment providers. Participants that intentionally explored the impact of childhood trauma while in the program identified trauma-informed treatment techniques as part of what specifically led them to have a positive MHC programmatic experience.

This conclusion can be situated within the larger body of related literature examining participant perceptions of CJS programs and PSCs in particular. This

conclusion surprised me, as I initially anticipated that the majority of participants would describe their MHC programmatic experience as negative and/or (re)traumatizing. I formed this initial assumption based on several factors, including findings from the larger body of related research related to this study's guiding conceptual frameworks.

For example, literature on trauma theory has identified a tendency for involvement in the CJS to be perceived by recipients as traumatizing and/or re-traumatizing (Parsons & Bergin, 2010, SAMHSA 2015b). Additionally, Traumatization and re-traumatization are presented in critical theory literature as consequences of society's use of the CJS to oppress or marginalize individuals with less power (Greenberg, 1993). Ultimately, I believe that use of self-reflexivity techniques (e.g., memoing) guided me to identify personal biases, which then allowed me to intentionally identify and explore findings that challenged such assumptions.

Conclusion 4: Adverse Childhood Experiences Can Impact Mental Health Court Outcomes

The fourth conclusion from this study is that ACEs may impact MHC outcomes. This conclusion is drawn from findings pertaining to the theme entitled "Impact of ACEs on MHC Outcomes," which is discussed in Chapter 5. These findings revealed that the majority of participants described positive MHC outcomes and no rearrests. Additionally, findings revealed that most participants believed their ACEs impacted their MHC outcomes in some way.

Specifically, these findings indicate that participants described ways that ACEs can both positively and negatively indirectly impact MHC outcomes. For example, while the majority of participants did not recidivate, the four participants who were re-arrested

each scored a 3 or higher on the ACEs measure. This finding suggests the possibility of a correlation between ACEs and recidivism, thus exemplifying one potential way ACEs may negatively impact MHC outcomes.

Contrastingly, many participants described how their ACEs had an indirect positive effect on their MHC outcomes in several ways. First, several participants reported that their ACEs resulted in traumatic symptoms that negatively impacted their functioning as an adult. However, through treatment in the MHC program, many participants were able to explore the impact of childhood trauma and develop sustainable coping skills that helped them achieve positive outcomes.

Second, many participants described how surviving ACEs ultimately lead them to develop resiliency. Specifically, participants described how they developed factors across the lifespan that helped them survive their ACEs, and these same protective factors were helpful in achieving and maintaining positive outcomes following MHC graduation. Healthy formal and informal social supports were the factors most commonly identified by participants as having the strongest impact on building resiliency.

These findings can be situated in the larger body of related literature on recidivism, and resiliency, especially as pertains to trauma and individuals in the CJS. For example, study findings identifying the presence of multiple ACEs among all of the participants that recidivated is consistent with research identifying a correlation between trauma and increased risk of re-arrests (Calhoun, Malesky, Bosworth, Beckham, 2005; Sadeh & McNiel, 2015). Additionally, findings from this study that show social support to be a protective factor are consistent with studies identifying the powerful impact of social supports in building resiliency (Ozbay, 2007; Southwick et al., 2016).

Limitations

There are several limitations pertaining to this study that warrant discussion. Many of the limitations discussed here are constraints frequently associated with qualitative research studies in general, including critiques regarding the ability to produce impactful and rigorous findings free of biases. However, it is noted that there is a lack of congruency among researchers as to what constitutes limitations in qualitative research, and perceptions pertaining to constraints and biases are largely guided by paradigmatic assumptions that vary among individual researchers (Galdas, 2017).

My philosophical assumptions (which fall within a transformative paradigm with a transactional epistemology) lead me to challenge the conceptualizations of limitations commonly associated with qualitative research. Ultimately, I believe that identification and discussion of constraints in qualitative research are typically rooted in the (contradictory) positivist philosophical assumptions of quantitative research, and that concern regarding quality of research should instead be placed on assessing the transparency of the researcher when discussing research methods. However, in order to reach both quantitative and qualitative audiences, this section will begin by addressing primary limitations most commonly associated with qualitative research.

The first limitation that will be discussed pertains to constraints on the generalizability of study findings. Despite its increasing presence in research, qualitative inquiry in general continues to receive criticism from scientists who push a more positivistic agenda and are skeptical of its ability to produce credible, useful findings (Mertens & Wilson, 2014). As is the case in most qualitative inquiries, this study did not aim to produce generalizable findings using a large sample, random sample. Instead, this

study aimed to examine a specific phenomenon (ACEs) in a certain population (the CJS) and unique context (a Southeastern MHC circuit), thus findings are likely to be somewhat specific to the particular study sample (Leung, 2015).

Additionally, there are potential biases associated with this particular sample, as these individuals were part of a high-functioning group of MHC participants given that they had successfully completed and graduated from the program. Future research in this area would benefit from mixed-methods studies with a quantitative design that contains a large sample with diverse participants, including individuals who did not graduate from MHC. Such methods would strengthen the limitations of this study by increasing the generalizability of findings and the scope of conclusions and implications.

The second limitation that will be discussed pertains to the propensity for unintentional research biases in qualitative studies, including instrumentation bias, researcher bias, and participant bias. If not appropriately managed, these biases potentially "pose a threat to the truth value of data obtained and information obtained from the data analyses" (Chenail, 2009, p. 16). For example, there is the potential for instrumentation bias in this study stemming from the semi-structured interview guide used to collect the primary source of data since this was not a pre-established instrument. Instead, I created the interview guide, thus it is possible that the questions were presented (e.g., ordered, phrased, etc.) in a way that elicited specific responses.

Additionally, there is also the potential for unintentional participant response bias in this study, as participants were asked to provide retrospective recollections of their past, which can often contain inaccuracies related to the passage of time (Oltmann, 2016). Additionally, there is a possibility for unintentional response bias in this study stemming

from untruthful and/or inaccurate interview responses by participants in effort to avoid negative feelings and/or acheive social desirability (Collins, Shattell, & Thomas, 2005). Furthermore, critiques could be raised regarding the presence of researcher bias in this study, such as the reflection of my own values throughout the study process (e.g., in the research questions selected, the data collection methods used, and how data was interpreted to form conclusions; Galdas, 2017).

Finally, the third limitation that will be discussed pertains to general limitations associated with use of the ACEs measure (Felitti et al., 1998) in data collection. A number of limitations pertaining to the original ACEs measure have emerged research on ACEs continues to evolve beyond the initial research conducted by Feletti et al. While a comprehensive critique of the ACEs measure is beyond the scope of this dissertation, the major limitations associated with the original ACEs measure identified by Finkelhor, et al., 2013 will be discussed.

One critique of the ACEs measurement pertains to the retrospective design of the questionnaire in which respondents are asked to recall past events from their childhood. As discussed previously, there are a number of potential limitations associated with recall bias (Oltmann, 2016). In this instance, inaccurate responses related to recall bias could challenge "…whether it is these particular childhood experiences or unmeasured covariates that are the most important predictor" of adverse outcomes associated with childhood trauma (Finkelhor et al., 2013, p. 70).

A second major limitation of the ACEs measure relates to how trauma is conceptualized and what events were included in the scale (Finkelhor et al., 2013; Greeson et al., 2013). For instance, scholars are increasingly discussing the omission of

several preventable childhood adversities from the ACEs measurement, such as poverty (Hughes, 2018), intergenerational trauma (McDonnell & Valentino, 2016), and community violence (Lee, Larkin, & Esaki, 2017). Current ACEs literature frequently discusses how the limited-range of adversities addressed in the ACEs measure has restricted advances in childhood trauma research, especially for non-white populations (Merksy, Topitzes, & Reynolds, 2014).

In fact, the ACEs has long been critiqued for failing to account for diversity, as the original ACEs measure was validated from research on a homogenous population of primarily white, upper-class participants (Felitti et al., 1998). Recent research on childhood trauma has identified the importance of expanding ACEs across diverse populations (Cronholm et al., 2015). The non-diversity characteristic of early ACEs research should be especially concerning for social justice-oriented research, as failure to account for diversity can indirectly perpetuate marginalization and oppression.

To address the above discussed limitations, I used a number of strategies throughout the research process to mitigate these limitations and strengthen the overall rigor of the study. For example, continuous adherence to transformative paradigmatic assumptions throughout the study provided protection against potential critiques regarding the utility of findings (e.g., that they are not generalizable and thus have reduced utility). For example, adoption of the concepts from complexity theory challenge the extent to which findings can be generalizable given the complexity of human. As such, these theoretical assumptions identify value in findings generated from research on specific populations in certain circumstances.

Additionally, the theoretical soundness of this study mitigated limitations related to research biases. For example, adoption of transactional epistemological assumptions guided me to utilize self-reflexivity to continuously explore my role as a research throughout the study process. As described by Galdas (2017), this intentional self-reflection enhanced the trustworthiness of the study by acknowledging that "those carrying out qualitative research are an integral part of the process and final product, and separation from this is neither possible nor desirable. The concern instead should be whether the researcher has been transparent and reflexive" (p. 2). To engage in self-reflexivity throughout the research process, I utilized techniques from Hesse-Biber (2007), including the use of memoing to consider the impact of my positionality and challenge my pre-conceived assumptions.

Finally, I also utilized Chenail's (2009) "interviewing the investigator" strategy to address instrumentation and research biases associated with the use of qualitative interviews in data collection. This strategy involved a role play in which I assumed the role of a study participant and completed the interview process with a colleague acting as a researcher collecting data using the study's interview guide. Chenail (2011) concluded that this technique can address research biases by helping the researcher with the following:

1. Identify personal feelings arising during the questioning,
2. Develop greater appreciation for the challenge of sharing all one knows about a Topic,
3. Make overt perspectives that might bias the researcher in the study,
4. Learn the value of patience in the interviewing process,

5. Gain an appreciation of feelings of being and not being heard,

6. Appreciate the vulnerability of the participant,

7. Identify a priori assumptions about the participants (p. 260).

In conclusion, utilization of empirical strategies to address limitations enhanced the overall trustworthiness of this study and strengthened findings so that they may be used to guide positive social change in this area.

Implications

Study findings addressed the study purpose by generating detailed descriptions depicting how ACEs can impact adult MHC involvement. Four research questions guided this study, with the aim of generating implications from findings that can guide positive social change. Informed by related literature on ACEs/trauma and CJS/MHC, conclusions from this study contain specific implications for how trauma-informed, criminal justice reform can be advanced through social work education, practice, research.

Education Implications

This study has several implications for social work education. First, the findings from this study contribute to knowledge that can expand the knowledge base on outcomes associated with MHCs for social work practitioners (and their interdisciplinary colleagues) who work in this area. Second, findings and implications from the qualitative inquiry design selected can be used to educate and guide future social work students and scholars who conduct research in this area, which is especially beneficial given the trend of MHCs partnering with academic institutions to conduct program evaluations. Finally, findings have the potential to enhance social workers' understanding of how trauma (and

ACEs specifically) impact MHC experiences and the lives of persons involved in the CJS.

Practice Implications

Study findings also have implications for practice with survivors of trauma involved in MHC, especially for social work and related disciplines. Specifically, knowledge from findings can be used enhance trauma-informed criminal justice reform, such as through the application of trauma-informed care approaches in the CJS in general, and MHCs specifically. For example, recent practice guidelines have identified five intercept points where communities can provide trauma-informed services to survivors of trauma in the community once they become involved with the CJS(SAMHSA, 2013a). However, despite advancement towards trauma-informed criminal justice reform, these guidelines also specifically noted the need for more research to inform interventions for childhood trauma survivors involved in the CJS as an adult.

Findings from this study explicitly address this gap by depicting how ACEs impact adult involvement in CJS via MHC involvement. Understanding how ACEs impact an individual's path to MHC involvement over time opens the door for identification of interception points and specific applicable trauma-informed interventions. Furthermore, findings from this study can provide insight into not only how to appropriately respond to outcomes associated with trauma, but also prevent trauma and promote resiliency.

Additionally, study findings can provide MHC programs with guidance on how to implement trauma-informed services using the recommendations and feedback provided

by participants. Such recommendations include the importance of providing trauma-education to mental health services providers involved in MHC programs, as well as court staff, judges, and law enforcement. Based on participant recommendations and findings from related literature, trauma-informed court staff could reduce (re-) traumatization from CJS involvement during the MHC program.

By examining outcomes associated with participation in MHC, findings from this study have the potential to justify policy changes that can assist in improving MHCs and outcomes for participants. For example, findings depicting the benefits of trauma-informed mental health care for adult MHC participants can support the formation of polices that call for an integration of trauma-informed approaches in the CJS. Such policies could be adopted at the local and state level, such as through statewide legislature encouraging court circuits to adopt trauma-informed approaches in PSCs.

Research Implications

Findings contained several implications for future research in this area. First, the study design provides future researchers with insight into how a qualitative research design can be used to explore the impact of trauma over time, such as the impact of childhood trauma on adult involvement in the CJS. Additionally, given that the study design was guided by a transformative paradigm, this study provides direction for future researchers interested in conducting critically-oriented, trauma-informed research that prioritizes the voices of participants and involves them in the construction of knowledge.

Additionally, findings provide several suggestions for how to strengthen future research in this area. First, implementation of a longer follow-up period for interviews following MHC graduation is recommended, as this would enhance findings on the long-

term effects of MHC outcomes (e.g., five-to-ten years following MHC graduation). Second, utilization of a larger sample size for data collection is recommended, as this can generate findings that are considered generalizable by more positivist audiences.

Third, implementation of mixed-methods research within a transformative paradigm is recommended, as it could strengthen study findings in this area by adding complementary quantitative results to enhance study findings. Such mixed-methods results can provide more insight into causal relationships between trauma, CJS involvement, and MHC outcomes. For instance, it is recommended that future research used a mixed-methods design explore the relationship between specific types of trauma history (e.g., ACEs, adult trauma, a combination of both) and MHC outcomes (e.g., recidivism, etc.) among a larger sample size.

Finally, while findings from this study can help fill the gap in research regarding the role of trauma in the MHC experience, more research in this area is needed. This study can provide direction for future trauma-informed research that is necessary to enhance our understanding of the impact of trauma on MHC experiences. Findings from such research will ensure that there is ongoing, updated evidence that can be used to improve trauma-informed practice in the CJS, and MHCs specifically. For example, future research is recommended that examines the benefits of assessing for trauma as part of the MHC referral.

Chapter Summary

In conclusion, this chapter provided a summary of study findings, followed by a discussion of conclusions form this research, limitations, and implications. In summary, this study was conducted with the purpose of exploring how ACEs impact adult MHC

involvement. Findings depicted how ACEs can have an impact on each stage of adults' involvement in MHC, including their paths to involvement in criminal activity and referral to MHC, their programmatic experience, and their outcomes following participation and/or graduation from MHC. These findings provide direction for future research in this area, as well as implications for enhancing trauma-informed criminal justice reform.

REFERENCES

Almquist, L., & Dodd, E. (2009). *Mental health courts: A guide to research-informed policy and practice*. New York, NY: Council of State Governments Justice Center.

Al-Rousan, T., Rubenstein, L., Sieleni, B., Deol, H., & Wallace, R. B. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health, 17*(1), 342 - 351.

Ambrosino, R., Ambrosino, R. J. Heffernan, J., & Shuttlesworth, G. (2015). *Empowerment series: Social work and social welfare.* Boston, MA: Cengage.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Amoah, J. (1997). The road to black feminist theory. *Berkeley Women's Law Journal, 12*(1), 84-102. doi:10.15779/Z38FP3B

Anestis, J. C., & Carbonell, J. L. (2014). Stopping the revolving door: Effectiveness of mental health court in reducing recidivism by mentally ill offenders. *Psychiatric Services, 65*, 1105-1112. doi:10.1176/appi.ps.201300305

Armour, C. Mental health in prison: A trauma perspective on importation and deprivation. *International Journal of Criminology and Sociological Theory, 5*(2), 886-894. Retrieved from https://ijcst.journals.yorku.ca/index.php/ijcst/article /viewFile/35703/32435

Arrigo, B. A. (2001). Transcarceration: A constitutive ethnography of mentally ill offenders. *Prison Journal, 81*, 162-186.

Arrigo, B. A. (1996). Desire in the psychiatric courtroom: On Lacan and the dialectics of linguistic oppression. *Current Perspectives in Social Theory, 16,* 159-187.

Babbie, E. (2013). *The practice of social research* (13th ed.). *Belmont, CA: Wadsworth.*

Benedict, A. (2014). *National resource center on justice involved women: Using trauma-informed practices to enhance safety and security in women's correctional facilities.* Washington, DC: Bureau of Justice Assistance.

Berkowitz, E. (2005). Medicare and Medicaid: The past as prologue. *Health Care Financing Review, 27*(2), 11–23.

Bloomberg, L. D., & Volpe, M. (2018). *Completing your qualitative dissertation: A road map from beginning to end.* Los Angeles, CA: Sage.

Bremmer, R. H. (1988). American philanthropy (2nd ed.). Chicago, IL: The University of Chicago Press.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Los Angeles, CA: Sage.

Bogdan, R., & Biklen, S. K. (1997). *Qualitative research for education*. Boston, MA: Allyn & Bacon.

Bronson, J., & Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates, 2011-12*. Washington, DC: U.S. Department of Justice, Office of Justice Program, Bureau of Justice Statistics.

Brown, T. J. (1996). Franklin Pierce's land grant veto and the Kansas-Nebraska session of Congress. *Civil War History, 42*(2), 95-115. doi:10.1353/cwh.1996.0036

Byrne, D., & Callaghan, G. (2014). *Complexity theory and the social sciences: The state of the art.* New York, NY: Routledge.

Calhoun, P. S., Malesky Jr, L. A., Bosworth, H. B., & Beckham, J. C. (2005). Severity of posttraumatic stress disorder and involvement with the criminal justice system. Journal of Trauma *Practice*, *3*, 1-16. https://doi.org/10.1300/J189v03n03_01

Canada, K. E., & Gunn, A. J. (2013). What factors work in mental health court? A consumer perspective. *Journal of Offender Rehabilitation, 52*, 311-337.

Canada, K. E., Markway, G., & Albright, D. (2016). Psychiatric symptoms and mental health court engagement. *Psychology, Crime, and Law, 22*, 513-529. doi:10.1080/1068316X.2016.1168422.

Canada, K. E., & Ray, B. (2016). Mental health court participants' perspectives of success: What key outcomes are we missing? *International Journal of Forensic Mental Health, 15*, 352-361. doi:10.1080/14999013.2016.1230155

Carson, A. E., & Anderson, E. (2016). *Prisoners in 2015* (Report No. 250229). Retrieved from Bureau of Justice Statistics website: https//www.bjs.gov/content/pub/pdf/p15.pdf

Carson, E. A. (2018). *Prisoners in 2016 (Report No. 251149).* Retrieved from Bureau of Justice Statistics website: https://www.bjs.gov/content/pub/pdf/p16.pdf

Castro, F. G., Kellison, J. G., Boyd, S. J., & Kopak, A. (2010). A methodology for conducting integrative mixed methods research and data analyses. *Journal of Mixed Methods Research*, *4*, 342-360. doi:10.1177/1558689810382916

Centers for Disease Control. (2016). *Adverse childhood experiences (ACEs).* Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/

index.html

Charmaz, K. (1995). The body, identity, and self: Adapting to impairment. *Sociological Quarterly*, *36*, 657-680. https://doi.org/10.1111/j.1533-8525.1995.tb00459.x

Chenail, R. J. (2011). Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report*, *13(4), 14-21. Retrieved from* http://nsuworks.nova.edu/tqr/vol13/iss4/14

Cole, D. (1999). *No equal justice: Race and class in the American criminal justice system*. New York, NY: The New Press.

Collier, L. (2014). Incarceration nation. *Monitor on Psychology, 45*(9). Retrieved from http://www.apa.org/monitor/2014/10/incarceration.aspx

Collins, M., Shattell, M., & Thomas, S. P. (2005). Problematic Interviewee Behaviors in Qualitative Research. *Western Journal of Nursing Research*, *27*, 188-199. https://doi.org/10.1177/0193945904268068

Cosden, M., Ellens, J., Schnell, J., & Yamini-Diouf, Y. (2005). Efficacy of a mental health treatment court with assertive community treatment. *Behavioral Sciences & the Law, 23*, 199-214.

Council of State Governments Justice Center. (2016). *Trauma-informed care in mental health courts*. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2016/05/Trauma-Webinr.pdf

Cox, P., & Hardwick, L. (2002). Research and critical theory: Their contribution to social work education and practice. *Social Work Education, 21*(1), 35-47. doi:10.1080/02615470120107004

Coyle, A., Fair, H., Jacobson, J., & Walmsley, R. (2016). *Imprisonment worldwide: The current situation and alternative future.* Bristol, UK: Policy Press.

Crespo, C. J., Keteyian, S. J., Heath, G. W., & Sempos, C. T. (1996). Leisure-time physical activity among US adults: Results from the Third National Health and Nutrition Examination Survey. *Archives of Internal Medicine, 156*(1), 93-98. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/8526703

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* Los Angeles, CA: Sage.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles, CA: Sage.

Cuadra, L. E., Jaffe, A. E., Thomas, R., & DiLillo, D. (2014). Child maltreatment and adult criminal behavior: Does criminal thinking explain the association? *Child Abuse and Neglect, 38,* 1399-1408. http://dx.doi.org/10.1016/ j.chiabu.2014.02.005

Czarniawska, B. (2004). *Narratives in social science research*. Los Angeles, CA: Sage.

de Laine M. (2000). *Fieldwork, participation and practice: Ethics and dilemmas in qualitative research.* London, United Kingdom: Sage.

Delgado, R., & Stefancic, J. (2012). *Critical race theory: An introduction* (3rd ed.). New York, NY: New York University Press.

Denzin, N. K. (1989). *Interpretive biography (qualitative research methods).* Los Angeles, CA: Sage.

Denzin, N. K. (2017). Critical qualitative inquiry. *Qualitative Inquiry, 23*(1), 8-16. doi:10.1177/1077800416681864

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The sage handbook of qualitative research* (3rd ed.). Los Angeles, CA: Sage.

Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. *Psychological Bulletin, 135*, 679-706. doi:10.1037/a0016311

Drake, R. E. (2017). Mental health shared decision making in the US. *World Psychiatry, 16*, 161–162. doi:10.1002/wps.20419

Dumont, D. M., Brockmann, B., Dickman, S., Alexander, N., & Rich, J. D. (2012). Public health and the epidemic of incarceration. *Annual Review of Public Health, 33,* 325–339. http://doi.org/10.1146/annurev-publhealth-031811-124614

Edalati, H., Nicholls, T. L., Crocker, A. G., Roy, L., Somers, J. M., & Patterson, M. L. (2017). Adverse childhood experiences and the risk of criminal justice involvement and victimization among homeless adults with mental illness. *Psychiatric Services, 68*, 1288-1295. doi: 10.1176/appi.ps.201600330

Ellis, L. A., Churruca, K., & Braithwaite, J. (2017). Mental health services conceptualised as complex adaptive systems: What can be learned? *International Journal of Mental Health Systems, 11(43),*1-8. doi 10.1186/s13033-017-0150-6

Engel, G. L. (2012). The need for a new medical model: a challenge for biomedicine. *Psychodynamic Psychiatry, 40*, 377-396.

Eysenck, H. J., & Eysenck, S. G. (1977). *Psychoticism as a dimension of personality.* New York, NY: Crane, Russak and Company.

Favril, L., Vander Laenen, F., Vandeviver, C., & Audenaert, K. (2017). Suicidal ideation while incarcerated: Prevalence and correlates in a large sample of male prisoners in Flanders, Belgium. *International Journal of Law and Psychiatry, 55*, 19-28.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359,* 545-550. doi:10.1016/S0140-6736(02)07740-1

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V...Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading cause of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245-258. doi:10.1016/S0749-3797(98)00017-8

Finegood, D. T. (2011). The complex systems science of obesity. In J. Cawley (Ed.), *The oxford handbook of the social science of obesity* (pp. 208 – 236). New York, NY: Oxford University Press.

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *JAMA pediatrics*, *167*(1), 70-75. doi:10.1001/jamapediatrics.2013.420

Fisler, C. (2015). Toward a new understanding of mental health courts. *The Judges Journal, 54*(2), 8-13. Retrieved from https://www.courtinnovation.org/sites/default/files/documents/JJ_SP15_54_2_Fisler.pdf

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* New York, NY: Pantheon Books.

Freire, P. (1973). *Education for critical consciousness*. New York, NY: Seabury Press.

Freire, P. (1996). *Pedagogy of the oppressed*. New York, NY: Continuum.

Freudenberg, N. (2001). Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 78*(2), 214–235. http://doi.org/10.1093/jurban/78.2.214

Fromm, E. (1941). *Escape from freedom.* New York, NY: Farrar & Rinehart, Inc.

Gage, N. L. (1989). The paradigm wars and their aftermath: A "historical" sketch of research on teaching since 1989. *Educational Researcher, 18*, 4-10. https://doi.org/10.3102/0013189X018007004

Garbarino, J. (2017). ACEs in the criminal justice system. *Academic Pediatrics, 17(*7S), S32- S33. Retrieved from https://www.academicpedsjnl.net/article/S1876-2859(16)30419- 3/pdf

Gerrits, L.M., & Verweij, S. (2015). Taking stock of complexity in evaluation: A discussion of three recent publications. *Evaluation, 21*, 481-491.

Gilgun, J. F. (2005). The four cornerstones of evidence-based practice in social work. *Research on Social Work Practice*, *15*, 52-61. https://doi.org/10.1177/1049731504269581

Gilligan, J. (2001). *Preventing violence.* New York, NY: Thames & Hudson.

Given, L. M. (Ed.). (2008). *The SAGE encyclopedia of qualitative research methods* (Vol. 2). Los Angeles, CA: Sage. doi:10.4135/9781412963909

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago, IL: Aldine.

Goldman, H. H., Buck, J. A., & Thompson, K. S. (Eds.). (2009). *Transforming mental health services: Implementing the federal agenda for change*. Washington, DC: American Psychiatric Association Publishing.

Goldman, H. H., & Morrissey, J. P. (1985). The alchemy of mental health policy: Homelessness and the fourth cycle of reform. *American Journal of Public Health, 75*, 727-731.

Gomory, T. (2001). A fallibilistic response to Thyer's theory of theory-free empirical research in social work practice. *Journal of Social Work Education, 1*(37), 26-50.

Goodale, G., Callahan, L., & Steadman, H. J. (2013). Law & psychiatry: What can we say about mental health courts today? *Psychiatric Services, 64*, 298-300.

Greeson, J. K., Briggs, E. C., Layne, C. M., Belcher, H. M., Ostrowski, S. A., Kim, S., ... & Fairbank, J. A. (2014). Traumatic childhood experiences in the 21st century: Broadening and building on the ACE studies with data from the National Child Traumatic Stress Network. *Journal of Interpersonal Violence*, *29*, 536-556. https://doi.org/10.1177/0886260513505217

Grob, G. N. (1994). Government and mental health policy: A structural analysis. *The Milbank Quarterly, 72*, 471-500.

Gross, A. G., & Keith, W. M. (1997). *Rhetorical hermeneutics: Invention and interpretation in the age of science.* Albany, NY: State University of New York Press.

Groves, B., & Sampson, R. J. (1986). Critical theory and criminology. *Social Problems, 33*, S58-S80.

Guba, E. G. (1990). *The paradigm dialog.* Las Angeles, CA: Sage.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Los Angeles, CA: Sage.

Guba, E. G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 191-215). Los Angeles, CA: Sage.

Habermas, J. (1970). *Toward a rational society: Student protest, science, and politics*. Boston, MA: Beacon Press.

Habermas, J. (1973). *Theory and practice.* Boston, MA: Beacon Press.

Habermas, J. (1984). *The theory of communicative action.* Boston, MA: Beacon Press.

Han, W., & Redlich, A. D. (2015). The impact of community treatment on recidivism among mental health court participants. *Psychiatric Services, 67*, 384-390. doi:10.1176/appi.ps.201500006

Haney, C. (2012). Prison effects in the era of mass incarceration. *The Prison Journal*. Advance online publication. doi:10.1177/0032885512448604

Harris, R., Holmes, H. M., & Mertens, D. M. (2009). Research ethics in sign language communities. *Sign Language Studies*, *9*, 104-131. doi: 10.1353/sls.0.0011

Harris, A., & Lurigio, A. J. (2007). Mental illness and violence: A brief review of research and assessment strategies. *Aggression and Violent Behavior, 12*, 542-551.

Held, D. (1980). *Introduction to critical theory: Horkheimer to Habermas.* Berkeley, CA: University of California Press.

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror.* New York, NY: Basic Books.

Hiday, V. A., Ray, B., & Wales, H. (2015). Longer-term impacts of mental health courts: Recidivism two years after exit. *Psychiatric Services, 67*, 378-383.

Hilton, Z. N., Ham, E., & Green, M. M. (2016). Adverse childhood experiences and criminal propensity among intimate partner violence offenders. *Journal of Interpersonal Violence, 62, 3247-3259.* doi:10.1177/0886260516674943

Hinton, E. (2016). *From the war on poverty to the war on crime: The making of mass incarceration.* Cambridge, MA: Harvard University Press.

Holtzman, E. (2012, March). A home away from home. *Monitor on Psychology, 43*(3). Retrieved from https://www.apa.org/monitor/2012/03/asylums

Hora, P. F., Schma, W. G., & Rosenthal, T. A. (1999). Therapeutic jurisprudence and the drug treatment court movement: Revolutionizing the criminal justice system's response to drug abuse and crime in America. *Notre Dame Law Review, 74*, 439-538.

Horkheimer, M. (1995). *Between philosophy and social science: Selected early writings*. (F. Hunter, M. S. Kramer, & J. Torpey, Trans.). Baltimore, MD: The Johns Hopkins University Press.

Horkheimer, M., & Adorno, T. W. (1972). *Dialectic of enlightenment.* (J. Cumming, Trans.). New York, NY: Herder and Herder. (Original work published 1947).

Hughes, M., & Tucker, W. (2018). Poverty as an adverse childhood experience. *North Carolina Medical Journal*, *79*, 124-126. doi: 10.18043/ncm.79.2.124

Huxter, M. J. (2013). Prisons: The psychiatric institution of last resort? *Journal of Psychiatric and Mental Health Nursing, 20*, 735-743.

Jaccard, J., & Jacoby, J. (2010). *Theory construction and model-building skills: A practical guide for social scientists*. New York, NY: Guilford Press.

Jäggi, L. J., Mezuk, B., Watkins, D. C., & Jackson, J. S. (2016). The relationship between trauma, arrest, and incarceration history among Black Americans: Findings from the National Survey of American Life. *Society and mental health, 6*, 187-206. doi: 10.1177/2156869316641730

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates.* Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Jansson, B. S. (2016). *Social welfare policy and advocacy: Advancing social justice through 8 policy sectors.* Los Angeles, CA: Sage.

Kahlke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods, 13*, 37-52. https://doi.org/10.1177/160940691401300119

Kendall, F. E. (2006). *Understanding white privilege.* New York, NY: Routledge.

Khan, M. M. R. (1963). The concept of cumulative trauma. *The Psychoanalytic Study of the Child, 18*(1), 286-306. doi:10.1080/00797308.1963.11822932

Kim, J. H. (2016). *Understanding narrative inquiry: The crafting and analysis of stories as research.* Los Angeles, CA: Sage.

Kimmel, L. H. (2018). Ur-Nammu establishes a code of law. In *Salem Press Encyclopedia*. Hackensack, NJ: Salem Press

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education, 6*(5), 26-41. https://doi.org/10.5430/ijhe.v6n5p26

Kohlberg, L. (1984). *The psychology of moral development: The nature and validity of moral stages.* San Francisco, CA: Harper & Row.

Kuhn, T. (1962). *The structure of scientific revolutions.* Chicago, IL: The University of Chicago Press.

Lamb, H. R., Weinberger, L. E., & Gross, B. H. (2004). Mentally ill persons in the criminal justice system: Some perspectives. *Psychiatric Quarterly, 75*, 107-126.

Lange, S., Rehm, J., & Popova, S. (2011). The effectiveness of criminal justice diversion initiatives in North America: A systematic literature review. *International Journal of Forensic Mental Health,10*, 200-214. https://www.tandfonline.com/doi/abs/10.1080/14999013.2011.598218

Langer, C. L., & Lietz, C. (2014). *Applying Theory to Generalist Social Work Practice*. Hoboken, NJ: John Wiley & Sons.

Lavrakas, P. J. (2008).*Encyclopedia of survey research methods*. Thousand Oaks, CA: Sage Publications, Inc. doi: 10.4135/9781412963947

Lee, E., Larkin, H., & Esaki, N. (2017). Exposure to community violence as a new adverse childhood experience category: Promising results and future considerations. *Families in Society, 98,* 69-78. doi: 10.1606/1044-3894.2017.10

Leung L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*, 324-327. doi: 10.4103/2249-4863.161306

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Las Angeles, CA: Sage.

Loong, D., Bonato, S., & Dewa, C. S. (2016). The effectiveness of mental health courts in reducing recidivism and police contact: A systematic review protocol. *Systematic Reviews, 5*(1), 123-128. doi:10.1186/s13643-016-0291-8

Lorenzetti, L. (2013). Research as a social justice tool: An activist's perspective. *Affilia: Journal of Women & Social Work, 28*(4), 451-457. doi:10.1177/ 0886109913505815

Lowder, E. M., Rade, C. B., & Desmarais, S. L. (2017). Effectiveness of mental health courts in reducing recidivism: A meta-analysis. *Psychiatric Services, 69*(1), 15-22. doi:10.1176/appi.ps.201700107

Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: implications for interventions and social policies. *Development and psychopathology*, *12*(4), 857–885.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: a critical evaluation and guidelines for future work. *Child development*, *71*(3), 543–562.

Lurigio, A. J., & Harris, A. (2007). The mentally ill in the criminal justice system: An overview of historical causes and suggested remedies. *Professional Issues in Criminal Justice, 2*, 145-169.

Lynch, S. M., DeHart, D., Belknap, J., & Green, B. L. (2009). *Women's pathways to jail: Examining mental health, trauma, and substance use.* Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice.

Mabry, L. (2010). Critical social theory evaluation: Slaying the dragon. *New Directions for Evaluation*, *2010*, 83-98. Mabry, L. (2010). Critical social theory evaluation:

Slaying the dragon. *New Directions for Evaluation*, *2010*, 83-98. https://doi.org/10.1002/ev.341

March, D., & Oppenheimer, G. M. (2014). Social disorder and diagnostic order: The US mental hygiene movement, the Midtown Manhattan study and the development of psychiatric epidemiology in the 20th century. *International Journal of Epidemiology, 43,* 29-42.

Marcuse, H. (1955). *Reason and revolution: Hegel and the rise of social theory.* New York, NY: Humanities Press.

McAreavey, R., & Das, C. (2013). A delicate balancing act: Negotiating with gatekeepers for ethical research when researching minority communities. *International Journal of Qualitative Methods*, *12*, 113–131. https://doi.org/10.1177/160940691301200102

McDonnell, C. G., & Valentino, K. (2016). Intergenerational effects of childhood trauma: evaluating pathways among maternal ACEs, perinatal depressive symptoms, and infant outcomes. *Child Maltreatment*, *21*, 317-326. https://doi.org/10.1177/1077559516659556

Merriam, S. B. (2002). Introduction to qualitative research. *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.

Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse and Neglect*, *37*, 917-25. doi: 10.1016/j.chiabu.2013.07.011

Mertens, D. M. (2009). *Transformative research and evaluation*. New York, NY: Guilford press.

Mertens, D. M. (2010). Transformative mixed methods research. *Qualitative Inquiry, 16*, 469- 474. doi:10.1177/1077800410364612

Mertens, D. M. (2012). Transformative mixed methods: Addressing inequities. *American Behavioral Scientist, 56*, 802-813. doi:10.1177/0002764211433797

Mertens, D. M., & Wilson, A. T. (2012). *Program evaluation theory and practice: A comprehensive guide.* New York, NY: The Guilford Press.

Meyer, A. (1942). Mental hygiene and national defense. *Mental Hygiene, 26,* 1-19.

Midgley, J. (2014). *Social development: Theory and practice.* Los Angeles, CA: Sage.

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology, 3*(1), 17246-17254. doi:10.3402/ejpt.v3i0.17246

Montross, C. (2016). Hard time or hospital treatment? Mental illness and the criminal justice system. *New England Journal of Medicine, 375*(15), 1407-1409.

Moore, M. E., & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior, 30*, 659-674.

Munro, E. (2002). The role of theory in social work research: A further contribution to the debate. *Journal of Social Work Education, 38*(3), 461-470.

National Institute of Justice. (2018). *Specialized courts.* Retrieved from https://www.nij.gov/topics/courts/pages/specialized-courts.aspx

National Institutes of Health. (2007). *NIH Curriculum supplement series.* Bethesda, MD: Author.

National Institute of Mental Health. (2017). *Mental illness.* Bethesda, MD: Author.

Neill, K. A., Yusuf, J. E., & Morris, J. C. (2015). Explaining dimensions of state-level punitiveness in the United States: The roles of social, economic, and cultural factors. *Criminal Justice Policy Review, 26*, 751-772.

Nicholson, N. (1995). Organization: Directions for theory and research. *Organization, 2*, 339-344. https://doi.org/10.1177/135050849522014

The Office of the Press Secretary. (2016). *Economic perspectives on incarceration and the criminal justice system.* Retrieved from https://obamawhitehouse.archives.gov/the-press- office/2016/04/23/cea-report-economic-perspectives-incarceration-and-criminal-justice

Ollerenshaw, J. A., & Creswell, J. W. (2002). Narrative research: A comparison of two restorying data analysis approaches. *Qualitative Inquiry, 8*, 329-347.

Oltmann, S. M. (2016). Qualitative interviews: A methodological discussion of the interviewer and respondent contexts. *Forum: Qualitative Social Research, 17*. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs1602156.

Orlin, M. B. (1978). Politics and the Pierce veto. *Journal of Social Welfare, 5*(2), 35-45.

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: From neurobiology to clinical practice. *Psychiatry, 4*, 35-40. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921311/

Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic stress disorder in the DSM-5:

Controversy, change, and conceptual considerations. *Behavioral Sciences*, *7*(7), 1-7. doi:10.3390/bs7010007

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Los Angeles, CA: Sage.

Pillsbury, S. H. (1989). Understanding penal reform: The dynamic of change. *The Journal of Criminal Law and Criminology, 80*, 726–780. doi:10.2307/1143897

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.

Pollack, D., & Feldman, J. M. (2003). Introduction to the special issue of community mental health journal commemorating the 40th anniversary of The Community Mental Health Centers Act of 1963. *Community Mental Health Journal, 39*, 377-379.

Polizzi, D., & Draper, M. R. (2016). *Forensic psychology reconsidered: A critique of mental illness and the courts.* New York, NY: Taylor & Francis.

Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services, 65*, 862-872.

Pycroft, A., & Wolf-Branigin, M. (2015). Integrating complexity theory and social work practice: A commentary on Fish and Hardy (2015). *Nordic Social Work Research, 6*, 69-72. https://doi.org/10.1080/2156857X.2015.1123459

Quinney, R., & Shelden, R. G. (2018). *Critique of the legal order: Crime control in capitalist society*. New York, NY: Routledge.

Rabe, K. (2012). Prison structure, inmate mortality and suicide risk in Europe. *International Journal of Law and Psychiatry, 35*(3), 222-230. https://doi.org/10.1016/j.ijlp.2012.02.012

Reavis, J. A., Looman, J., Franco, K. A., & Rojas, B. (2013). Adverse childhood experiences and adult criminality: How long must we live before we possess our own lives? *The Permanente Journal, 17*(2), 44-48. doi:10.7812/TPP/12-072

Riessman, C. K. (1993). *Narrative analysis.* Los Angeles, CA: Sage.

Riessman, C. K. (2008). *Narrative methods for the human sciences.* Los Angeles, CA: Sage.

Roberts, A. R., & Kurtz, L. F. (1987). Historical perspectives on the care and treatment of the mentally ill. *Journal of Sociology and Social Welfare, 14*(4), 75-94.

Rosen, S. (1987). *Hermeneutics as politics.* Oxford, UK: Oxford University Press.

Rothman, D. J. (1980). *Conscience and convenience: The asylum and its alternatives in progressive America.* Piscataway, NJ: Transaction Publishers.

Roxburgh, S., & MacArthur, K. R. (2014). Childhood adversity and adult depression among the incarcerated: Differential exposure and vulnerability by race/ethnicity and gender. *Child Abuse and Neglect, 38*, 1409-1420.

Rubin, A., & Babbie, E. (2017). *Essential research methods for social work*. Boston, MA: Cengage.

Rubin, A. (2017). Pennsylvania prison system. In *The Encyclopedia of Corrections.* Hoboken, NJ: John Wiley & Sons, Inc.

Sanger, M., & Giddings, M. M. (2012). A simple approach to complexity theory. *Journal of Social Work Education, 48*, 369-376. doi:10.5175/JSWE.2012.201000025

Sarteschi, C. M. (2013). Mentally ill offenders involved with the US criminal justice system: A synthesis. *Sage Open, 3*(3), 1-11. doi: 2158244013497029.

Sarteschi, C. M., Vaughn, M. G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice, 39*(1), 12–20. doi:10.1016/j.jcrimjus.2010.11.003

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., …Jinks, C. (2017). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity, 52*(4), 1893-1907. doi: 10.1007/s11135-017-0574-8

Scheyett, A., Pettus-Davis, C., McCarter, S., & Brigham, R. (2012). Social work and criminal justice: Are we meeting in the field? *Journal of Teaching in Social Work, 32*, 438–450. doi:10.1080/08841233.2012.705241

Schoenborn, C. A. (1991, September). Exposure to alcoholism in the family: United States, 1988. *Advanced Data, 205*, 1-13. Retrieved from https://www.ncbi.nlm .nih.gov /pubmed/10114780

Scott, C. K., Coleman-Cowger, V. H., & Funk, R. R. (2014). Trauma and posttraumatic stress disorder among substance-using women entering Cook County Jail. *Women and Criminal Justice, 24*(1), 44-61.

Scull, A. (2015). *Madness in civilization: A cultural history of insanity, from the Bible to Freud, from the madhouse to modern medicine.* Princeton, NJ: Princeton University Press.

Shaw, I. (2012). The positive contributions of quantitative methodology to social work research: A view from the sidelines. *Research on Social Work Practice, 22*, 129-134. doi:10.1177/1049731511420171

Shumate, D. J. (2003). National Association of Juvenile Correctional Agencies celebrates 100 years. *Corrections Today, 65*(4), 30-31.

Siegel, P. Z., Frazier, E. L., Mariolis, P., Brackbill, R. M., & Smith, C. (1993, August). Behavioral risk factor surveillance, 1991: Monitoring progress toward the nation's year 2000 health objectives. *Morbidity and Mortality Weekly Report, 43*(4). Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/00025850.htm

Slobogin, C. (1995). Therapeutic jurisprudence: Five dilemmas to ponder. *Psychology, Public Policy, and Law*, *1*(1), 193–219. doi:10.1037/1076-8971.1.1.193

Small, M. L. (2011). How to conduct a mixed methods study: Recent trends in a rapidly growing literature. *Annual Review of Sociology*, *37*, 57-86. https://doi.org/10.1146/annurev.soc.012809.102657

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*, 761-765.

Strauss, M. A., & Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptions to violence in 8,145 families*. New Brunswick, NJ: Transaction Publishers.

Stuart, P. (1997). Community care and the origins of psychiatric social work. *Social Work in Health Care, 25*(3), 25-36.

Substance Abuse and Mental Health Services Administration (US). (2011). Trauma-

specific interventions for justice-involved individuals. Retrieved from The National Gains Center website: https://pdfs.semanticscholar.org/e455/24e60f99db7f9628f95a7de2fe743c186882.pdf

Substance Abuse and Mental Health Services Administration (US). (2013a). *Creating a trauma-informed criminal justice system for women: Why and how*. Retrieved from https://www.nasmhpd.org/sites/default/files/Women%20in%20Corrections%20TIC%20SR(2).pdf

Substance Abuse and Mental Health Services Administration (US). (2013b). *Essential components of trauma-informed judicial practice.* Retrieved from https://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf

Substance Abuse and Mental Health Services Administration (US). (2014a). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Retrieved from http://www.traumainformedcareproject.org/resources/SAMHSA%20TIC.pdf

Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services: Treatment improvement protocol (TIP) series, No. 57*. Rockville, MD: Center for Substance Abuse Treatment (US).

Substance Abuse and Mental Health Services Administration. (2015). *A guide to GPRA data collection using trauma-informed interviewing skills.* Retrieved from https://www.integration.samhsa.gov/about-us/Trauma-InformedInterviewingManual- 508.pdf

Substance Abuse and Mental Health Services Administration (US) (SAMHSA). (2017). *Emerging issues in behavioral health and the criminal justice system*. Retrieved

from https://www.samhsa.gov/criminal-juvenile-justice/behavioral-health-criminal-justice.

Substance Abuse and Mental Health Services Administration (US) (SAMHSA). (2018). *Trauma and violence.* Rockville, MD: Center for Substance Abuse Treatment (US).

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. *JRSM short reports*, *4*. doi: 10.1177/2042533313479197

Thyer, B. (2001). What is the role of theory in research on social work practice? *Journal of Social Work Education, 1*(37), 9-25.

Thyer, B. (2008). *Comprehensive handbook of social work and social welfare.* Hoboken, NJ: John Wiley & Sons.

Toms, J. (2012). Political dimensions of 'the psychosocial': The 1948 international congress on mental health and the mental hygiene movement. *History of The Human Sciences, 25*(5), 91-106. doi:10.1177/0952695112470044

Torrey, E. F. (1997). *Out of the Shadows: Confronting America's mental illness crisis.* New York, NY: John Wiley & Sons.

Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states.* Arlington, VA: Treatment Advocacy Center.

Trattner, W. (1999). *From poor law to welfare state: A history of social welfare in America*. New York, NY: The Free Press.

Travis, J., Western, B., & Redburn, F. S. (2014). *The growth of incarceration in the United States: Exploring causes and consequences.* Washington, D.C.: The National Academies Press.

Trestman, R. L., Appelbaum, K. L., & Metzner, J. L. (2015). *Oxford textbook of correctional psychiatry*. New York, NY: Oxford University Press. doi:10.1093/med/9780199360574.001.0001

Vourlekis, B. S., Edinburg, G., & Knee, R. (1998). The rise of social work in public mental health through aftercare of people with serious mental illness. *Social Work, 43*, 567-757.

Warren, K., Franklin, C., & Streeter, C.L. (1998). New directions in systems theory: Chaos and complexity. *Social Work, 43*, 357-372.

Wexler, D. B. (2018). Mental health law and the seeds of therapeutic jurisprudence. In T. Grisso & S. L. Brodsky (Eds.), *The Roots of Modern Psychology and Law: A Narrative History* (pp. 78-96). New York, NY: Oxford University Press.

Wildeman, C., & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *The Lancet, 389,* 1464–1474. doi:10.1016/S0140-6736(17)30259-3

Willison, J. S., & O'Brien, P. (2017). A feminist call for transforming the criminal justice system. *Affilia*, *32*(1), 37-49.

Wisner, E. (1960). The uses of historical material in the social work curriculum. *Social Service Review, 34*, 265-272. doi:10.2307/30017471

Woehle, R. (2007). Complexity theory, nonlinear dynamics, and change: Augmenting systems theory. *Advances in Social Work, 8*(1), 141-151.

Wolff, N., Frueh, B. C., Shi, J., Gerardi, D., Fabrikant, N., & Schumann, B. E. (2011). Trauma exposure and mental health characteristics of incarcerated females self-referred to specialty PTSD treatment. *Psychiatric Services, 62,* 954-958. doi:10.1176/ps.62.8.pss6208_0954

Wolff, N., Shi, J., & Siegel, J. A. (2009). Patterns of victimization among male and female inmates: Evidence of an enduring legacy. *Violence and Victims, 24*, 469-484. doi:10.1891/0886-6708.24.4.469

Wolff, N., & Shi, J. (2012). Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. *International Journal of Environmental Research and Public Health, 9*, 1908–1926. http://doi.org/10.3390/ijerph9051908

Zwelling, S. S. (1985). *Quest for a cure: The public hospital in Williamsburg, Virginia 1773-1885.* Williamsburg, VA: Colonial Williamsburg Foundation.

APPENDIX A

RECRUITMENT SCRIPT

PHONE SCRIPT:

"Hello, this is Porter Jennings from the University of Georgia, may I speak with ___________. How are you doing today? I am calling because we have been asked by the mental health courts of *[insert county name]* to conduct a follow-up interview of court graduates as part of a research project, and your name was given to us as a recent graduate. The courts have asked us to follow-up with participants to gather information about their experiences in order to provide an opportunity for participant feedback and court improvement. I was wondering if you we could schedule a time where I could come out and meet with you in the upcoming weeks to speak with you about your experience?"

*-[If **no**: "Thank you very much for your time."]*

*-[If **yes**: "Great, thank you. Let me tell you a little more about the program. Everyone who has graduated from the MHC is eligible for participation. By participating in this research, we will ask you several questions concerning your experiences as a court participant, your experience since graduating from the court, and your recommendations for improving the court. The benefits from participation in this research include the opportunity to provide valuable information that can be used to improve the MHC for future participants. There are no foreseeable risks associated with participation. All participants will be compensated $10 for participation in a 60-to-90-minute interview. If you agree to participate, you may withdraw from the study at any point, with no penalty. These interviews will be recorded by the researcher and later transcribed for coding of participant responses. Responses will be kept confidential to the extent that federal, state, and local statues permit.*

I am happy to come to you for the interview to make it easier, and we can meet at a location that is comfortable for you, such as your home or a public location near your residence. What would you prefer?"]

------------------------------[*if no answer after first call, leave voicemail #1]*-------------------

VOICEMAIL #1:

"Hi, this is Porter Jennings from The University of Georgia calling for *[insert name]* calling regarding a program in *[insert county name]* that you are a part of, and I was

hoping to set up a time to speak with you in the upcoming weeks. If you could please give me a call back at (470) 418-2016."

---------------------------*[wait 24 hours after leaving voicemail #1]*----------------------------

TEXT MESSAGE FOLLOWING VOICEMAIL #1:

"Hi, my name is Porter Jennings and I am with the University of Georgia and I am trying to reach *[insert name]* regarding a voicemail I just left about scheduling a time to discuss a *[insert county name]* county program you are involved in. Please give me a call or text back to discuss."
---------------------------*[wait 48 hours after sending first text message]*----------------------

VOICEMAIL #2:

Hi, this is Porter Jennings from The University of Georgia calling for ______ , and I am following up to a voicemail I left you a few days ago regarding a program in (Newton/Walton County) that you are a part of, and I was hoping to set up a time to speak with you in the upcoming weeks. If you could please give me a call back at (470) 418-2016.

----------*[if no response after four days following two voicemails and one text message, stop contact attempts and seek assistance from gatekeepers per IRB protocol]*-------------

APPENDIX B

INFORMED CONSENT

Approved by University of Georgia
Institutional Review Board
Protocol # MOD00005747
Approved on: 4/16/2018
For use through: 5/22/2020

UNIVERSITY OF GEORGIA
CONSENT FORM
Evaluation of the Alcovy Circuit Mental Health Court

Researcher's Statement
We are asking you to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. This form is designed to give you the information about the study so you can decide whether to be in the study or not. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, you can decide if you want to be in the study or not. This process is called "informed consent." A copy of this form will be given to you.

Principal Investigator: Orion Mowbray
School of Social Work
279 Williams St.
Athens, GA 30602
omowbray@uga.edu
706-542-5441

Purpose of the Study
The purpose of this study is to conduct follow-up interviews with the Graduates of the Alcovy Circuit Mental Health Court and assess how well trauma-related experiences are addressed among court participants. You have been identified by the Court Staff as a Graduate, and we would like to know your experiences while you were in the Court, how the Court has prepared you for life after graduation and what recommendations you have for how to improve the court for future Members and Graduates.

Study Procedures
If you agree to participate, you will be asked to complete a brief trauma screening questionnaire and participate in a 90-minute interview where you will be asked about your experiences as a Court member, experiences since graduation from the court and future recommendations for how the Court can help member's and Graduate's needs. During these interviews, we will ask questions about how you felt as a Court Member and your experiences after Graduation. If any question is too personal or sensitive, you will not be required to answer.

Risks and discomforts
If you discuss any criminal activity that is unknown/undocumented to law enforcement officials, there is a danger that officials who view the study results may want to know your identity. All participants are reminded not to disclose any criminal activity unknown/undocumented to law enforcement officials. Additionally, some of our questions ask about several subjects (relating to childhood) that could provoke emotional response. However, you may choose not to answer these if preferred. Please do not discuss unresolved or undiscovered cases to avoid possible issues with the court.

Benefits
While there are no direct benefits to the participant in this research, your participation will help improve the experiences of future Members and Graduates of the Alcovy Circuit Mental Health Court and benefit society by improving its understanding of what it's like to be a Member and Graduate of a Mental Health Court.

Incentives for participation
All participants will be compensated $10 for their time dedicated to this research.

Page **1** of **2**

Approved by University of Georgia
Institutional Review Board
Protocol # MOD00005747
Approved on: 4/16/2018
For use through: 5/22/2020

Audio/Video Recording
All interviews will be audio-recorded so that the research team can later create a transcript of each interview. All audio recordings will be kept in an electronic format on a password secured computer. The transcripts from the audio recording will not contain any identifiable information and will be examined only by the entire research team for common responses across all participants. After completion of the research, transcripts will be kept stored on a secured computer inside the locked offices of the research team. All audio-recordings of participants will be destroyed after the data are collected and data analysis has been complete.

Please provide initials below if you agree to have this interview audio recorded or not. You may still participate in this study even if you are not willing to have the interview recorded.

_______I do not want to have this interview recorded.
_______I am willing to have this interview recorded.

Privacy/Confidentiality
You will not be identified in any reports on this study. The records will be kept confidential to the extent provided by federal, state and local law. The research staff will not release identifiable results of the study to anyone other than individuals working on the project without your written consent unless required by law. If any discussion of criminal activity that is unknown/undocumented to law enforcement officials occurs, we must inform these officials.

Taking part is voluntary
Your involvement in this research is voluntary. You may refuse to participate before the study begins, and discontinue at any time, with no penalty or loss of benefits to which you are otherwise entitled.

If you have questions
The main researcher conducting this study is Orion Mowbray, an Assistant Professor at the University of Georgia. Please ask any questions you have now. If you have questions later, you may contact *Orion Mowbray* at omowbray@uga.edu or at 706-542-5441. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, you must sign on the line below. Your signature below indicates that you have read or had read to you this entire consent form, and have had all your questions answered.

Name of Researcher	Signature	Date
Name of Participant	Signature	Date

Please sign both copies, keep one and return one to the researcher.

APPENDIX C

INTERVIEW SCRIPT

STARTING SCRIPT:

Begin interview by *greeting participant, introducing purpose of study, and explaining interview process (informed consent, and administration of ACEs measure followed by interview).*

"Hello! Thank you for meeting with me today to speak about your experience in the MHC Program. Not a lot of studies have examined how participants such as yourself describe their MHC experience, and events in their lives that may or may not have impacted their MHC experience. One thing I am interested in learning is how certain childhood experiences may or may not have impacted you as an adult. Therefore, the purpose of this interview is to learn more about your life experiences, especially relating to your MHC participation.

"I want to start by reviewing the process of the interview with you, including a description of what it entails, as well as your rights. All participation is voluntary, which means that you can decide to stop participation at any point with no penalty. The interview typically takes between 60-to-90-minutes, and involves completion of a 10-question survey, followed by interview questions that I will ask you.

If you give consent, the interviews will be recorded so that the audio can be transcribed later for analysis. The benefits from participation in this research include the opportunity to provide valuable information that can be used to improve the MHC for future participants. There are no foreseeable risks associated with participation. All participants will be provided a $10 Walmart gift card for participation. If you agree to participate, you may withdraw from the study at any point, with no penalty. These interviews will be recorded by the researcher and later transcribed for coding of participant responses. Responses will be kept confidential to the extent that federal, state, and local statues permit. I will now review the consent form with you:

> -*[Review Informed Consent and complete if participant in agreement; complete UGA Cash/Payment Log (obtain signature and date for each gift card administered), provide participants with a copy of the informed consent (highlighting the contact information if they have follow-up questions or concerns), and finally ask participant if they have any questions or need clarification.]*

"To begin, would you be willing to complete a brief questionnaire that asks about events you may or may not have experienced as a child? Your responses will be kept confidential, and you may decide not to answer certain questions or to stop responding if at any point you feel uncomfortable."

> -*[If participant does* ***not*** *agree to completing ACEs measure, thank them and inquire about their interest in completing interview*. If they say no to this, too, say, "Thank you for your time."]*
>
> -*[If participant* ***does agree****, provide participant with a paper copy of the ACEs questionnaire, a pencil, and say, "Thank you. You may read and answer the questions on your own, or I can read them out loud to you-which would you prefer?"]*
>
> - *[If prefers to* ***complete independently*** *say, "Okay thank you. This is the questionnaire, and it asks you to check here (indicate where on paper) if you have experienced each event. Let me know if you have any questions."]*
> - [*If prefers to have the questionnaire* ***read out loud*** *say,* "Okay. The directions state… *(read from ACEs questionnaire)."]*
>
> -Upon completion of ACEs questionnaire say, "Thank you for answering those questions about experiences that you may or may not have had as a child. Now I would like to hear more from you in your words about (these and) other experiences in your life, including your MHC experience. To begin, could you tell me…" *(see interview guide)*

CONCLUSION SCRIPT:

"Thank you very much for your time. Your answers are a valuable tool in understanding how to help improve the experiences and outcomes of MHC participants. Some people may experience different feelings after talking about life events, including adverse childhood experiences. If you feel you wish to talk to someone further after discussing these topics, you may talk to your current mental health provider (if applicable), or here is a number that you can call to connect you with resources."

APPENDIX D

ACES MEASURE

Adverse Childhood Experiences Questionnaire

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often or very often** … Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt?
   ______Yes ______ No   If yes, enter 1
2. Did a parent or other adult in the household **often or very often** … Push, grab, slap, or throw something at you? **Or Ever** hit you so hard that you had marks or were injured?
   ______Yes ______No   If yes, enter 1
3. Did an adult or person at least 5 years older than you ever … Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?
   ______Yes ______No   If yes, enter 1
4. Did you **often or very often** feel that … No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?
   ______Yes ______No   If yes, enter 1
5. Did you **often or very often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ______Yes ______No   If yes, enter 1
6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
   ______Yes ______No   If yes, enter 1
7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ______Yes ______No   If yes, enter 1
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   ______Yes ______No   If yes, enter 1
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ______Yes ______No   If yes, enter 1
10. Did a household member go to prison?
   ______Yes ______No   If yes, enter 1

APPENDIX E

SEMI-STRUCTURED INTERVIEW GUIDE

I. Background Information:

1. When did you first become a member of the *[County One or County Two]* MHC?
2. How did you come to be involved in the MHC?

II. ACEs, Paths to MHC Involvement, and MHC Programmatic Experience:

1. Looking at your responses to the written questionnaire you completed at the beginning of this interview, I see that you experienced *[summarize frequency of individual # of ACEs reported, if zero see below*]* difficult childhood experiences. How do you feel these experiences impacted the behavior you just described led to you become involved in the MHC?"

**[If participant did not experience any ACEs or indicated they do not feel the ACEs they reported have impacted their behavior leading to involvement in the MHC ask ,*"How did these experiences impact you in any way after they occurred?" *and/or* "What are any other events or experiences that have occurred in your life that you believe may have impacted the behavior that resulted in you being involved in the MHC?"]

2. How did anyone in the MHC program help you address these experiences and their impact on your behavior?

**[If responded reports that they did not address these experiences/impact during the MHC program, consider following up-prompt:* "How might getting support from MHC program staff for these issues have been helpful?"]

3. What was your overall experience like as a court participant?

4. Did you experience any difficulties as a court participant?

5. When you were a participant in the court, what did you think your life would be like after you graduated?

6. How did you feel as you moved closer to graduating from the court?

III. Outcomes/Experiences Since Graduating from MHC:

1. When did you graduate from the court?

2. How have you been since graduating from the court?

3. How have the childhood experiences [*or other life experiences if appropriate*] you mentioned affected your behavior affected you since graduation?

4. What did you learn through being a court participant that you still use to this day?

5. Was there anything you learned as a court participant that turned out to be not useful?

6. Have you had any legal problems since you graduated from the court?

7. Do you still have any contact with any of the services you received while you were a court participant?

8. Were there any other ways the court helped or did not help you, especially related to the events you experienced as a child *[if applicable]*?

IV. Recommendations for Improving MHC:

9. Looking back. What would be most helpful to assist court participants graduate and stay out of trouble in the future?

10. What kind of recommendations would you make to the court staff to help participants?

11. Do you know what the word "resilient" means? *[provide summary of definition]*
*You evidence strong resiliency because you graduated from the MHC, something that not all participants do. What do you believe has made you resilient?

12. What else (if anything) would you like to add?

APPENDIX F

PARTICIPANT HANDOUT

Sometimes talking about these experiences may be difficult and may lead to you to experience feelings that can be potentially distressing. If this happens, we encourage you to reach out to your current therapist or treatment provider. You may also call the **Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Referral Helpline at 1-800-662-HELP (4357)** if you need help finding support. Thank you for speaking with us. The information you gave can help improve the program.

APPENDIX G

SAMPLE SECTION OF CODEBOOK

THEME	CODE	SUB-CODE	DEFINITION
#1: PREVELENCE OF ACES	ACE Frequency	None	0 ACEs
		Low-to-medium	1-3 ACEs
		High	4+ ACEs
	ACE Category	Abuse	ACE Measure Items 1-3
		Neglect	ACE Measure Items 3-5
		Household Challenges	ACE Measure Items 5-10
	ACE Type		ACEs Measure Item 1
			ACEs Measure Item 2
			ACEs Measure Item 3
			ACEs Measure Item 4
			ACEs Measure Item 5
			ACEs Measure Item 6
			ACEs Measure Item 7
			ACEs Measure Item 8
			ACEs Measure Item 9
			ACEs Measure Item 10
#2: IMPACT OF ACES ON MHC INVOLVEMENT	MHC Involv.	Weak Impact	-0 ACEs -Effects of ACEs had little-to-no impact on criminal behavior/arrest
		Moderate Impact	-Effects of ACEs impacted criminal behavior/arrest + other factors -Effects of ACEs had some impact on criminal behavior/arrest
		Strong Impact	-Effects of ACEs directly related to criminal behavior/arrest
#3: IMPACT OF ACES ON MHC	MHC Exp.	Positive Experience	-Restorative/healing -Beneficial to overall well-being

PROGRAM-MATIC EXPERIENCE			-Would recommend to others
		Mixed Experience	-Some parts were restorative/healing and some parts were harmful -Some parts were beneficial, and some parts were unbeneficial -May recommend
		Negative Experience	-(Re-)traumatizing/ harmful -Unbeneficial to overall well-being -Would not recommend to others
#4: IMPACT OF ACES ON MHC OUTCOMES	MHC Out.	Recidivated and Vulnerable	-Re-arrested -Not meeting mental health needs -Relapse/substance misuse
		Recidivated but Resilient	-Re-arrested -Meeting mental health needs -Sobriety
		Resilient and Thriving	-No re-arrests -Meeting mental health needs -Sobriety